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THE ROLE OF IDENTIFICATION IN THE RESOLUTION OF TRAUMA: THE ANNA FREUD MEMORIAL LECTURE

BY HAROLD P. BLUM, M.D.

In studies on the consequences of trauma, identifications have too often been overlooked. Trauma is experienced as an assault and can lead to an automatic, unconscious identification with the aggressor. Trauma is associated with a constellation of identifications, including identification with the aggressor, with the victim, with the rescuer, and with the caregiver. Identifications are important for the recovery from and mastery of trauma.

The concept of identification with the aggressor was formulated by Anna Freud as a chapter in her classic book, *The Ego and the Mechanisms of Defense* (1936). It is related to the mastery of stress and shock trauma and to the tendency of the ego to be active where it was formerly passive or helpless. Identification with the aggressor can be seen in situations ranging from pediatrics to politics, from child abuse to terrorism. The concept is intrinsic to the explanation of why abused children may become abusive parents, why haughty snobbery may follow social humiliation, and why hostages of terrorists may adopt the convictions of their captors. Anna Freud's work with children and their parents has demonstrated the continuous interaction of psychic reality and external reality. Identification with the aggressor is an intrapsychic reaction which takes into account real models and threats, and actual traumatic experience.

Building upon the work of Freud and Anna Freud, I shall

The Anna Freud Memorial Lecture was presented in Vienna, November 14, 1986.

elucidate the significance of identification in the recovery from and consequences of psychic trauma and in the mastery of danger, passivity, and helplessness. Identification has too often been overlooked in studies of psychic trauma. The identifications consequent to trauma may be adaptive or maladaptive, beneficial or pathogenic, transient or permanent. Further, identification with the aggressor may be an inevitable outcome of trauma.

The tendency to identify with the aggressor is rooted in the child's use of identification to overcome feelings of fright and helplessness, and to obtain aggressive as well as libidinal gratification (Arlow, 1986). Identification with the aggressor is a subset of the universal tendency toward imitative identification and later identifications in the service of defense and mastery, coping and competence. The child who uses imitative identification to feed itself and feed the mother will later comfort the doll as the child has been comforted by the mother. Identifying with the mother who is absent and then reappears, the toddler whom Freud (1920) discussed discards and retrieves a spool as part of the mastery of separation anxiety and anger. The developmental roots of identification with the aggressor are indicated in what Spitz (1965) described as identification with the "no" and the beginnings of internalization of parental prohibitions which the child will verbalize in the latter half of the second year. Identification with the aggressor, however, is a far more selective response than the fluid, imitative, and global identifications of earliest life.

As important as identification with the aggressor is for ego and superego function and for the restoration of psychic equilibrium after trauma, the resolution of trauma also involves other kinds of identifications. (Trauma, as I shall use the term here [A. Freud, 1967], implies a state in which the ego is so overwhelmed that it cannot cope, is reduced to archaic modes of defense, and is forced into regression.) There are always additional identifications, even if they do not have the same clinical and developmental significance. Study of the traumatized

individual also reveals identification with the victim, the rescuer, the comforter, and with love objects in their caretaking and sustaining roles.

Object loss may lead to trauma and to its perpetuation if there is no substitute object available and no caregiver or comforter. Whereas the early literature on object loss emphasized identification with the lost object (Freud, 1916-1917), current developmental studies have indicated the importance of identification with surviving and sustaining objects. In the case of loss of a parent, the child or the adolescent cannot complete development without having other love objects to turn to. Identification with the lost object is usually combined with identification with the surviving objects. Identifications are universally involved in attempts at restitution or replacement of the lost object and revenge for the loss. Identification is not the only defense or means of adaptation in recovery from trauma, and trauma itself may have pathogenic or adaptive consequences, depending on vulnerability and mastery (Rangell, 1967). Nor does ego activity in cases where the ego was formerly immobilized necessarily depend upon identification. The nature of the identifications which are related to the traumatic situation may depend on past object relations; thus identification with the aggressor or with the rescuer may repeat earlier identifications. Within the constellation of identifications, paired self-object representations, e.g., the self as secure and the object as endangered, may be used to screen their opposites (Kernberg, 1983). In broad context, the individual's predisposition to trauma and the effects of the trauma are connected to ego capacities and object relations (Neubauer, 1967).

Patients who have been so traumatized and structurally damaged that disorders of object relationship and identification occur may constitute an exception to the typical outcome of the process of identification. Beyond undifferentiated "primary identification," identification is a relatively sophisticated process which may be radically altered in cases of deep regression, or as a result of developmental arrest or deficit. In such patients the

process of identification may have been impaired so that they are not able to utilize identification appropriately. Identification may only be along regressive lines, or it may be fragmentary, shifting, and imitative. In severe cases, there may also be fragmentation or fusion of self- and object representations; the more developed and complex concepts of identification with the aggressor and victim, perpetrator and protector, may not apply.

Anna Freud demonstrated the particular relevance of identification with the aggressor for superego development, and she also demonstrated its clinical importance for the understanding of melancholia and paranoia, and for excesses of blame, criticism, and reproach. Identification with the aggressor is associated with projection of blame and guilt; it is a defensive configuration which combines introjection and projection. When this defense is prominent, the individual tends to be hypercritical without being self-critical. Since the object, endowed with aggressive and punitive qualities, is not securely internalized, the process of internalization is not necessarily brought to completion. Identifications, such as identification with the aggressor, are found to be part of an unconscious fantasy system, but conscious fantasy is not excluded. Fantasies of being an object, or the same as or like an object, may contribute to the process of identification, the identifications being elaborated in fantasy (Abend and Porder, 1986). Identification with the aggressor involves role reversal in fantasy: the attacked person exchanges roles with another individual who then becomes the attacked victim (Sandler and A. Freud, 1985). The role reversal in fantasy may be enacted in behavior, often as part of the repetition of traumatic experience. What is unique in relation to trauma, in addition to the victim's tendency toward repetitious behavior, is that identifications are extraordinarily predictable, whereas in ordinary life, identifications are relatively unpredictable.

Identification is usually associated with love. Paradoxically, there is an automatic identification in states of traumatic terror. Trauma is frequently, perhaps inevitably, experienced as an as-

sault. The helplessness of the ego is compensated for by identification with the aggressor, an expectable defense and a mode of adaptation. Children or adults introject characteristics of the anxiety-provoking object or the aggressor and thereby attempt to assimilate the experience of panic and helplessness to which they have been subject. Anna Freud (1936, p. 113) stated, "Here, the mechanism of identification or introjection is combined with a second important mechanism. By impersonating the aggressor, assuming his attributes or imitating his aggression, the child transforms himself from the person threatened into the person who makes the threat."

Identification with the aggressor, while automatic in the case of trauma as experienced or threatened aggression, frequently occurs in less extreme forms of unpleasant or distressing situations. One of the earliest reports of identification with the aggressor can be found in Freud's reactions to being frustrated in his professional ambition to become a university professor. The appointment of Freud and some of his friends was being prevented by anti-Semitic sentiment within the government. Freud (1900, p. 137) dreamed that one of these respected friends, R., was his uncle, a man who had been considered a fool and a disgrace to the family because of some criminal activity. Freud's interpretation revealed that in the dream he was accusing his friend R. of being a fool and his friend N. of being a criminal. Anti-Semitism would therefore not be the cause of their not having gained appointments; they would not have deserved the appointments because of these other reasons. In further analyzing the dream, Freud essentially outlined identification with the aggressor. This identification gratified underlying motives of power and vengeance. Freud observed, "In mishandling my two learned and eminent colleagues because they were Jews, and in treating the one as a simpleton and the other as a criminal, I was behaving as though I were the Minister, I had put myself in the Minister's place. . . . He had refused to appoint me *professor extraordinarius* and I have retaliated in the dream by stepping into his shoes" (p. 193).

In *Beyond the Pleasure Principle*, Freud (1920) further illus-

trated the significance of this change from the passive to the active role as a means of assimilating unpleasant or traumatic experiences in infancy: "If the doctor looks down a child's throat or carries out some small operation on him, we may be quite sure that these frightening experiences will be the subject of the next game; but we must not in that connection overlook the fact that there is a yield of pleasure from another source. As the child passes over from the passivity of the experience to the activity of the game, he hands on the disagreeable experience to one of his playmates and in this way revenges himself on a substitute" (p. 17). Identification with the aggressor is related to strain as well as to shock, and under favorable inner and outer conditions, it facilitates the transformation from panic to pleasure, from peril to play. Identification with the aggressor in a dream or in a vengeful daydream of "turning the tables" is not structurally equivalent to forms of enactment. When the identification is confined to fantasy, to controlled play, or to verbalization rather than being acted out, it may be assumed that the trauma has probably already been partially mitigated or mastered.

Trauma is unconsciously interpreted; it has importance not only in the economic sense of the ego's being overwhelmed, but also in the way in which it is unconsciously understood (Fenichel, 1945). Trauma may be experienced in terms of aggression, transgression, punishment, masochistic gratification, the validation of death wishes, violent fantasies, etc. After the traumatic experience, the ego attempts to control frightening, chaotic overstimulation and to give meaning to nameless panic and the confusion about what really happened. Consider the case of the Wolf Man, in which the patient's developmental disturbance was related to severe infantile trauma (Freud, 1918). His identifications with his tormented, hypochondriacal mother in his beating fantasies and his identification with the victimized Christ were related to his prominent maternal identification in the primal scene. The Wolf Man as Christ, born on Christmas Day, also identified with Freud as God, the omnipotent parent

who would protect and comfort him eternally. The Wolf Man's elaborate fantasy system included multiple identifications with parents and parent surrogates and with the analyst with whom he unconsciously anticipated and feared repetition of his infantile traumatic experience. As is typically the case with what seems to be a single shock trauma, the Wolf Man's primal scene would now appear to telescope traumatic experience from all levels of development.

Whether due to accident, illness, or surgery, whether the result of a natural or a man-made disaster, whether sought or provoked, the traumatic situation itself usually mobilizes aggression and sadomasochistic fantasy. The individual identifies with the aggression and anger of the attacking object. But the mobilization of the person's own internal aggression and punitive tendencies is also very important. Pointing to the angry attacker, traumatized patients may defend against awareness of their own rage. The position of victim (or victimizer) may be held tenaciously, and identification with either the victim or the aggressor may be a formidable resistance in psychoanalytic treatment.

Children and immature adults cannot realistically assess responsibility for injury or trauma. The parent may be blamed for the child's discomfort and pain, and illness itself may be unconsciously misinterpreted by the child as an attack by a persecutory or punitive object. The parent may also be blamed for being unable to comfort the child sufficiently or for not omnipotently making the pain go away and restoring the child to health. The mother, of course, cannot meet the demand to kiss the injured area and ease the hurt. Identifications occur with anxious parents who are themselves frightened by the child's illness or injuries; and such identifications are combined with identifications with the medical staff who all too often contribute to, rather than alleviate, the trauma. Illness, hospitalization, and surgery, perceived as an assault (as in "heart attack"), may also intensify the untamed aggression in the identification with the aggressor. In addition to the harsh handling and the

cold indifference that are all too often components of scientific medicine, altered states of consciousness, painful procedures, and confinement, with various degrees of immobilization and surrender of control over bodily functions, inevitably tend to be experienced as aggression and punishment.

Along with identifications with the aggressor, with the victim, and with comforters and caretakers, there are frequently fantasies of rescue and rebirth. A constellation of such identifications can be inferred in clinical studies of trauma, for example, in Holocaust survivors (Bergmann and Jucovy, 1982). In situations of helplessness, identification with the aggressor has an anxiety-relieving protective function, restoring to the ego a sense of power and mastery. Since aggressive issues may be more potent and pressing in the traumatic situation and since an aggressor may actually dominate the situation or may have usurped the role of the caretaker, identification with the aggressor may become more prominent and powerful than any other form of identification. In the traumatic situation itself, there is no comfort and no opportunity for assimilation or verbalization; recovery from traumatic helplessness and terror can occur only after the traumatic situation is no longer a reality. "Crisis intervention" may terminate the trauma and then assist in recovery and reintegration. Identifications with the rescuer, protector, and therapist are important in the process of recovery.

Psychoanalysis began with the study of actual child abuse. Freud never abandoned the concept of the reality of traumatic experience. When he gave up the seduction theory, he did not negate the importance of seduction and other forms of trauma. In addition to the importance of constitutional disposition—for example, the child's own seductive tendencies, vulnerability to stimulation, or tolerance of anxiety—Freud early noted that seduction trauma occurs in a family setting of overstimulation and lack of protection. Siblings who had already been seduced by an adult, especially those seduced by a parent or other close adult relative, were likely to seduce younger siblings. This was

an example of the identification of the older child with the aggressor or abuser, so important in the re-enactment of the traumatic experience.

The child's identification with the abuser includes the tendency to enact the abuse. Turning passive into active, and achieving illusory power through identification and role reversal, some individuals inflict trauma on others. They may derive reassurance, revenge, and gratification from the helplessness and horror of their victims. The majority of muggers and rapists have been abused in their own childhood. Some sexually abused children have been genitally mutilated, in punishment for their own and their parents' participation in incest. A parent identified with the aggressor and projecting blame and unconscious guilt may appear to be self-righteous; the child will be regarded as wanton and wicked, in need of harsh discipline. Through identification and the repetition of trauma, the sins of the parents are indeed visited upon the children through the generations. Aggression, retaliation, and punishment may become condensed and almost indistinguishable.

The abuse may be denied and isolated and never mentioned in a conspiracy of silence. The identifications may also interfere with superego regulation and integration. The harsh, punitive superego of the abused child may at the same time be lax and inconsistent. Irrational and illict behavior may be simultaneously condemned and condoned. This behavior may invite punishment directly, or indirectly through identification with the victim.

Identifications are not always permanent and may undergo varying degrees of developmental transformation. The internal world of self- and object representations changes with identifications and developmental accretions and modifications. Past identifications uncovered and observed in psychoanalysis may not recapitulate the original process or product of identification; identification with the aggressor may not endure unchanged after mastery of trauma (Blum, 1986).

The nature of the identifications at the time of and subse-

quent to the traumatic experience is determined by a number of factors. These include the innate endowment of the child, the developmental phase and personality organization at the time of the trauma, the reactions of parents and caretakers, and the influence of antecedent and later experience. The child's identification with the caretakers is of immediate significance. It is clearly a pathogenic complication if the child cannot turn to the parent for comfort and protection because of the parent's absence, abusiveness, or emotional unavailability. Trauma will be intensified by the absence of caregivers and comforters; feelings of abandonment may be a critical dimension of the traumatic situation. Some individuals may be able to utilize fantasy objects for comfort and protection. Whether this is based on magical thinking, denial, idealization, or the capacity for self-comfort (Furer, 1967) is significant for the outcome. There are great variations in the capacity to endure pain and deprivation, and to comfort oneself. For the individual to endure and surmount trauma, much depends on the degree of self and object constancy, and on core superego benevolence.

One of the most difficult clinical problems may be determined both by parental demand for the child's silence and by the child's identification with parental silence. Even in the adult, this may take the form of superego injunctions against remembering, reporting, and comprehending the traumatic experience. The conspiracy of silence may be maintained as a masochistic bond, as well as to avoid further punishment and loss. Revealing and facing the truth may be felt as a breach of promise which would increase rather than diminish the shared burden of responsibility and guilt within the family. The enforced silence may be a fantasy elaboration of the parents' actual attitudes, but it may also become internalized along with impairment of curiosity and alterations in the sense of reality.

On the other hand, more resilient children may displace their curiosity into other areas, sometimes highly sublimated. A child who has suffered repeated bouts of illness may become a meteorologist who warns against impending storms or a doctor who

cures and prevents disease. Doctor games are well known for the enactment of voyeurism and exhibitionism and the repetition of trauma experienced in the course of medical and dental care. Close inspection of some of these games in their later derivatives will reveal that the doctor, representing the parent, is simultaneously perceived as the caretaker, aggressor, and rescuer. Rescue fantasies, so often shared by parent, doctor, and patient, sometimes contribute to masochistic character and masochistic perverse tendencies. Actual efforts to salve the pain and even save the child's life may contribute to the child's condensation of or confusion over helping and hurting, caring and tormenting. The child's identification with the doctor as aggressor, but also as rescuer and comforter, may contribute to associations of salvation through suffering. Relief of pain and release from stress may lead to fantasies or enactments of self-induced, self-regulated pain which has a happy and pleasurable conclusion. It must also be noted in passing that a number of children have actually been traumatized by parents who are themselves doctors, dentists, and nurses. These children have sometimes been subjected to all manner of procedures and manipulations, enemas, infusions, and injections without the parents' conscious realization that the doctor games of their own childhood and derivatives of their own traumata are being repeated with their children. When identification with the comforter turns out to be an important component of reaction formation against cruelty, the kindly comforter may all too readily change into the cruel abuser. Some correctly perceived reality usually survives denial, confusion, and deception. Even in the phase of post-traumatic stress syndrome, following initial recovery from traumatic shock, the traumatized individual may distinguish between conscious helpfulness, dissimulation and hypocrisy, and disguised sabotage or sadism.

The attitude of caretakers, the community, and the culture is important in the recovery of all traumatized individuals, but the relationship to and identification with the caretakers is of critical importance for the traumatized child. The child's defenses

may be modeled on those of the parents: the child may identify with their calm and reasonable attitudes or with their denial and isolation and their protective detachment. The child may also identify with the parents' self-recrimination, taking on the parents' guilt. The parents, in turn, may not only project guilt and blame but also evoke feelings of guilt in the child, stressing how much the child was at fault—in causing the accident, in making herself or himself and the parents miserable, in not heeding parental advice or admonitions, in concealing sexual molestation from one or both parents, etc. Since children lean on parents for their sense of reality, doubt about what really happened and confusion between fantasy and reality may be fostered by parental attitudes. When trauma is compounded by parental denial, doubt, or falsification of reality, the child's immature judgment and reality sense will be impaired, as will the developing superego. When a child has been severely traumatized, the parents are simultaneously stressed. Their own modes of coping and attempted mastery, with which the child may identify, may impede or promote the child's recovery and ego reorganization. In the case of sibling loss, the child may not be able to obtain comfort from parents who are themselves grieving and depressed and unable to help their child cope with the common loss. The loss of the sibling is even more likely to impair the development of the child if the parents are unable to talk about the traumatic experience with each other and with their child.

The following clinical vignette illustrates such simultaneous child-mother stress and shock trauma, and the importance of identification in the resolution of trauma. This complicated case appears particularly instructive for its relevance to the reciprocal identification of child and parent, under conditions of prolonged traumatization and strained recovery. In this case identifications with the aggressor and with the protector were clearly demarcated in the patient's associations and in the transference. Splitting of the ego was associated with denial and dissociation, and the patient's self and object world tended to be

divided between love and hate, idealization and denigration, protection and punishment (Freud, 1940; Blum, 1983). The aggressor was also the persecutory and punitive illness as an attacking object, and the protector was also the comforter and rescuer.

An adult woman began analysis ostensibly because of a marital crisis. She considered her husband to be a philanderer who had betrayed her trust, cheating her sexually and financially, and driving her "crazy." She was hypersensitive to noise and was very angry at herself for being a party to loud altercations. She vacillated between shouting accusations and imprecations, being immersed in depressive silence and avoidance, and having feelings of remorse and mature concern for her family. Despite all the discord, she retained a core of basic trust and object love. During the analysis it developed that she was sensitive to any feelings of injury or rejection, had always been fearful of illness and injury, and had earlier intimidated her parents with threats of self-injury. These threats were also unconscious expressions of her hostile dependency and her demand for their love and protection. The self-punitive and punitive trends were derivatives of childhood traumata, with attempts at omnipotent manipulation and mastery.

When she was four and five years old she had suffered from recurrent pharyngitis and mastoiditis requiring several hospitalizations. The hospitalizations included anesthesia and surgery for tonsillectomy and for mastoidectomies. The surgery had been preceded by several excruciatingly painful myringotomies (lancing of her eardrums). She had many feelings about her head and about disturbances in the head; these were related to her fears of going crazy and of penetration and impregnation through the ear. Identifying with Christian martyrs, she was also both the Virgin Mary and the wicked whore who had disobeyed her mother. She had been defiant, dirty, and a masturbator. Her illness was unconsciously regarded as retaliation and punishment for her shortcomings and transgressions. Her mother was frantic about her child's frightening recurrent ill-

nesses with their fever, pain, confusional states, and threats of complications of meningitis and encephalitis. The patient had fantasies of crushing her husband's skull, and then cradling the crushed victim in her arms like the Virgin holding the limp, crucified Christ in the *Pietà*. Her ambivalence was associated with both cruelty and compassion, and her conscience required undoing and expiation. These fantasies were related not only to her own "head injuries" and fears about brain and ego damage but also to the specific effects of her illness upon her parents, and to her mother's conflicts in particular.

The patient had two types of daydreams which she referred to as heterosexual and hostile, on the one hand, and homosexual and comforting, on the other. Heterosexual rape fantasies were related to the repeated otolaryngological procedures and to the fact that her parents and the medical staff would forcibly hold her while she was being examined. At times the mother would plead for the child's cooperation and try to allay her fears and pacify her; at other times she would scream at the child and tell her that she was unfair to the doctors and ungrateful for their patience and therapeutic efforts. The patient looked to her mother for help, but the mother was not consistently available with appropriate behavior. The trauma of the illness, the surgery, the intense parental anxiety and ambivalence, and the probable simultaneous traumatization of the parents, were all condensed in the violent, abusive rape fantasy. Sometimes the rapist demonstrated some compassionate concern after the attack. The compassionate concern, however, was far more openly expressed in the patient's wishes for comfort and consolation in the homosexual fantasies.

The abuse and affection were largely dissociated from each other as the representation of her mother was sometimes split between the wicked witch and the devoted loyal lover. In another dissociation, her father and mother were respectively assigned opposite negative and positive qualities, her father associated with her male doctors as aggressor-seducer, and her mother regarded as caretaker-protector. Repetitive trauma had

contributed to various forms of dissociation and confusion. She and the analyst were both victim and aggressor in the transference-countertransference field.

While the fantasy of homosexual love included accretions from all layers of development, it was particularly related to her phase-specific oedipal traumas and to the pathetic pleading of the desperately ill child for comfort and consolation. The female lover held the patient's head against her bosom, cradling her head and rocking her, stroking her long beautiful hair. The patient's hair had actually been cut and her head shaved at the time of the surgical procedures. She had later desired to have long full hair to cover the mastoid scars. The scars were also psychological lesions, representing her feeling of castration, narcissistic injury, and inferiority.

In the transference the patient would complain about my having her head in a vise. She often felt that my interpretations were piercing and painful and that my voice was too harsh, too loud, too abrasive. Initially, she experienced the couch as a rack; the pillow was like a rock. This repetition of trauma in the transference coincided with her fear of re-experiencing pain, panic, and helplessness. She would be very hurt and angry when I did not directly respond to her or answer her questions. This proved to be related to her mother's avoidance of the subject of the patient's life-threatening illnesses and to the lack of any clarification about the recurrent traumatic situation, or any acknowledgment of the parents' enmeshment in the traumata. Her doctors and nurses offered sweets and sweet talk without real clarification or confrontation of the child's anxiety. She unconsciously identified her husband with her mother, and she identified her husband's deception with parental and medical deception. In the initial phase of analysis, she was unsure whether she really had my ear, whether I could truly separate the important signals from all the noise, whether I would be able to tolerate all her complaints without turning a deaf ear. Later, identifying with the comforter, she would offer to console and comfort me for all that I had to put up with, both with

her and with my other patients. She accepted responsibility for the "grief" she caused her children, and she wondered how her parents had survived her survival. As she became more affectionate and empathic, the regression/progression balance shifted favorably.

During one of the patient's early hospitalizations, her mother had a miscarriage. Simultaneous traumatization intensified the interidentifications of mother and daughter as aggressor-victim, with reciprocal demands for care and comfort. Her mother's miscarriage increased the patient's guilt because of her intolerance of any rivalry for maternal affection and attention. Similarly, the miscarriage probably increased her mother's guilt concerning both her sick child and the lost fetus. The patient's identifications with the aggressor and with the comforter were fantasy elaborations and distortions of her parental and medical models. Her identifications with aggressor and rescuer were also related to doing and undoing (killing and curing) and to her efforts at self-comforting and at consoling her parents, as well as to her parents' mutual recriminations and attempts to comfort each other. The parents and the child feared recurrences of the traumatic illness, while denying their vigilance and concern. The parents in this case, as in so many others, were both a help and a hindrance. Parents have a significant influence upon a child's recovery and upon the child's further vulnerability to traumata or resilience in the face of life's adversities.

To sum up, repeated traumata suffered by the patient, involving recurrent illnesses, hospitalizations, separations, anesthesia, and surgery, were related to her oedipal phase and to ego development. In addition to overwhelming the ego, trauma has special psychological significance in terms of pre-existing conflicts and unconscious fantasy elaboration. In such cases, defense is inevitably intensified, including identification with the aggressor and with the protector. The defenses associated with trauma may also serve "to buy time," and temporary denial may permit a moratorium, a psychological respite during which

resumption of progressive ego function promotes recovery. Reorganization can then be more gradually and effectively accomplished, particularly with the help of the benevolent and supportive relationship of love objects. New identifications fortify the earlier internalization of affectionate care and helpful intervention. Identification proceeds unconsciously according to the child's needs and style and includes identification with the aggressor and with the victim, identification with protective and with punitive objects.

The helplessness, passivity, and panic of the traumatized child can be mitigated by the presence of a reassuring parent and an empathic medical staff. On the other hand, trauma may be intensified when the parents are simultaneously traumatized or when they are a traumatic influence or perpetrators of the trauma, as in cases of child abuse. Parental denial, regression, and confusion may be internalized by the child, which adds to the child's cognitive confusion arising from the traumatic situation. Trauma is often associated with unconscious guilt and stifled rage and with the need both to accuse and to exonerate the parent and the self. Traumatized patients tend to anticipate recurrence of the traumatic situation, with both fear of and need for repetition. Omens and other warnings may be sought in the effort to avoid, prepare for, or master traumatic recurrence. Where the trauma has been recurrent, as in the case of repeated illness, and where this is feared by both parent and child, the anticipatory search for signs and omens is likely to be intensified as vigilance is maintained against surprise attack. Ego and superego function may become progressively altered and constricted. Trauma tends to arrest development at the time of the traumatic experience. Fixation to the trauma may have a persistent pathogenic influence on subsequent development.

My patient had remained anxious and depressed, with intense feelings of volatility and fragility. She lacked a sense of self-confidence and felt that she would not be able to take charge of her life. Affective numbing coexisted with immature affect storms. Inappropriate affect would appear with the re-

turn of the repressed. Emotional reactions would be enacted with the wrong persons and in the wrong places many years after the traumatic experience of childhood. Her marital problems reactivated unresolved traumata and were complicated and aggravated by her own inner conflict. The "punishing" parent, to whom her husband was unconsciously linked, was split off from the "protective" parent, as one means of dealing with traumatic assault. The recurrent trauma itself may have been unconsciously interpreted by the child, and by my adult patient in crisis, as counterattack and vengeance for her own inner resentment and rage. As the trauma is repeated in the transference, the analyst is bound to be experienced by the patient as hurter and helper, as omnipotent protector and deliberate attacker.

Nightmares, symptomatic acts, play, and regressive transference reactions which repeat traumatic experience demonstrate crucial identifications consequent to trauma. The identifications will be important to the understanding of the traumatic situation and its aftermath, and will be related to earlier and current attempts at mastery of trauma. Even in the face of bombing and violent destruction, children have been noted to be relatively calm, given the reassuring presence of their parents, just as parental panic readily induces reactive panic in the child (A. Freud and Burlingham, 1944). Crucial identifications with caretakers may ameliorate or aggravate the effects of trauma. Whether trauma reinforces a dominant developmental phase, or whether it leads to severe regression and possibly to ego and developmental phase disorganization, depends in part upon the child's relationships with the parents and their capacity to resist regression and to maintain a stable and healthy personality organization. Traumatized individuals who can help themselves and help others may be not only those with unusually resilient endowment, but also those with powerful identifications with objects who maintained stability, and were helpful and comforting in times of crisis.

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ON THE VICISSITUDES OF FREUD'S EARLY MOTHERING

I: EARLY ENVIRONMENT AND LOSS

BY HARRY. T. HARDIN, M.D.

Utilizing case examples and published accounts of Freud's infancy, I attempt to demonstrate that an upheaval in Freud's life, with a desperate turning to his mother and to oedipal issues, was the result of the loss of his nurse.

Freud lost his nursemaid when he was two years and eight months of age, an event which occurred suddenly, when the nursemaid was apprehended and jailed for stealing from the family. Some forty years later the first stage of Freud's self-analysis culminated in the retrieval of memories of her. Utilizing findings from a clinical study of primary surrogate mothering, I wish to re-examine Freud's early infant-mother relationships, as analyzed by Freud and elaborated by others in the psychoanalytic literature.

In three letters written in October 1897, Freud (1887-1902) reported to Fliess that important material had come to light in his self-analysis. On October 3, he stated that

> my "primary originator" [of neurosis] was an ugly, elderly but clever woman who told me a great deal about God and hell, and gave me a high opinion of my own capacities; [and] that later (between the ages of two and two-and-a-half) libido towards *matrem* was aroused. . . . If . . . I succeed in resolving my hysteria, I shall have to thank the memory of the old woman

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> who provided me at such an early age with the means for living and surviving (pp. 219-220).

That night he had a dream:

> She was my instructress in sexual matters, and chided me for being clumsy and not being able to do anything. . . . Also she washed me in reddish water in which she had previously washed herself . . . and she encouraged me to steal "Zehners" to give to her (pp. 220-221).

On October 15, he wrote that he had asked his mother if she remembered the nursemaid.

> "Of course," she said, "an elderly woman, very shrewd indeed. She was always taking you to church. When you came home you used to preach, and tell us all about how God conducted His affairs. At the time I was in bed when Anna was being born" (Anna is two-and-a-half years younger) "she turned out to be a thief, and all the shiny Kreutzers and Zehners and toys that had been given you were found among her things. Your brother Philipp went himself to fetch the policeman, and she got ten months" (pp. 221-222).

And further on in the same letter:

> But I have another unexceptionable and amusing piece of evidence. If the woman disappeared so suddenly, I said to myself, some impression of the event must have been left inside me. Where was it now? Then a scene occurred to me which for the last twenty-nine years has been turning up from time to time in my conscious memory without my understanding it. I was crying my heart out, because my mother was nowhere to be found. My brother Philipp (who is twenty years older than I) opened a cupboard for me and when I found that mother was not there either I cried still more, until she came through the door, looking slim and beautiful. What can that mean? Why should my brother open the cupboard for me when he knew my mother was not inside it and that opening it therefore could not quieten me? Now I suddenly understand. I must

> have begged him to open the cupboard. When I could not find my mother, I feared she must have vanished, like my nurse not long before. I must have heard that the old woman had been locked, or rather "boxed" up, because my brother Philipp, who is now sixty-three, was fond of such humorous expressions, and still is to the present day. The fact that I turned to him shows that I was well aware of his part in my nurse's disappearance (pp. 222-223).

In the course of these three letters the nursemaid emerges in Freud's memory as a figure of great significance—she provided him "at such an early age with the means for living and surviving"—only to be obscured by the image of his mother in his associations to the cupboard scene.

During the next twenty-seven years Freud made further interpretations of that screen memory. After noting in 1901 (p. 51) that the "sudden disappearance of the nurse had not been a matter of indifference to me," he concluded that the memory represented an absence of his mother and her return following his sister's birth, in a slim, unpregnant state. A footnote added in 1924 modified the strong affects described earlier: "I was crying my heart out" became transformed into a mild "affect of disappointment" derived from "the superficial motivation for the child's demand," a wish for his mother's return. At a lower level of his unconscious the cupboard represented his mother's womb. When he could not reconcile the empty womb with the affect of disappointment, he wrote, "On the other hand, his great satisfaction over his mother's slimness on her return can only be fully understood in the light of this deeper layer" (Freud, 1901, pp. 51-52, n.). The nursemaid had been consigned to oblivion once again.

Erikson (1955) acknowledged Freud's self-analytic breakthrough "to the first 'pre-historic Other' of them all: the mother, or rather the mother-image, as shared by his natural mother and by his old Kinderfrau . . ." (p. 10). He believed Freud's infantile trust and gratitude, described in the letter of October 3, 1897, provided evidence of an intense infant-nurse

tie. In addition, he interpreted Freud's urge to see Rome as a return of the longing for his *Kinderfrau*. However, he limited the duration of the nursemaid's care of Freud to the period "when his mother gave birth to the first siblings" (p. 10). Gedo (1968) implied that the complex "two mother" childhood situation and Freud's "unresolved infantile longings for the two pregenital mothers" were factors contributing to the interminability of his self-analysis. Commenting on the child's intense attachment to his nurse, he concluded, "My thesis is that an infantile depression, caused by a presumed interruption of his original mothering, had been relieved by a close attachment to his Nannie from whom he was separated at age three. This trauma was transcended through repression of pregenital issues" (pp. 115-116).

In contrast, Schur (1972) confronted the "family legend," i.e., Freud's dreams, memories, and associations, with "actuarial truth." He noted that a register of maids working for Jewish families in Freiburg yielded information that the Jacob Freud family shared a maid with the family of Emanuel Freud. Also, he explained that the Freud women frequently worked in the warehouse of the family business, packing goods, while a maid cared for the children. He concluded that Freud's *Kinderfrau* was only a half-time nurse, "actually a simple maid" (p. 124). He believed the sudden loss of the nursemaid was significant only in the context of other happenings in Freud's childhood.

In a comprehensive study of Freud's dreams involving the nursemaid, Grigg (1973) equated the nurse with his mother, the former serving as a displacement, or "medium," for Freud's oedipal strivings toward the latter. Swan (1974) concluded in the same vein, "Freud's discovery of the oedipus complex emerges not only from memories of a small boy's guilty, aggressive lust for his mother, but from memories of dependence on her, too, —a dependence remembered, however, as a seduction of a small bourgeois, Austrian boy by a Czech working-class woman . . ." (p. 64). Blum (1977) noted that Freud's references to the nursemaid in his letters represent one of the first of his preoed-

ipal reconstructions. Blum regarded the cupboard recollection as a "haunting memory concerning separation from his nursemaid, also representing his beloved mother" (p. 768). In a footnote, Blum stressed his idea that the nursemaid was probably used as a "screen for his mother . . ." (p. 768, n.).

In general, these writers acknowledged the nursemaid's importance in Freud's development. Some observed that she was one of Freud's two mothers; others noted his unresolved longing for her, at times speculating about her role in the evolution of his ideas about religion and in the train phobia. All agreed that she was important, functioning as a displacement or screen figure for his natural mother. However, they stopped short of considering her to have been a significant figure in her own right, i.e., as Freud's primary caretaker during much of the time she worked in the household. The same can be said of their writings about the influence on his development of the tragic loss of that beloved figure. In this regard, the authors followed Freud's lead, adhering to his interpretation of the screen memory of the cupboard:

> The cupboard scene described to Fliess . . . which kept recurring from Freud's childhood related to maternal abandonment and to his mother's pregnancies. Probably also . . . it dealt with wished-for nonpregnancies . . . i.e., the empty womb (Harrison, 1979, p. 406).

In an introductory paper (Hardin, 1985), I reported on a group of patients who, like Freud, had histories of intense relationships with surrogate mothers whom they subsequently lost. The following case examples, condensed from that paper, demonstrate that during treatment data emerged indicating that surrogate mothers were distinct and significant figures in my patients' infancies. Insights derived from these patients may help us to better understand Freud's experience of mothering.

My first patient's vague description of his mother revealed a profound alienation from her. My questions about early care-

takers led to his recollection of a live-in maid who had cared for him and a sibling while their mother worked long hours in the father's business. The nursemaid entered the household when my patient was born and remained until he was about three years old. Together they slept in her room and enjoyed listening to the radio. Often, since she was deeply religious, she took her Jewish charge to Catholic church with her. A disagreement about days off led to her sudden departure.

While contemplating his early history he came upon a recurrent memory, which filled him with longing:

> I am sitting on the kitchen counter in our house, beside the radio which is playing. My mother is there, her back to me, doing the housework. I am very sad (Hardin, 1985, p. 615).

Social work interviews with his mother and sister added to our understanding of the meaning of this kitchen screen memory. Components associated with sudden loss of the maid were clearly evident: deep sadness, the kitchen, the radio playing, and his mother's back.

His sense of alienation from his mother was noted in his psychological test responses as well. He perceived women with capes, hoods, and masks. In a Thematic Apperception Test response a mother had both eyes closed, unaware of what was happening around her.

In her initial interview, my second patient, a young woman, quickly focused on her deeply troubled relationship with her mother. Although she behaved as if her acute suffering followed a dramatic shift in that tie, it became clear that she had felt alienated from her mother throughout her life.

> She is so phony. She isn't real with people. I dream of her as a witch with her back turned toward me, laughing. I feel like I'm in a "twilight zone" with her and it's frightening! I'm haunted by my resemblance to her and I feel I'm of a different species. I have no perspective on her (Hardin, 1985, p. 616).

Her early history, revealing the presence of a primary care

nurse during her first two and a half years, clarified the emotional turmoil surrounding the mother. In addition, it furnished clues about her first memory, a scene in a bedroom of her childhood home. In that recollection, while her mother insisted that she was a big girl, she was moved from her crib to a bed, desperately grasping at the sheets because she feared she would fall. Her mother later explained she had shared the room with the nurse.

The memory concealed the bewildering loss of the beloved nurse and the longing for her, an interpretation supported by her later childhood behavior concerning that room. She frequently napped in the doorway, pulled tufts from the carpet at its threshold, and chipped away at the beige paint on the windowsill to uncover the blue paint of her early years.

Later, she recalled a nightmare in which a woman, viewed from the back, showed a strong resemblance to her mother. On turning around, the woman revealed herself as a stranger; the patient became agitated and confused when the woman behaved as if she were her mother. Fearful of the fate of the mother, the patient awoke. This nightmare was interpreted as portraying the childhood situation at the time the patient lost her nurse. Alienated from her daughter because of the child's intense relationship with the nurse, the mother had become a stranger.

Psychological testing lent supportive evidence to this reconstruction. In the Rorschach the patient perceived two women fighting over a baby they both loved. Her Thematic Apperception Test responses were replete with nurturing figures other than natural mothers.

My last example is a distillation of the second analysis of an executive in his mid-thirties who sought help for difficulties in forming intimate relationships with women. He described his mother in terms which lacked warmth and closeness. Rather he maintained a worshipful attitude toward her, an admiration for her spiritual and physical qualities which appeared to represent some distortion of the incest barrier. For long periods during

the analysis he was respectfully remote from me, behavior which appeared to indicate a maternal transference. Early in treatment he began a relationship, largely fantasized, with a computer programmer in his plant. Though she was neither socially nor intellectually appealing, her simplicity and physical softness provided him with a sense of tranquility. A parapraxis associated with her name introduced to the analysis his nursemaid from early infancy until he was two and a half years of age. This relationship had been an exclusive one because of his mother's depression during that time. The surrogate mother left to be married, an event which coincided with the birth of the patient's brother.

The patient's involvement with his employee represented a repetition of his infantile situation, with the analyst serving as mother and the employee as surrogate. Only after many months did behavior indicative of a surrogate mother transference[1] evolve. He associated an intense desire for eye contact with me to "sinking deeply into the warmth of Nan's [the nursemaid's] eyes." Such yearnings evoked considerable anxiety; it became evident that approaching closeness threatened repetition of the past tie with his surrogate and the painful experience of her loss. Other memories of the nursemaid slowly surfaced, such as images of her black hair (like that of his employee) and of the pattern of a dress she had worn. In a later stage of the retrieval of memories and images of Nan, we became aware that the experiences inevitably resulted in an apparent merger of the "two mothers," in which the image of only one—the biological mother—was retained. Ultimately, as the image of Nan repeatedly emerged and disappeared during the treatment, the process was perceived to be similar to that of an eclipse, a term denoting the specificity of the obscuring figure—the biological mother—and the efficacy of her screening of the surrogate.

Clinically demonstrating estrangement from their natural

[1] This phenomenon had been anticipated by Blum (1974) in his speculation on Ruth Mack Brunswick's being the Wolf Man's "Nanya."

mothers, these three patients presented a history of early primary surrogate mothering which terminated during their third year. In the analysis of their memories, dreams, and, in the last case, surrogate mother transference and eclipsing phenomena, the image of the natural mother was perceived to screen the surrogate. From the point of view of the clinical observer, in these examples natural mothers replace surrogates in the patients' emotional lives. The presence of the natural mother (i.e., the "remaining" mother) serves to screen from the infant its experience of the catastrophic loss of the surrogate. When memories of the lost and longed-for early figures return in treatment, painful affects associated with that relationship are re-experienced.

In my view, the eclipse of the surrogate mother, as revealed in the treatment of these patients, embodies an essential element of Freud's repetitive memory of the cupboard. Freud achieved a remarkable insight when he associated the cupboard with jail and the sudden loss of his nursemaid. Like my patients, in his self-analysis he was faced with a formidable task: bridging the gap between mother and nursemaid to re-experience the intensity and exclusiveness of his tie with the latter and the anguish following its severance. It appears that Freud was unsuccessful in achieving this goal.

There is little direct information about Freud's mother in his published works, as noted by Grigg (1973). Gedo (1968) attributed Freud's attachment to his nursemaid to "some temporary disruption in Freud's unusually close relationship to his doting mother. (The intensity of Amalie Freud's preference for Sigmund is vividly described in Martin Freud's memoirs [1957])" (p. 106). In the same vein, Blum (1977) commented, "Doubtless the most important relationship . . . which is not delineated in his 1897 comments or in the analytic literature on his letters or dreams is the (rapprochement) relationship with his mother" (p. 768).

●ther investigators turned to Freud's scientific writings for inferences about the mothering he received. Bowlby (1969)

stated, "In reading [Freud's] works we are at once struck by the fact that it was not until comparatively late that he appreciated the reality of the infant's close tie to his mother, and that it was only in his last ten years that he gave it the significance we should all give it today" (p. 361). Bowlby suggested that this circumstance might have stemmed from Freud's having so many patients who were raised by nannies. Blum has consistently commented on the significance of the mother and the role of surrogate mothers both in Freud's early life and in the lives of his patients. Elaborating on the Wolf Man's multiple mothers, Blum (1974) wrote, "The mother-child relation and maternal influence (as in the other Freud case histories) is in the background and hardly considered" (pp. 734-735). Likewise, he noted, about Freud's nursemaid, "We do not have the data to indicate just how important a mother surrogate and how significant an influence his Czech Catholic nursemaid was . . ." (1977, pp. 767-768).

Harrison (1979), seeking evidence of early traumata that distorted Freud's rapprochement phase relationship with his mother, wrote, "Even in the mid-thirties he still had not taken the infant's early experiencings of its mother fully into account . . ." (p. 402). Among many such references in Freud's writings he quoted the 1931 passage about primary maternal attachment:

> Everything in the sphere of this first attachment to the mother seemed to me so difficult to grasp in analysis—so grey with age and shadowy and almost impossible to revivify—that it was as if it had succumbed to an especially inexorable repression (p. 226).

Both Bowlby and Harrison reflected on the far-reaching effects on psychoanalysis of Freud's neglect of the infant-mother relationship. Harrison (1979) concluded, "Momentous consequences for psychoanalysis have followed upon Freud's displacement of causative factors in human development from the personal early life to the postulated archaic history. With the

emphasis on parricide the infant-mother relationship was eclipsed" (p. 404). Expanding on Blum's ideas about Freud's preoedipal and oedipal reconstructions, and implicating Freud's remarks on oceanic feeling, he asserted that "Freud simply isolated the most traumatizing aspects of his early life with explicit aversion" (p. 414). However, Harrison overlooked the importance of preoedipal trauma surrounding Freud's love for, and loss of, his surrogate mother, as well as its possible contribution toward the development of his life-long "shadowiness" where the infant-mother tie was concerned.

The nature of Amalie Freud's mothering is not known. This will continue to be the case until further insights concerning that mother-child relationship are gained from the existing literature or until further information becomes available. Whatever maternal attributes she possessed—there is no evidence of deficiency in this area—her functioning as a mother was dependent as well on the total environment she shared with her child. Writers generally place emphasis on Julius's birth and death, and Amalie's third pregnancy, as reasons for the disruption in Freud's relationship with his mother, rather than examining the total mothering environment (Blum, 1977; Harrison, 1979; Lehmann, 1983; Schur, 1972).

Sufficient information about the early marital background of Freud's parents does exist to make possible an evaluation of factors which could have impeded or interrupted Amalie Freud's ability to mother. At age nineteen she married a man twenty-one years her senior, already twice married, the father of two sons, and a grandfather. Following the marriage, she, a Viennese, moved to a small town in Moravia where she immediately became pregnant with Sigmund. Her stepson, Emanuel, five years her senior, his pregnant wife (two years older than Amalie), and their two-year-old son lived nearby. Across the street was the home of another stepson, Philipp, Amalie's own age (Bernfeld, 1944; Jones, 1953; Schur, 1972).

In this family situation, Amalie Freud was expected to function as matriarch, wife, and eventually mother, roles requiring

the maturity of someone twice her age. The extent to which she leaned on others for support, including maids, both before and after Sigmund's birth, is unknown. Many distressing, even tragic, months followed, with trauma sufficiently overwhelming to effect an increasing involvement of others in her life, and, more significant for this paper, in her son's care. When Freud was about fifteen months old, she gave birth to Julius, only to lose him eight months later (when she was pregnant with Anna, and when Sigmund was still wetting his bed [Jones, 1953, p. 7]). Several months later, the twenty-three-year-old mother gave birth to Anna. Concurrently, the nursemaid disappeared; Freud was then two years, eight months of age.

The ease with which the figures of the nursemaid and his mother became interchangeable during his self-analysis and in his dreams implied that the nursemaid was a constantly available, though not necessarily exclusive, figure in Freud's infancy, at least until late in his mother's pregnancy with Julius. Available information regarding Freud's second and third years indicates that the woman became, in effect, his sole caretaker when Julius died, a near exclusiveness that continued to the time of her disappearance.

Given this milieu, Freud's earlier mentioned gratitude may have been directed to the nursemaid as a real, rather than a displacement, figure, through his practicing and rapprochement phases as well as at the beginning of emotional object constancy. The surrogate mother-child relationship may have maintained and prolonged Freud's infantile grandiosity and omnipotence through difficult times. His mother's comment supports this speculation: "She was always taking you to church. When you came home you used to preach, and tell us all about how God conducted His affairs" (Freud, 1887-1902, p. 221). It is likely that Freud's churchgoing with his nursemaid was highly significant in terms of the closeness of their tie. One can imagine the bright, precocious little boy, adept at conversing and "preaching" in Czech, winning the affection and special regard of the nursemaid. Her presumed theft of the "Kreutzers

and Zehners and toys" may have been, in part, the result of activity typical of the rapprochement phase (ironically making Freud an accomplice). Such activity, according to Mahler, Pine, and Bergman (1975), involves "the toddler's continual bringing things to the mother . . . objects that he [has] found in his expanding world. . . . the main emotional investment [lies] in the child's need to share them with her . . ." (p. 90).

Freud's analysis of his screen memory seems valid insofar as it pertains to: 1) some degree of loss of his mother, e.g., during pregnancies and perhaps other separations; 2) early experience of his mother and his nursemaid as complementary and interchangeable; and 3) his mother as an idealized, available figure. In the screen memory these facilitated a condensation of his mother as herself and as a cover for the lost nursemaid.

That Freud was unable in his self-analysis to comprehend the full impact of the indelible childhood experience latent in the cupboard memory is apparent throughout the time it held his attention. From the beginning comment, "unexceptionable and amusing piece of evidence," to one twenty-seven years later citing an "affect of disappointment" rather than "crying my heart out," Freud revealed a circumvention of memories and affects associated with the sudden loss of the nursemaid and his desperate search for her. In his analysis, the affect associated with losing the surrogate became split off from the idea and attached to a lesser fear—that of the temporary loss of his mother.

The screen memory ended with a manifest return of his mother after a short absence, "looking slim and beautiful." Freud uncovered latent meaning in her appearance, interpreting slimness as a sign of her being restored to him after his sister was born. Later he added that her slimness satisfied him because he "was full of mistrust and anxiety that his mother's inside might conceal still more children" (1901, p. 51, n.2: 1924 footnote). Her restoration to Freud did, in fact, occur following the nursemaid's disappearance. Freud appeared to view the slim and beautiful mother and the empty cupboard as synonymous with an exclusive relationship with her. This may have

represented a longing to revive the past, i.e., the months following his birth during which his mother alone may have cared for him. However, equally pertinent to the theme of his mother's return is Freud's wish, in an urgent turning to his mother, to regain the kind of exclusiveness he despaired of having when his nursemaid disappeared.

A number of my observations in analytic work, in particular the analysis of the third patient discussed above, show a remarkable similarity to the situation in Freud's childhood depicted by the cupboard screen memory. Like Freud, this patient described his mother in terms of beauty and bearing rather than motherliness, demonstrating alienation, idealization, sexualization. My patient's first analysis had focused primarily on oedipal issues, involving what appeared to be a limitless rage toward his father; this concerned his father's role in causing his mother to be unavailable to him. He developed a strongly ambivalent relationship with his brother, behaving at times as if this sibling did not exist.

Similarily, when Freud turned to his mother, he was confronted by the necessity of sharing her with siblings, with his father, and with her other involvements and responsibilities. In addition, like my patients, he probably lost some of the ability to adapt to his mother, to cue with her (Mahler, Pine, and Bergman, 1975), because his involvement with the nursemaid resulted in some separation from his mother. This was a mutual loss, shared by mother and son, creating an emotional distance between them.

It is a distant mother, a disappointing replacement for the surrogate, who twice entered the scene immediately following a recollection about the nursemaid. In both memories, she is sexualized.[2] Thus, in the October 3, 1897, letter, Freud's introductory remarks about the nursemaid preceded his comment, "li-

[2] This occurred as well in the interpretation of the bird-beaked figures dream, where Freud (1900) denied anxiety over the fear of losing his mother. "The anxiety can be traced back, when repression is taken into account, to an obscure and evidently sexual craving . . ." (p. 584).

bido towards *matrem*," which was presumably aroused in him on a trip to Vienna more than a year later. The other allusion was contained in the screen memory of the cupboard: his mother came in the door, looking slim and beautiful. The entry of a sexualized and idealized mother into Freud's self-analysis appeared to be a re-enactment of his oedipal situation.

In short, Freud's discovery of the oedipus complex in himself may have occurred because of a unique family constellation and the situation in which it arose. One could speculate that when Freud, a grief-stricken little boy, turned in desperation to his natural mother after the loss of his nursemaid, he was hurled into an oedipus complex. His desperate reaching out for his mother was countered by rejection in the form of a bewildering lack of exclusiveness, as noted in the October 15, 1897, letter: "I have found love of the mother and jealousy of the father in my own case too . . ." (Freud, 1887-1902, p. 223).

Other consequences of Freud's intense involvement with the nursemaid may have cast an even deeper shadow on his struggle to reunite with his mother. During the practicing and rapprochement periods, through the mirroring (Mahler, 1968) imparted with some exclusiveness by his nursemaid, Freud, as described earlier, suffered a separation from his mother. Because the nursemaid was able to adapt to his separation-individuation process along a significant portion of its course, the child had moved closer to her and had become emotionally less the son of his mother. Freud was then confronted by a mother from whom, in terms of mutual adaptation over the months of some separateness, he had, to some degree, become alienated. One might infer that a distortion of the incest barrier, noted in my third patient, who, like Freud, suffered such alienation, may have determined the propulsive force of Freud's involvement in an oedipal conflict. It may be that this same distortion facilitated his access to an awareness of the manifestations of the oedipus complex and, thence, to its discovery.

SUMMARY

Writers commenting on Freud's nursemaid perceive her primarily as a displacement figure, a screen for his mother. In three clinical examples I have attempted to demonstrate the emergence of surrogate mothers as distinct and significant figures in the patients' infancies. Like Freud, these patients lost their nursemaids in their third year. In their memories, dreams, the surrogate mother transference, and eclipsing phenomena, the surrogate is perceived to have been obscured by the mother. This screening of the surrogate is postulated as an essential element of Freud's repetitive memory of the cupboard. Further inferences from the literature on his early family environment and his scientific writings support the following reconstruction: unable in his self-analysis to relive the latent tie with his nursemaid and the anguish following her loss, Freud again turned to his mother and, consequently, to oedipal issues.

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ACTIONS SPEAK LOUDER

BY WAYNE A. MYERS, M.D.

Case material is presented from three analyses in which dramatic, unexpected movements by patients on the couch dominated the analytic hours for long periods of time. The psychoanalytic literature pertinent to this area of acting in is reviewed, and some formulations regarding the shift from verbalization to motor behavior are presented. These center on the proposition that the patients had identified with aggressor parents who regarded actions, not words, as the ultimate conveyers of reality. The analyst's use of countertransference responses as clues to the understanding of the actions is discussed.

Analysts normally expect that in the analytic hour patients will enter the office, lie down on the couch, and proceed to relate their thoughts and feelings; in other words, to free associate. Analysts also expect that patients will bring forth their associations verbally and not by means of actions or movements. A certain amount of fidgeting or postural shifting on the couch is normal, but dramatic movements by patients on the couch are unexpected and unsettling to analysts.

In this paper, I will present clinical material from three analyses in which dramatic, unexpected movements were a prominent feature of certain periods of treatment. Although the patients involved were all highly articulate, verbal individuals, they never felt that words alone were sufficient to communicate intense emotions to other people, or to defuse within themselves the intensity of powerful affects, once they were experienced. Only actions were felt to be of any real value in handling these problems. For these patients, actions truly spoke louder than words.

After presenting the clinical material, I will review the literature on the subject of movements within the analytic hour. From this review of the thoughts of other analysts and from the historical material garnered from my patients during their treatments, I will attempt to offer an explanation of this fascinating phenomenon. I will also discuss the use of my countertransference responses to these movements, as an aid to understanding their underlying meanings.

CLINICAL MATERIAL

Case 1

Mr. A, a tall, huskily built businessman in his middle thirties, entered analysis because of conflicts with his mother over becoming engaged to his girlfriend. In the past, he had submitted to his mother's wishes and had terminated an earlier engagement. On this occasion, he felt committed to his girlfriend but was extremely distressed about the possibility of a rupture in his relationship with his mother.

Judging from his school and work successes, and from his history of good object relationships in his past, he seemed like an ideal analytic patient. Hence, after a couple of face-to-face sessions, I suggested to him that he commence using the couch, which he did.

During the first week on the couch, however, while relating some sadomasochistic masturbatory fantasies about women, he suddenly sprang over from his back onto his abdomen, into a position in which he was facing me. He then crouched on all fours, as if he were about to spring forward at me, his eyes at a level with mine. My initial response was to be startled by his action. In addition, I managed to lean back so rapidly and so precipitously in my chair that I almost fell over in the process.

This kind of behavior on the part of the patient continued, at irregular and unpredictable intervals, for the next two years of

the treatment. Suffice it to say that our attention to this unique resistance to the process of free association became a major focus of the treatment during this period. From our analysis of his behavior, we came to recognize that Mr. A's aberrant movements during sessions had a number of important historical determinants. I was frequently aided in my endeavor to help him uncover the genetic roots of his actions by ongoing analysis of my countertransference responses to his movements.

Initially, I felt "startled" and "assaulted" by his behavior, "rudely shocked" out of my usual analytic reverie. In addition, I felt "forced" into action, and here I specifically mean forced into speaking to him, and angry at having to do so "against my will." At moments of repose after the sessions were over, I began to reflect upon what was happening and what I was experiencing. In so doing, I began to feel a growing sense of conviction that the patient must be reversing a pattern of childhood experiences with me, turning passive into active, in a sort of belated identification with the aggressor.

When I first began to question him about his desire to frighten and assault me, he quickly concurred with this idea. He related this wish to his own intense fear that I would harm him for having revealed to me his angry, sexual desires concerning women. In his mind, I had become a combination of his angry, punitive father and his cold, domineering, narcissistic mother.

As we proceeded further, and particularly when I addressed the issue of his forcing me to speak by virtue of his having substituted movement for verbalization, we came to understand something of the intensity of the fear which he had experienced as a child when his mother had administered enemas for his frequent constipation. By forcing me to speak, he was reversing his mother's enema assaults and getting me to talk and to end my own "verbal constipation," essentially by "scaring the shit" out of me. Needless to say, the movements also contained a message for both of us in terms of reversing the feared, yet desired, anal homosexual assaults from me on the couch: earlier in his life he had feared and wished for such assaults both from

his father, because of his sexual desires for the mother, and from the "phallic" mother of the enema assaults. This was related to conflicts with her over issues of dominance and submission and to his sense of himself as a separate individual and as a man.

As we came to understand the various determinants just mentioned, the frequency of the dramatic actions lessened considerably. The movements did not cease, however, until we recognized his need to make me feel almost as futile in my own verbal endeavors, my interpretations, as he had felt in his early verbal interactions with his parents. When I finally commented on this to him, he noted:

> No matter how many times I used to scream out to her to stop giving me the enemas when I was a child, it did me no good. It was as if she never heard me. Words were pointless with her. Only when I got older and bigger, and used to pull out the tube and the shit and water would go all over the floor, would she ever listen to me. It wasn't the words I spoke, but what I did, the actions I performed. It's still the same with her now. No matter what I say to her, she never hears me. It's as if I'm speaking to her through a dark, endless ocean of water. My words get drowned before they ever see the light of day. It's futile to even bother trying to talk to her. Only if I flail out at her, do I get her to react to me. It's better to feel her horror and rejection than to babble at her endlessly and not even to see a glimmer of a response go across her face. It's the same thing when I'm on my back in here. I can't even see your face then, let alone tell if you're responding to me. But when I turn like that, I can read you like an open book. I know I've impacted on you then.

Case 2

Ms. B. was an attractive, intelligent woman who entered analysis in her mid-thirties. She sought treatment because of her inability to achieve orgasm during sexual intercourse with her

husband and because of a feeling that she was not fully realizing her potential in her acting career.

From the early weeks of her analysis, she exhibited signs of an erotized transference. At the time that she began to speak about her sexual wishes toward me, she also began to turn from side to side in a very suggestive manner on the couch. She would frequently turn over on her stomach and stare up at me with a seductive gaze. My initial response to her behavior was one of an awareness of the intensity of her sexual desires and of a certain degree of arousal on my own part as a reaction to the sexual nature of her movements.

As her sexually provocative movements continued despite my suggestions that she attempt to analyze her need for them rather than attempt to carry them out, I found myself becoming increasingly irritated by her activity. Her thrustings and turnings on the couch seemed to me to be more defiant in tone than sexual. I had to struggle, during sessions in which she would turn over and face me, to keep myself from becoming emotionally detached from her as an expression of my irritation. As with Mr. A, I felt compelled to respond to her, pressured "against my will" to speak, in order to address the unusual activity.

From my own responses to her movements, I came to recognize that Ms. B was unable to sustain her adult seductiveness for very long. For some reason, her anger and guilt led her to undermine the surface presentation and to adopt a driving insistence in her actions. This insistence not only "turned me off" sexually, but it prompted me to want to withhold from her what she so desperately appeared to want me to give her: my words and my erotic and romantic love. I felt at such times as if I were more involved in a preoedipal struggle for control with a nasty maternal figure than in an erotic interaction with an oedipal girl or a postoedipal woman. From my responses to Ms. B's actions, and from much other data which accumulated in sessions involving the analysis of her movements as resistance to the pro-

cess of free association, a considerable degree of understanding of the genesis of these movements was achieved.

For one thing, Ms. B's father had not responded in her childhood to her verbal protestations of love and affection, nor had a teacher who served as a father surrogate when she became an adolescent. More specifically, her father had always seemed uninterested in her or in what she had to say to him when she was a child. If she "pushed" him, however, she could force a response from him, even though the forced response was most often one of rejection. The parallel with her actions in the transference was obvious.

Similarly, with the idealized teacher during her adolescence, the patient had attempted to show her love and desire for him by performing for him scholastically and theatrically in his class. But this did not draw from him the wished-for level of response. Hence, she felt she had to escalate her level of activity, until she finally resorted to attempting to kiss him one day after class. This only resulted in his rejecting her also, as her father had done.

As a result of these rebuffs, the patient developed a sense of futility and depression about her interactions with men. In an attempt to deny this overriding affect in the transference with me, she would dream of being my daughter and of my being more interested in her than in my wife. Or, consistent with her love of music and her remarkable talent in this area, she would dream of my playing an exquisite instrumental solo to her, which she equated with the wished-for words of love and adoration which I "cruelly and indifferently withheld" from her during our work.

At other times, her rage against her father and other men surfaced toward me in the transference. I was seen as a male chauvinist pig, who only respected creatures with penises. Action was then equated by her with the qualities of being visible and erect, for I, she felt, must believe in the credo that seeing was believing, and the vagina was an "unseen thing" that did not stand out for all to see in its "pristine visibility." Passivity,

which she saw me as equating with beings who were nonentities and blobs, could only lead to her being disregarded. Only if she actively wrested Excalibur from the stone, as she did in one especially poignant fantasy, and attained a phallic equality with me, could she have a meaningful impact on me and not be reduced to being the passive blob who was subject to being beaten and mistreated by men. The projections onto me of her self-perceptions were apparent, as were her masochistic wishes, clearly related to masturbatory beating fantasies.

What was not so apparent, however, was where she derived her image of women as passive, masochistic, castrated blobs. Her mother did not seem to be the source. If anything, Ms. B's mother seemed to be more of a domineering, phallic presence than was her father. Only after the patient recalled the family maid's being sent away, when Ms. B was about four years old, did we come to understand the basis for her image of women. The maid, who was largely responsible for Ms. B's early care, had suffered her ignominious dismissal by the patient's parents without a word of protest. The patient had begged and pleaded with her parents to retain the woman until she was "blue in the face," but her protestations were to no avail. "They barely even noticed that I was talking," she said. "Only when I began to bang my head against the walls did they take any notice. Words never mattered to them anyway, only actions did."

As we came to analyze in greater depth the patient's insistent attempts to force me, by virtue of her actions, to talk to her and to do her bidding, we began to understand more of her early interactions with her mother and with the maid. As was the case with Mr. A, Ms. B had also been involved in continual struggles with both the maid and the mother over control of her feces. When she did not produce the demanded daily bowel movement, she was given enemas, which she also vehemently protested verbally, to little avail. Again, both her own wishes for control over her bodily functions and her sense of herself as an individual were violated by the mother and the maid in the toilet training struggles. These preoedipal defeats became the

prototypes for the later oedipal ones with the father and the teacher, as well as the earliest anlage for her ongoing masturbatory beating fantasies, in which men humiliated and degraded her and treated her as a sexual plaything rather than as a person. The defeats also contributed to her propensity for action, which became so prominent in the analysis.

In speaking both of her career and of her movements on the analytic stage, the couch, she once noted,

> Acting is a way of proving that I'm alive. I feel real when I hear a response from the audience or when I see something in your face, even if it's negative. I feel connected then. I don't have to worry about being dead. Even more, when the audience responds to me in the theater, or you do in here, I get to find out second hand what I'm feeling. I've buried everything so deeply inside of me, because of all the hurts I've suffered, that half the time I don't even know what I'm feeling, until the other person cues me into it by virtue of their response. I make my living by acting, but the words don't mean shit to me, only the actions do. That's where the feelings are, and that's all that counts.

After a long period of analysis, Ms. B finally began to mute her tendency toward action within the analytic sessions. The movements did not entirely cease, however, until she felt that I had experienced, not simply heard, most of the feelings which she had gone through at her parents' hands throughout her life. Thus, through an identification with aggressor parents, the patient was belatedly attempting to master the anxiety and other dysphoric affects which she had suffered at their hands.

In effect, what she did in the early years of the treatment was to attempt to tease me sexually, with the hope that I would make advances which she could reject. I would be the one to feel rejected then, as she had felt as a child with her father and later with the teacher. She would continue to move on the couch, no matter what I said. Through the expression on my face and the tensions in my body, she would know that I was

powerless to stop her, unable to hold her down, as the maid and the mother had done in her childhood. I would be forced to produce words of protest and of pleading, as she had once been forced to produce feces and the vain entreaties to keep the good-mother maid. And the failure of my interpretive endeavors to really modify her behavior in any way would render me as impotent in my own eyes as she had long imagined herself to be. Only when she could read from my response that her performance had consistently been a convincing one, could she feel at peace and let go of her need to act within the confines of the analytic hour. And only then was she able to achieve a more complete sexual gratification in bed with her husband and a greater degree of satisfaction from her performance on the stage.

Case 3

Ms. C was an intelligent, dynamic woman in her early forties, who entered analysis because of difficulties she was encountering in allowing her two-and-a-half-year-old daughter to separate and individuate from her. Her husband was troubled by her presumed overconcern about the child's "health and welfare," as manifested by her tendency to keep the child in the bedroom with them at night to "guard against illness," which, of course, interfered with their sexual activities. He was also upset by an almost contradictory attitude his wife exhibited at other moments, in which she could best be described as being "cavalier" and "rejecting" toward the child's needs, preferring to spend inordinate periods of time with a coterie of drug-using cronies.

Throughout the first year of the treatment, Ms. C. frequently remarked how difficult it was for her to remain supine on the couch. Initially, these comments seemed unrelated to any specific content of the sessions. Toward the latter part of the first year of the analysis, however, as the patient's sexual desires

toward me in the transference crystallized, she experienced repeated episodes of what she referred to as "claustrophobia."

These "claustrophobic" interludes consistently arose in the context of her expressing strong sexual feelings toward me, which she invariably associated to similar desires she had felt toward her father earlier in her life. At such moments, she felt as if my couch were "enveloping" her body, and she feared that her "basic essence" would be "destroyed" or "extinguished." She would then begin to hyperventilate and would frequently find it necessary to sit up with her back toward me, or to turn toward me in a prone or kneeling position, or even to get up from the couch and walk over to the window to turn on the air conditioner. If I were silent at such times, she would frequently exhort me to tell her what was going on that was causing her to feel and to act in this manner, or to reassure her that she would not "go crazy." She spoke of needing me "to talk," so that she could be certain that I was still "in tune" with her and that she was still "okay."

My response to her movements was quite different from what it had been to those of Mr. A and Ms. B. Rather than feeling pushed to behave in a way that was contrary to the manner in which I wished to behave, I felt quite sympathetic to her plight. The severity of her anxiety was obvious, and I felt a desire to move toward her as she walked away from the couch and to comfort her, as one might physically soothe a troubled child. It then became immediately apparent to me, however, that this empathic fantasy represented a means of gratifying her oedipal sexual wishes toward me in the transference, albeit in a regressive form. Also contained within this fantasied countertransference enactment was my perception of both the patient's claustrophilic wish to regress to a primitive state of union with an early maternal imago and her claustrophobic terror at being annihilated within the enveloping womb-couch (oedipal mother) for having displayed her incestuous sexual desires toward me as the oedipal father.

As the episodes of movements on and off the couch con-

tinued during the second year of treatment, the intensity of Ms. C's erotic desires toward me began to escalate, as did her feelings of rejection by me. She consistently complained of feeling "pushed out of the door" by me at the end of analytic hours. Her feelings of rejection and depression were so acute that I began to wonder to myself if I had made an error in my decision to analyze her. Despite my momentary anxieties about the somewhat "primitive" nature of her character structure, we continued with the analytic work.

The "claustrophobic" feelings finally reached a peak of intensity during the latter half of the second year of the analysis, when the patient reported a dream of observing a couple having intercourse, and of then attempting to run away from them when they became angry at her interference with their pleasure and began to chase her. She awakened from the dream in terror when the black earth on which she had been running (which she immediately associated to the color of my couch) seemed to open up and suck her into an airless, dark morass from which she saw no hope of escape.

In relating the dream to me during the session, Ms. C felt an overpowering urge to sit up and then step off the couch and go over to the window to turn on the air conditioner. When the accompanying episode of hyperventilation from which she had been suffering eased up, she was able to inform me, as a second association to the dream, that she had spent the first five years of her life sharing the bedroom and often the parental bed itself with her parents. Although she had no direct visual recall of having seen her parents having intercourse, she felt certain that she must have witnessed them engaging in a variety of sexual acts with each other. The feelings of being both included and excluded from the most intimate details of their lives was seen as being causally related to her sexual yearnings for her father, which she re-experienced toward me in the transference.

In addition, when she was five years old, her parents had divorced and her father had "pushed" her mother and her out of the household. He soon remarried. This turn of events was per-

ceived by the patient as an extraordinary rejection of her by her father, and she easily related it to her feelings of being "pushed out" of my office at the end of analytic hours. We subsequently learned that the mother had also remarried at this time, and the patient had been excluded from the bedroom in the new marital relationship, which only served to heighten her sense of being completely abandoned and rejected.

What also became much clearer, through the patient's elaborations of this series of events, was that her own verbalized desires as a child had had no effect on the parents' actions. Whatever she said to them did not seem to matter. She felt that she did not have any impact upon them at all; otherwise, before the divorce they would not have treated her as if she did not exist by keeping her in the bedroom as a witness to their fights and to their lovemaking. Little wonder, then, that Ms. C sometimes drew her own daughter intensely close to her in her own bedroom, in a conflicted attempt to recreate the early primal scene exposures. Her subsequent periodic abandonments of the child also reflected her belated attempt to master the childhood seductions and abandonments by both of her own parents.

In referring to her propensity for action within the analytic sessions, the patient observed the following:

> It's as if I have to move now, because I couldn't move then [as a child in the bedroom]. I'm sure the fears and feelings of being swallowed up now on the couch are the same as the ones I felt then with them in the bed. I wanted it, yet it must have seemed like death to me then. It's the same thing now, only now it's got the added idea of being forbidden as well. Besides, when I want you, you don't respond, the same way that neither of them responded to me then. Then my feelings well up within me and I can't breathe and I have to get up. Only then, when I'm ready to burst, do I really believe as if I'm getting across to you. I don't think I've ever really put any faith in the communicative value of words. They've never seemed to be enough to me.

Thus for Ms. C, as well as for the two patients previously de-

scribed, the credo of actions speaking louder than words seemed emblazoned in bold relief on the innermost reaches of her psyche. What seemed different about her, as compared to the other two patients, was that she did not seem to feel the need to frustrate my interpretive efforts, to reverse her own childhood sense of impotence vis-à-vis the parents. Rather, she seemed to welcome my help as evidence of my acknowledgment of her existence. She was able to work with my comments quite fruitfully and to work through her proclivity for action to a considerable degree.

REVIEW OF THE LITERATURE

Reports of dramatic, unexpected movements on the couch are not common in the psychoanalytic literature. Such events seem to be most frequently described only in passing, in articles dealing with other subjects. For example, Freud (1909), in his description of the Rat Man case, noted how his patient got up off the couch just before relating the dread obsession about the rats, presumably because of his fear of retaliation by the analyst for his forbidden sadistic wishes. Similarly, in the Wolf Man case, Freud (1918) noted how the patient turned his face toward him from time to time when he feared that Freud would devour him, as the wolf had devoured the seven little goats in the fairy tale which the patient had been telling him.

Sharpe (1930), in one of her papers on technique, referred to a female patient who became agitated and could not remain on the couch when she envisioned the analyst as being similar to the mother of her childhood whom she feared: her mother was always lying in wait to administer a dreaded enema to her. Reich (1933), in his book, *Character Analysis*, mentioned a patient who went through a brief phase of extreme activity during analytic sessions. The man would thrash his limbs about, grab his own throat, pull his legs up, and spread them apart. The actions were conceptualized by Reich as representing a type of

compromise formation between the patient's murderous impulses toward the analyst-father and his defenses against these impulses; involved was his identification with his mother, whom he imagined as having been violated by the dangerous, castrating father.

Reich chose to deal technically with the patient's actions as a resistance to the process of free association. As the patient came to recognize this and to inhibit his movements, the underlying content of the material was presumably able to be more fully elucidated. In my experience, however, while the movements certainly did serve as a dramatic resistance to the process of free association, the introduction of a mere injunction against them, or a direct attempt by the analyst to get the patient to analyze them, was only of limited help. Only after the historical determinants of the movement resistances were clearly understood and worked through, did they tend to disappear.

Schmideberg (1948), in a brief paper on claustrophobia, noted that patients who perceive the analysis as a form of claustrophobic commitment often are unable to remain still on the couch. This is certainly consistent with my experience, and was particularly manifest in the case of another patient I will mention below.

Greenacre (1950), in a paper on acting out, implicated disturbances during the second year of life, when walking, toilet training, and speech are in the process of being mastered, as being of prime importance in the genesis of later tendencies toward action. She saw speech tending to become "degraded in its functioning, being used for exhibitionistic purposes rather than for communication" (p. 461) in individuals with a history of such disturbances. She noted how these patients often utilize bodily gestures and other forms of action as replacement for words in the analytic situation.

In a subsequent paper on the same general subject Greenacre (1963) also cited disturbances in toilet training and exposures to primal scenes as being of importance in the genesis of later in-

stances of acting out. She noted how episodes of acting out during sessions were generally attempts by the patient to deny painful experiences from the past, through an involvement of the analyst in a present-day enactment whose desired conclusion was to undo the painful traumata of childhood. Needless to say, this last factor, and a number of others that Greenacre cited, were of considerable importance in the histories of the three patients whom I have presented.

Deutsch (1952), in his treatise on "analytic posturology," attempted to correlate the appearance of particular movements in sessions with the presence of certain underlying psychodynamic themes and with the idea of enactments in the analytic transference of special interactions with objects from the patient's past life. The overall tenor of his ideas is consistent with the data I have described.

Glover (1955), in his book on psychoanalytic technique, mentioned the regressive use of action by patients in the terminal phase of analysis. He graphically described individuals mouthing inarticulate noises and making wild, inchoate movements, and suggested that the best method of dealing with these episodes is by offering transference interpretations.

Zeligs (1957), in a paper on postural attitudes observed during analysis, coined the phrase "acting in." As an example of acting in, he cited postural attitudes of a patient on the couch, which he related both to underlying unconscious masturbatory fantasies and to selective amnesias of childhood traumata. He saw such phenomena as being closely related to conversion symptoms.

In a similar vein, Rangell's (1959) paper on the nature of conversion also detailed the wild movements of a patient who was able to communicate verbally with his mother but who had to utilize defiant, rebellious actions to interact with his father, in a manner which was later repeated with the analyst. Rangell related the patient's actions on the couch to the state of the transference and saw them as representing a conversion pro-

cess. He further conceptualized the shift from verbal communication back to movements as a means of emotional expression, in terms of ego regression and ego weakness.

Anthony (1961), in an article on screen sensations, mentioned how his borderline adolescent female patient had to sit up unexpectedly when she wondered if he was dead, asleep, or bored and also when she expected that he might attack her. Thus her actions served to mitigate her anger toward him and to diminish her anxiety about his retaliative rage.

Gehl (1964), in a paper on depression and claustrophobia, linked the fear of entrapment within the claustrum with the specific feeling of being unable to move within the enclosed space. This idea seems particularly pertinent to Ms. C's difficulties in remaining supine on the couch.

Asch's (1966) comments about the primitive fantasies associated with fears of entrapment in claustrophobia also seem remarkably relevant to all three of the patients I have described. The fear of being flushed away as a smelly stool, and thereby being forcibly separated from the mother, was one of the important anxiety-producing elements in the early enema struggles with the mothers in the cases of Mr. A and Ms. B. In addition, the fear of the total extinction of the self, through a primitive fantasy of merging with the annihilating maternal claustrum, which Asch also described, was a very prominent feature of Ms. C's anxieties.

Dickes (Panel, 1966), in a panel on regressive states during analysis, discussed a patient who became enraged at him for failing to comply with a request. The patient got up off the couch and refused to talk until Dickes had spoken to him and quieted him down.

Anna Freud (1968), in a paper from a panel on acting out, noted that in adolescents (in particular in delinquents) and in addicts, acting out and the use of movement in place of speech is the rule rather than the exception. She related this to the fact that, in her experience, such disturbances could be traced back to "periods of life before thinking had become an acceptable

substitute for motor action" (p. 168). She further observed that the possibility that reconstructions of the early traumata will aid in the patient's recovery is dependent "not on the quantity or quality of the acting out itself but on the intactness or otherwise of the ego's synthetic function to which the regained material is submitted" (p. 169).

Moore (1968), in a paper contributed to the same panel, noted, "Locomotion provides the means for either independence from or reunion with the mother and inevitably becomes influenced by ambivalence toward the object. If traumatic overstimulation has caused painfully intense libidinal or aggressive impulses, action more than speech becomes the preferred means of preserving either the object or the self by escape to more displaced objects" (p. 184). These latter authors suggest that preverbal traumata unleash excessive amounts of aggression and that this may contribute to the tendency toward action in these patients—to their preference for movement over speech in adult life when they are feeling extreme anxiety.

Giovacchini (1969), in a paper on aggression, mentioned a paranoid schizophrenic patient whom he placed on the couch in analysis. The man writhed and kicked on the couch, screamed out and cried, clenched and unclenched his fists, beat his head against the wall and finally rolled off the couch, thrashed on the floor, and bit the rug before the analyst interrupted the analysis per se, in order to help him regain control over his behavior. It is of interest to note that this man, like Anthony's (1961) patient and my own cases, tended to interpret any postural shifts on the part of the analyst as evidence that the doctor found him uninteresting, which made him feel impotent and enraged. Giovacchini saw the patient's rages as being related to a "loss of symbiotic fusion in the transference" (p. 83).

Gaddini (1982), in a paper on acting out in sessions, described a young woman who was extremely mobile on the couch. She frequently changed position and continually uncovered her legs and exposed her breasts. This patient, however, did not have an erotized transference, but rather denied the presence of the an-

alyst, utilizing him primarily as a narcissistic extension of herself. Gaddini noted how frustrating and anger-provoking such patients can be and how they often render one's interpretive efforts impotent, a finding which is in keeping with my own experiences.

Boesky (1982), in a paper on acting out, noted that action may feel more real to a patient than thought or verbalization, "partly because thinking is reversible and action is often irrevocable and final . . ." (p. 49). He went on to comment that the shift in analysis from verbalization to motor behavior is still not completely capable of being explained, although he saw the strong affects attached to emerging transference fantasies as being largely responsible for such a shift. I would certainly concur with this idea.

Finally, in a recent paper (Myers, 1987), I described the case of a man whose interest in spelunking was a manifestation of a type of counterclaustrophobia. One element involved in the genesis of the man's claustrophobia, and the consequent analytic manifestation of extreme movement on the couch, was his childhood history of testicular entrapment in the inguinal canals. His confusion of the movements of his testicles into his inguinal canals during defecation with the movements of the fecal balls themselves lent a special intensity to his fear of being flushed away from his mother by an expulsive anal birth from the claustrum. In addition, the anxiety aroused when his testicles would become trapped in the inguinal canals during his childhood was an important forerunner of his adult fears of his total self being trapped in confined spaces, such as on the couch (his claustrophobia).

DISCUSSION

In the histories of the three patients I have described, as well as in those of most of the cases cited in the literature review, early strain traumata (such as chronic primal scene exposures, repeated enema assaults, or the frequent occurrence of testicular

entrapment within the inguinal canals) seem to be implicated in the genesis of the later dramatic movements observed on the couch during the analytic sessions. In addition to having shared similar traumata early in their lives, the patients in question also had in common the experience of having been brought up in households where the narcissistic parents were either indifferent to or inimical to the needs of their children. I refer here to the needs of the children to experience themselves both as separate individuals, with unique feelings and wishes of their own meriting respect, and as emerging sexual beings requiring appropriate positive feedback to bolster their sense of themselves as adequate and desirable males and females.

Another feature shared by my patients, and by many of those described in the literature, can best be described as an identification with aggressor parents. Here I am addressing the need of these individuals to reverse the narcissistic mortifications they passively experienced as children at the hands of their parents in later adult interactions with the analyst. They have dealt with hypertrophied aggressivity resulting from the childhood narcissistic traumata in a variety of ways, such as by the prominent use of sadomasochistic sexual fantasies, along with a concomitant inhibition of actual interpersonal sexual activity and gratification, and by other behavioral and occupational inhibitions which seem geared toward preserving important object relationships.

My experience with these three patients, as well as with the patient interested in spelunking, and my understanding of those described in the literature lead me to believe that the majority of patients who exhibit a propensity for movements during analytic sessions also possess tendencies toward action outside of the sessions as well. It would probably be most reasonable to state that all of these patients can be placed along a broad continuum in which those exhibiting actions only in sessions are at one end and those manifesting actions only outside of the analytic hours are at the other.

What is harder to explain, however, is why certain patients

exhibit greater degrees of activity than others do, whether in or out of the analyst's office. Constitutional factors aside, the most frequent explanations offered seem to focus on the proposition that a causal relationship exists between early traumata and the concomitant derailment or distortion of the developing functions of speech and thought, with a consequent need to underscore the reality and cogency of action as opposed to verbalization. While it is probably safest to say, as Boesky (1982) did, that we cannot adequately explain the shift in an analysis from verbalization to motor behavior, I would like to add here a few more thoughts on this issue.

From my work with my patients, it seems apparent that their early struggles with their parents over autonomy and individuality, whether in the sphere of locomotion, toilet training, or sexuality, had their verbal components but were generally settled by concrete actions, such as forcing the child to have an enema or disregarding the child's existence when having intercourse, etc. Thus, only actions tended to be regarded by both the parents and the children as being the ultimate conveyors of reality. The development of the sense of reality in such individuals therefore tended to be organized around actions rather than verbalizations. To these people, actions truly did speak louder than words.

In addition, it seems clear that the early and ongoing disappointments which they experienced at the hands of narcissistic or indifferent parents had left them angry and with a sense of impotence regarding the value of verbal communication. Only through the use of action could these individuals achieve any sense of having an impact on their parents, even if the impact was negative.

The idea that this type of interaction with the parents was an ongoing one over a period of many years also helps to account for the fact that actions per se became the most prevalent means, in such individuals, of defending against a variety of anxieties stemming from different psychosexual and ego developmental levels. Since the action mode was the one most fre-

quently utilized by the parents themselves in dealing with their own affects and anxieties, this predisposed the patients to the later identification with the aggressor which I have described.

Also, for these individuals, actions often brought them into contact with their own blocked-off feelings, particularly by eliciting responses from others which helped to identify and clarify the warded-off affects within themselves. In addition, actions restored a sense of control, of potency, and of being alive to these patients, who often feared that they were out of control, impotent, anesthetic, entrapped, or dead, both concretely and emotionally. And finally, actions in the analytic hours represented an attempt by such patients to engage a new object, the analyst, in a type of re-enactment of past struggles, in the hope that this time around they could belatedly be mastered.

A few final words on countertransference seem in order here. When patients exhibit these dramatic, unexpected movements during analytic hours, we are likely to feel startled, anxious, and irritated in response. Such responses, including involuntary movements of our own, may often help to provide us with clues, as Jacobs (1973) noted, to the underlying meaning of the patient's behavior and to the type of reversal and re-enactment of the past which they wish to engage us in. Self-analysis can then be utilized to modify the dysphoric affects aroused within the analyst by the patient's behavior and to help to restore an appropriate feeling of empathic attunement.

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Topsy—Living and Dying: A Footnote to History

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TOPSY—LIVING AND DYING: A FOOTNOTE TO HISTORY

BY LYNN WHISNANT REISER, M.D.

This paper explores the significance of Marie Bonaparte's book, Topsy: The Story of a Golden Haired Chow. *The manifest importance of* Topsy *has been attached to the fact that the Freuds translated it out of gratitude to Bonaparte and because of their love for dogs. Another level of significance emerges when the book is placed in historical context.* Topsy *elucidates the relationships between Marie Bonaparte, Sigmund Freud, and Anna Freud. It reflects Bonaparte's feelings about Freud's illness and is part of an ongoing dialogue with him. The persistent misplaced emphasis on the "dog story" has obscured the more profound issues. The author suggests that the conflicting needs to appreciate transience and to avoid mourning may account for both the importance of the book and for its obscurity.*

I

INTRODUCTION

In its English translation, *Topsy: The Story of a Golden Haired Chow*,[1] by Marie Bonaparte, is a slight volume, only seventy-nine pages, wrapped in a black and silver dust jacket. Its cover carries a picture of a fluffy chow standing in a field of flowers. The book is illustrated by black and white snapshots of this dog.

The author gratefully acknowledges the contributions of Peter Gay, Ph.D., Elizabeth Young-Bruehl, Ph.D., Lottie Newman, and Morton F. Reiser, M.D., who commented on earlier drafts of this manuscript.

[1] All quotations are from Bonaparte (1940). Hereafter, the book will be referred to as *Topsy*.

Topsy appears to be a storybook. The type is large and the chapters brief, with titles such as "Dogland," "Topsy and I in the Garden," "Magical Dog," "Topsy by the Sea," "Lethal Lullaby." The sudden incongruity of "lethal" as a modifier for "lullaby" is startling. A premonition stirs that this book may represent something other than a delightful memoir of a favorite pet.

A further clue to the significance of the book appears on the dust jacket. A single sentence is printed there: "Sufficient indication of the enduring worth of this unusual dog story is the fact that the German translation was made by Sigmund and Anna Freud."

This paper explores the previously unnoticed significance of Marie Bonaparte's book. The manifest importance of *Topsy*, as expressed by Anna Freud and by subsequent biographers, has been attached merely to the fact that the Freuds translated it out of gratitude to Marie Bonaparte and because of their love for dogs.

Another level of significance emerges when the translation of the book is placed in historical context. The Freuds translated *Topsy* into German during the fifteen months just before their flight from Vienna. The full impact of the book, however, is apparent only when its subject matter is related to events in Freud's life at the time of the translation and to the parallels between these events and those occurring in Marie Bonaparte's life.

Topsy is presented as a lovely dog story with a happy ending. This "fairy tale for adults" sets forth a perilous situation, shows how it is overcome, and ends in a state of bliss. However, underlying this simple plot is a profound meditation on living and dying.

Topsy had a cancer of the oral cavity, the same location as Freud's cancer. The dog suffered the same symptoms and received treatments similar to those given Freud. Nowhere in the book, however, was this explicitly acknowledged. In the correspondence between Freud and Marie Bonaparte during these months, the similarities and the significance of this and other parallels are evident.

Topsy elucidates the relationships between Marie Bonaparte, Sigmund Freud, and Anna Freud. It reflects Marie Bonaparte's feelings about Freud's illness and is also part of an ongoing dialogue with him. It also suggests something about the nature of Sigmund Freud's relationship with his daughter, Anna (as seen through Marie Bonaparte's eyes), as does the fact of father and daughter having chosen to undertake this task of translation together.

This paper calls attention to the way in which the persistent misplaced emphasis on the "dog story" obscures the more profound issues noted above. It also suggests that the simultaneous conflicting needs to appreciate transience and to avoid mourning, discussed in 1916 by Freud himself, may account for both the importance of the book and for its obscurity.

A letter from Freud to Marie Bonaparte in December 1936, acknowledging the receipt of the manuscript, *Topsy*, was the first mention of the book (E. Freud, 1960, pp. 434-435):

> My dear Marie
>
> Just received your card from Athens and your manuscript of the Topsy book. I love it; it is so movingly genuine and true. It is not an analytical work, of course, but the analyst's thirst for truth and knowledge can be perceived behind this production, too. It really explains why one can love an animal like Topsy (or Jo-fi)[2] with such extraordinary intensity: affection without ambivalence, the simplicity of a life free from the almost unbearable conflicts of civilization, the beauty of an existence complete in itself; and yet, despite all divergence in the organic development, that feeling of an intimate affinity, of an undisputed solidarity. Often when stroking Jo-fi I have caught myself humming a melody which, unmusical as I am, I can't help recognizing as the aria from *Don Giovanni*:
>
> A bond of friendship
> Unites us both . . .
>
> And if you, at the youthful age of fifty-four, can't help thinking so often of death, are you surprised that at 80½ I

[2] Jo-fi was Freud's chow at this time.

keep brooding on whether I shall reach the age of my father and brother,[3] or even that of my mother, tortured as I am by the conflict between the desire for rest, the dread of renewed suffering (which a prolonged life would mean), and by the anticipation of sorrow at being separated from everything to which I am still attached?

Warm greetings to you (and Topsy) from

Your

Freud

The two parts of the letter, separated by the aria, reflect the two aspects of *Topsy*: a dog story, expressing the deep bonds between humans and animals; and a story about human life, and death.

II

WHAT BIOGRAPHERS SAY ABOUT THE BOOK

Jones (1957) commented that "Freud entered fully into the spirit of the book—a fondness for chows was one of the many links between him and the author—and liked it greatly" (p. 224). Jones did not discuss the content of *Topsy* further.[4]

Schur's (1972) biography of Freud focused on Freud's illness, but omitted mention of *Topsy*, except to footnote the translation and date of publication (p. 491, n.7).

Biographers of the Freuds (Peters, 1985; Stein-Monod, 1966), if they addressed *Topsy* at all, stressed the first part of Freud's letter—his feelings about dogs—without mentioning

[3] Freud's father and his brother lived to be eighty-one and a half.

[4] Jones mentioned that another dog story (Cervantes' *Coloquio de los perros*) had been important to Freud during his adolescence (Jones, 1953, p. 164). Vranich (1976, p. 74) pointed out that the significance of that dog story to Freud seems to have been dismissed by Jones.

the way in which Freud related the dog's situation to himself or the sense of impending death evident in the second part of the letter of December 6, 1936 (previously quoted).

Anna Freud herself, in 1981, writing the preface to a new German edition of *Topsy*, referred only to her father's role as translator. She made no mention of herself, but stated that Freud translated the book both because his analytic practice had been disrupted by the Nazis' entering Vienna, and because of his eagerness to do a favor for Marie Bonaparte "in gratitude for her unflagging helpfulness" (A. Freud, 1981, p. 359). She added that "not only the person of the author but, above all, *the topic of the book* . . . influenced Freud's choice" (p. 359, italics added). She then addressed Freud's love for dogs. Nowhere did she refer to the central topics of the book—direct confrontation with illness, old age and death—issues which preoccupied her father at that time and were central in the ongoing conversations and the letters he exchanged with Marie Bonaparte during these years.

Anna Freud ended the foreword with: "The work of translation he devoted to the book should at the same time be regarded as part of the gratitude and indebtedness which he endeavored to repay to Yo-fi and Lun-yu [his chows] for many years of friendship" (p. 361).

Marie Bonaparte was a prolific writer. It must be significant that this is the *one* work of hers Freud chose to translate.

III

HISTORICAL BACKGROUND

Marie Bonaparte wrote *Topsy* during the interval from March 1935 to June 1936. She sent the completed manuscript to her close friends, the Freuds, in December 1936. Their translation into German was completed April 9, 1938. *Topsy* was published in 1937 in Paris in French, in 1939 in Amsterdam in German (the Freud translation, *Topsy, der goldhaarige Chow*), and in 1940

in London in English (translated by Marie Bonaparte's daughter, Princess Eugenie of Greece; reprinted in 1945). A recent edition of the Freud translation (now titled *Topsy: Die Geschichte eines goldhaarigen Chows*) was published in Frankfurt in 1981.

Freud and Dogs

Marie Bonaparte shared with the Freuds a love for dogs. As Anna Freud (1981) remarked in her preface to *Topsy*, friendships with dogs were important to Freud: "What Freud valued in his dogs was their gracefulness, devotion and fidelity; what he frequently stressed and praised as a decided advantage over men was their absence of any ambivalence. 'Dogs,' as he used to say, 'love their friends and bite their enemies, in contrast to men who are incapable of pure love and must at all times mix love and hate in their object relations' " (p. 360). The Freuds' first dog, Wolf, a "large, not undangerous Alsatian dog" (p. 360), had been Anna Freud's dog, given to her by her father and then shared with him (Young-Bruehl, 1987). In 1930 Marie Bonaparte gave Freud a chow—his own animal:[5] "Jo-fi, a female chow in bearing and appearance not unlike a little lion, soon became his daily companion, accompanied him on excursions, patiently participated in all analytic hours, sat next to him at mealtimes" (A. Freud, 1981, p. 360). H.D. (1956), the American poet in analysis with Freud, described her introduction to the chow which greeted her with Freud at her first analytic hour: "A little lion-like creature came padding toward me—a lioness, as it happened. She had emerged from the inner sanctum or manifested from under or behind the couch . . ." (p. 98). H.D. complained of feeling annoyed "as Jo-fi would wander about

[5]Freud's first chow, Lun, was a gift from Dorothy Burlingham. Lun was killed in an accident—to Freud's grief. Jo-fi was a replacement for Lun. Jo-fi had two puppies who had to be sent away because she was so jealous of them. When she died, one of her puppies, Lun-yu, replaced her (Young-Bruehl, 1987).

and I felt that the professor was more interested in Jo-fi than he was in my story" (p. 162). Other analysands have enjoyed recounting similar episodes of the chow's participation in their analysis with Freud (Grinker, 1985).

Shortly after the Freuds received the manuscript of *Topsy*, Jo-fi died suddenly (late January 1937) after surgery for an ovarian cyst. Jo-fi's daughter, Lun-yu, took her place.

Freud's Illness

In 1937 Freud was in poor health. Since 1923 he had suffered from a malignant tumor of the palate and jaw which had required numerous palliative operations and radiation treatment with both Roentgen rays and radium (Jones, 1957, p. 188), and which left him with a scarred and disfigured oral cavity. He had difficulty talking and chewing. Care of his prosthesis was unrelenting, painful, and difficult.

Anna Freud

Freud's youngest daughter, Anna, undertook responsibility for nursing him. His special closeness to her was cemented by the onset of his illness. His speech was impaired by the scarring, and he depended upon her both for nursing care and as a professional collaborator: she typed his letters from dictation, delivered his papers at scientific congresses, and represented him in the psychoanalytic community (Gay, 1986).

Marie Bonaparte

Marie Bonaparte met Freud and became close to him shortly after he became ill (September 1925). She had herself been preoccupied for a long time with thoughts about illness and death. Her mother had died shortly after Marie was born, and her father and paternal grandmother had been constantly soli-

citous about Marie's health. A Princess of Greece and Denmark and a very wealthy woman, she was a descendant of Napoleon Bonaparte's brother. She was interested in psychoanalysis and was active in the analytic community in Paris; she was also fascinated by medicine and audited courses at the medical school.

Marie Bonaparte had first read Freud's works while confined to her house by the tasks of nursing her father for about a year, beginning in April 1923 (Bertin, 1982): "It was at her father's bedside that she read Sigmund Freud's 'Introductory Lectures on Psycho-Analysis' and began to rethink the problems of her life" (p. 139). She came to Vienna in 1925 at age forty-three (thirteen years older than Anna Freud) to seek analytic training. Over the next several years, she was to be analyzed on and off by Freud, a few months at a time. When they first met, Freud already assumed that he was dying; their whole relationship was colored by this.

Marie Bonaparte went from one dying father to another: "All my life I was to care about the opinions, approval and love of only a few 'fathers,' selected ever higher and of whom the last was to be my grandmaster Freud" (Stein-Monod, 1966, p. 401). In her correspondence, she repeatedly addressed Freud as "dear Father." She very quickly became a close friend of Freud and his family. He kept her picture on his desk. Freeman and Strean (1981, p. 94) declared that "Jones was later staggered when he learned the many intimate details Freud had divulged about himself to Marie."

From early on, Marie Bonaparte was involved in seeking out medical treatment for Freud. She had recommended Max Schur, her own physician, to Freud in 1929, a few years after he became ill. Schur assumed the medical care of Freud for what were to be Freud's last years, even joining him in England in 1938.

Political and Social Background

During the time she wrote *Topsy* and while it was being translated, Marie Bonaparte was a frequent visitor to the Freuds in

Vienna and constantly corresponded with them. Their letters to each other included Freud's comments on her work and papers on psychoanalysis, his ongoing work, personal news of family, and feelings about life and death.

In December 1936, when the Freuds received the manuscript of *Topsy*, Sigmund Freud was eighty and one half years old, and Anna Freud was forty-one. Politically, it was a very difficult time. The Austrian Chancellor had been assassinated in Vienna in 1934, and the threat of fascism in Austria loomed ominously. For several years Jews and intellectuals—analysts and artists—had begun to think of leaving the country. H.D. (1956) described the swastika chalked on the Freuds' door, the deserted streets, the guns stacked on street corners, and the general fearfulness of that time. Freud was reluctant to leave. He wrote to Marie Bonaparte in February 1938 (Jones, 1957, p. 217): "It undeniably looks like the beginning of the end for me. But we have no other choice than to hold out here."

A month later the Nazis invaded Austria, and the Freuds were placed under house arrest. Hearing of this, Marie Bonaparte immediately went to Vienna, arriving on March 17, 1938 (Bertin, 1982, p. 200). Only after Anna Freud had been detained for a day (March 22, 1938) by the Gestapo was Freud finally convinced to leave. Marie Bonaparte helped with the preparations for departure. She and Anna Freud together went through Freud's notes and correspondence and collected his memories about his early life. Her political connections as a member of two royal families and her wealth were central in enabling the Freuds to escape at this late time. Finally, on June 4, 1938, the Freuds departed from Vienna, spending a day with Marie Bonaparte in Paris en route to London.

IV

A READING OF *TOPSY*

Marie Bonaparte wrote *Topsy* as a kind of diary during the illness of a pet dog, expressing her attitudes about disease, old

age, life, and death. She began *Topsy* by saying that for a long time she had avoided having pet dogs because they die. In her childhood, when a pet dog had died, "the brightness of the sun, of the flowers was dimmed for a few days" (*Topsy*, p. 9). "Why thus squander my heart away? Have we not sorrows enough on earth, which come to us through human beings, from children, without creating others by adopting dogs? . . . And as a dog's life is so short, to have one, to love one, is, if one is still young enough, gratuitously to invite Death into one's house" (p. 34).

She relented, however, and bought a dog for her invalid daughter. Soon her household was full of dogs, but none was particularly dear to Marie Bonaparte until Topsy, a four-year-old chow, became ill with a tumor under her right lip. Suddenly, Topsy seemed special—a "magic dog," as she referred to her in the book. Deeply touched by the dog's illness, Marie Bonaparte determined to try to save Topsy. She then recorded, over the next fifteen months, her thoughts about the dog's illness, treatment, possible death, old age, and, finally, recovery.

The book was divided into short meditations on aspects of illness, aging, death, and life as each is raised by the dog's situation. Writing in the first person in an intimate tone, Marie Bonaparte referred to her own family, her garden, and her travels.

Bonaparte's style in *Topsy* is mannered, self-conscious, poetic—yet specific and therefore powerful. As an example, one of its twenty-nine chapters contains only forty-one words and is quoted here in full: "Topsy's sentence has been pronounced: under her lip, which is again swelling, there is a lympho-sarcoma, a tumour that will develop, grow, spread elsewhere, ulcerate, suffocate her, and condemn her in but a few months to the most atrocious of deaths" (p. 13).

"Topsy's sentence has been pronounced": a poetic metaphor for the histological diagnosis of the tumor, which contains the sense of helplessness of a prisoner awaiting a judge's verdict. She continued: "The tumour under her lip, which has grown and spread till now it is inside her right nostril, from day to day deforms and obstructs it ever more, so that now she cannot run

down the paths . . . without sneezing and sneezing again and again . . ." (p. 15). The concrete description was ended, again by a metaphorical transformation: . . . "like the sound of a death knell."

Later, likewise in graphic clinical detail, Bonaparte observed Topsy's growing thinner, her "emaciated flanks heaving and breathing, oppressed by the summer air." All that will remain is "melting flesh, crumbling bones, and a repellent tangle of fur" (p. 45), the fur that was also a beautiful "golden shroud" (p. 15).

Marie Bonaparte addressed euthanasia as directly as she did the ravages of cancer: "If, some day, that ill which entered into her . . . should break out here or there . . . the only merciful action would be to put her to sleep forever" (p. 31).

The photographs in *Topsy* reinforced these themes. They were souvenirs—stark black and white snapshots, informal records of happy times and of the progress of an illness ("Topsy's Whitened Head," p. 60), and they too were metaphors. For example, a photograph of Topsy lying on an oriental carpet spread over the grass was titled "Topsy Sleeping" (p. 18). The dog was stretched head down, eyes closed, legs extended—peacefully sleeping (or dead?).

Bonaparte wrote that she would arrange to have the dog die by lethal injection at a laboratory, and she described how Topsy's heart would slowly beat, then stop. She fantasized about the death: "Her paws have stiffened, and her body has grown cold" (p. 38), and even about the autopsy: her body, "opened by others, to see inside, the better to understand what it was that doomed her" (p. 38). She gave a description of the burial—the corpse wrapped in a white sheet, buried in her garden—and afterwards: "You . . . in dissolution will already wholly have merged into the earth of my garden. Only your bones, skeletally sincere, that unlike the hypocrite mummy, seek no denial of death, will rest upon that bed of sand . . ." (p. 41).

Meanwhile, Bonaparte had taken the dog to a physician who recommended surgical removal of Topsy's tumor, followed by x-ray treatments. Marie Bonaparte had donated vast sums to

the Curie Institute (Bertin, 1982, p. 192), and she had previously consulted the Director, Professor G. V. Rigaud, about radium treatment for Freud (p. 182).

After several months the cancer seemed to be responding to the treatment. Topsy, oblivious to Marie Bonaparte's concerns, ran and played in the garden. Bonaparte declared that she learned from Topsy, who "knows better than humans that life is in the present, and nothing but the moment that one lives" (*Topsy*, p. 46). Marie Bonaparte left Topsy for the summer. She was still uncertain if the dog was cured, but she realized that, in any case, "She [Topsy] will have to grow old. Then her grace, before her will die." Again Bonaparte's scenario included the specific physical changes: "She will lose her teeth . . . and some day, her eyes may lose their sight. Her body in any case, grown heavy, will no longer be able to bound in the ivy . . ." (p. 50). She concluded that perhaps it would have been "better had she disappeared in the full gracefulness of her vigour" (p. 50).

Then the growth dissolved; the radiologist pronounced Topsy cured! From that point, the roles of Topsy and Marie were reversed, as Marie Bonaparte focused more directly on her own sense of mortality and helplessness rather than on Topsy's fate.

As Bonaparte anticipated her own aging and death, Topsy embodied a child or sick father for her to love, protect, and care for (as she did her own father and Freud), a nursemaid or guardian from danger from outside (robbers) and from inside (illness and death itself), and a messenger of death.

Topsy was now the "magic dog" that guarded Marie Bonaparte from her own death—from "the ghosts of those who are gone—my mother, my dead mother who wants her child back; my dead father come back to claim me" (*Topsy*, p. 27); ". . . it will be Death, the roaming Death that prowls in the garden, who will, perhaps, come into my house, into my room" (p. 28). A photograph of Topsy hunting mice in the garden illustrated this—for Topsy herself was death for the mice.

V

PARALLELS BETWEEN THE STORY OF TOPSY AND FREUD'S ILLNESS

Topsy contained parallels to Freud's illness, his concern about death, his thoughts about an afterlife, and his views on euthanasia: ". . . when the flesh is dead, the spirit is extinguished, were it the spirit of the greatest of men . . . or that of Topsy, the little dog" (*Topsy*, p. 44). Marie Bonaparte described in Topsy a tumor located in the oral cavity—the same position as Freud's tumor (both were even on the right side). The local spread and symptoms (such as difficulty chewing) were similar, as was the treament by palliative surgery, Roentgen rays, and radium.

Topsy's imagined fate was close to that which Freud would suffer a few years later, in the months before he died: "To be able to breathe no longer, your nostrils day by day more obstructed by the atrocious spongy mass? No longer to be able to eat. . . . For your soft lip to ulcerate, and gradually dissolve into pus and stench?" (*Topsy*, p. 36).

In *Topsy* Marie Bonaparte wrote about Topsy's old age. Freud, too, was concerned with the physical changes of aging and was blunt in addressing them. On December 1, 1936, Freud had written to her about this (Schur, 1972): "For the last few days I have been suffering from the spread of my chronic catarrh to the trachea and the bronchi. Actually nothing serious, but with every illness new signs of the deterioration of old age push themselves forward. One can acknowledge this as unavoidable and cannot demand an ounce of sympathy for it" (pp. 484-485).

In *Topsy*, Marie Bonaparte imagined life after death, reunions with her mother, father, Topsy. On January 27, 1938, Freud, who had just learned of a recurrence of his own malignancy, participating in her fantasy, wrote to her from the "Elysian Fields" (Schur, 1972): "Well, I've been imagining how I would

greet you on the Elysian Fields, after learning of your arrival. It's fine that you've finally gotten here. You let me wait so long . . ." (p. 493). Like Bonaparte, Freud was direct and graphic about details of physical illness. He continued: "Perhaps you will even notice that I've actually been beautified. Wasn't I disfigured by a sebaceous cyst, an atheroma, which you never mentioned, probably out of tact? I had that ornament removed during my last—I mean of course next-to-last operation" (pp. 493-494).

In *Topsy* Marie Bonaparte detailed at great length her own feelings about euthanasia. Schur (1972), Freud's physician, suggested that Freud had thought about actively choosing death. He vividly recounted Freud's request for a lethal dose of morphine at the end of his life:

> On . . . September 21, while I was sitting at his bedside, Freud took my hand and said to me: "Lieber Schur, Sie erinnern sich wohl an unser erstes Gespräch. Sie haben mir damals versprochen mich nicht im Stiche zu lassen wenn es so weit ist. Das ist jetzt nur noch Quälerei und hat keinen Sinn mehr." ("My dear Schur, you certainly remember our first talk. You promised me then not to forsake me when my time comes. Now it's nothing but torture and makes no sense any more.")
>
> I indicated that I had not forgotten my promise. He sighed with relief, held my hand for a moment longer, and said: "Ich danke Ihnen" ("I thank you"), and after a moment of hesitation he added: "Sagen Sie es der Anna" ("Tell Anna about this"). All this was said without a trace of emotionality or self-pity, and with full consciousness of reality.
>
> I informed Anna of our conversation, as Freud had asked. When he was again in agony, I gave him a hypodermic of two centigrams of morphine. He soon felt relief and fell into a peaceful sleep. The expression of pain and suffering was gone. I repeated this dose after about twelve hours. Freud was obviously so close to the end of his reserves that he lapsed into a coma and did not wake up again. He died at 3:00 A.M. on September 23, 1939 (p. 529).

In accord with Freud's wishes, his ashes were placed in a Greek vase Marie Bonaparte had given him (Bertin, 1982, p. 209). This question of the manner of his own death must have been on Freud's mind at the time he and Anna translated *Topsy*.

VI

GUARDIANS—SIGMUND FREUD, ANNA FREUD, MARIE BONAPARTE, TOPSY

In *Topsy* Marie Bonaparte expressed not only her feelings about her relationship to her dog and about her own life, but also (without acknowledging it) her feelings about Freud's illness and perhaps her perception of his relationship with Anna Freud.

In the last part of *Topsy*, Bonaparte and Topsy reverse roles, mirroring the role reversal of Anna Freud, who had become her father's nurse and guardian, and the later role of Marie Bonaparte herself, Freud's pupil and analysand, who would save him from the Nazis. H.D.'s (1956) remark that envoys of "The Princess" were stationed outside to protect the Freuds (p. 61) is reminiscent of Topsy's beginning to sleep outside Marie Bonaparte's own door after a robber had broken into her villa. Bonaparte's earlier fear of robbers at night is evocative of the Freuds' situation in Vienna, where, lying awake, they awaited the knock of the Gestapo.

The relationship of parents and children in caretaking was also explored in *Topsy*, paralleling the relations of Anna Freud, her father, and Marie Bonaparte.

Several chapters of *Topsy* addressed Topsy's "childlessness": "Topsy, little spark of life, why, when miraculous life was yours, did you always, whenever the life-giving cells were stirring in your loins, obstinately squat down and bare your teeth, repelling the approaches of the male?" (p. 23). Anna Freud had chosen to remain unmarried and childless. Childless, Topsy was free to be completely devoted to Marie Bonaparte, as Anna Freud was to her father.

Jones (1957) described Freud's relationship with Anna Freud during these years as follows:

> There had grown up in these years a quite peculiarly intimate relationship between father and daughter. Both were very averse to anything at all resembling sentimentality and were equally undemonstrative in matters of affection. It was a deep silent understanding and sympathy that reigned between them. The mutual understanding must have been something extraordinary, a silent communication almost telepathic in quality where the deepest thoughts and feelings could be conveyed by a faint gesture. The daughter's devotion was as absolute as the father's appreciation of it and the gratitude it evoked (p. 224).

This echoes Marie Bonaparte's description of the sense of understanding between Topsy and herself: ". . . on certain days Topsy seemed to pair off with me, and we made a kind of unique self-absorbed couple, and the garden walls shut in our close happiness" (*Topsy*, p. 25). This may also reflect Freud's relationship with his chow, Jo-fi. Jones (1957) quoted Freud's letter to Marie Bonaparte, December 17, 1936, after a minor operation (December 12) when he was in severe pain: "I wish you could have seen what sympathy Jo-fi shows me in my suffering, just as if she understood everything" (p. 210).

In describing his appreciation of Anna Freud's devotion he had written to Lou Andreas-Salomé: "I of course rely more and more on Anna's care, just as Mephistopheles once remarked: 'In the end we depend on the creatures we made.' In any case, it was very wise to have made her" (E. Freud, 1960, p. 425).

Marie Bonaparte herself had nursed her father through his terminal illness with cancer, as Anna Freud nursed Freud. Her father's illness had offered Marie a way to be needed and close. "Because of his illness, he will remain mine for a long time, forever, unable to go away, to escape, to make me cry, as when I was a little child and he was going out to dinner or leaving on a trip . . ." (Bertin, 1982, p. 138).

Perhaps nursing Topsy provided Marie Bonaparte with a substitute for the physical closeness to Freud from which she was excluded. Bertin (1982, p. 138) remarked that Bonaparte felt that nothing could happen to her dying father as long as she was in the room. Topsy came to represent this kind of guardian for her. "A simple dog, lying there by me, just like Mimau[6] by the child that I was, she guards me, and by her presence alone must bar the entrance of my room to a worse ill, and even to death" (*Topsy*, p. 79).

Certainly Marie Bonaparte tried to hold on to Freud, as she did to Topsy, through writing notes about their relationship (Jones's biography of Freud relied heavily on Marie Bonaparte's notes) and through taking photographs—both portraits (Freud in his office and Topsy in the garden) and action scenes (home movies of Freud and shapshots of Topsy racing about).

VII

THE PRINCESS'S "FAIRY TALE"

The significance of this book, like most of Marie Bonaparte's work, has not been reckoned with. She was taken seriously only as "The Princess"—a wealthy and influential woman who used her power to promote psychoanalysis, anthropology, and social causes. Even Anna Freud implied, somewhat condescendingly, that Marie Bonaparte's work was translated out of "gratitude." Yet there is every evidence in her correspondence with Freud that he, although not always in agreement with her, took Marie Bonaparte seriously. For instance, Schur commented upon Freud's writing to Bonaparte about theory and metapsychology. Schur (1972) noted that on May 27, 1937, Freud sent her "one of his most succinct and lucid formulations about the vicissitudes of the aggressive drive, its relation to sublimation, and its repression" (p. 490).

[6] Marie's childhood nurse.

Topsy was presented as a "fairy tale for adults" (a phrase Marie Bonaparte used to describe some of her writings). Bonaparte imagined herself a child again at the end of the book. The manifest autobiographical nature of Bonaparte's writing helped to obscure other meanings. Freud had advised her to write about herself, yet the content of this book is most often referred to as "the story of a pet dog."

Marie Bonaparte was aware that she was viewed as a frivolous society lady, preoccupied with her dog while the real world went on outside the garden walls. "They turn the love—truly often too exclusive—of some society lady for her lap dog, to derision" (*Topsy*, p. 74). Yet she also recognized that "Topsy, my pretty live toy, from a flippant joy, has suddenly become the tragic messenger of the most atrocious of deaths—the death my father suffered, and which I myself may possibly suffer some day. Death by cancer" (p. 34).

VIII

"YET YOU WILL WEEP AND KNOW WHY"[7]

The Princess, too, with her "toy," was engaged in matters of life and death. Here she told a story and revealed a caring and profound personality. It is nowhere explicit that Marie Bonaparte —or for that matter Anna Freud or Sigmund Freud—admitted consciously how close the parallel was between Topsy's and Freud's illnesses. Marie Bonaparte herself did not refer to Freud's illness in *Topsy*; she declared that the memory she was haunted by was that of her father, who had died of metastatic cancer of the prostate twelve years earlier.

Marie Bonaparte, Freud, and Anna Freud referred to *Topsy* only as a dog story. The parallels were so very close, and the second half of Freud's letter (December 6, 1936) so directly referred to his own concerns about the topics addressed in the book that the significance of the book must have been trans-

[7] See Hopkins (1880, p. 94).

parent to each of the three. *Topsy* may well have served as a way simultaneously to avoid and to express (indirectly) thoughts and concerns which all three shared.

Freud wrote to Jones (1957, p. 225) in May 1938, just as the translation was finished, that "between beloved friends much should be obvious and remain unexpressed." Similarly, Anna Freud (1981) wrote, in her preface to *Topsy*, that in the political situation of the time, characterized by the "impression of unrelenting brutality and blind lust for destruction . . . *it became easier to look away from one's fellowmen and turn to animals*" (p. 360, italics added).

The focus on Topsy and on *Topsy* offered Bonaparte and the Freuds ways to acknowledge the nature of their suffering and hopes, and yet to keep some distance. The dog, inside her world of the garden, put human events into perspective: ". . . nations might clamor threateningly, money markets collapse, but you knew nothing of it all" (*Topsy*, p. 25).

A later letter from Freud, August 13, 1937, to Marie Bonaparte sheds further light on how the three of them (and later readers) approached this book (E. Freud, 1960, pp. 436-437):

> My dear Marie
>
> I can answer you without delay, for I have little to do. Two days ago "Moses II" was finished and laid aside, and the best way to forget one's minor ailments is by exchanging thoughts with friends.
>
> To the writer immortality evidently means being loved by any number of anonymous people. Well, I know I won't mourn your death, for you will survive me by years, and over mine I hope you will quickly console yourself and let me live in your friendly memory—the only form of limited immortality I recognize.
>
> The moment a man questions the meaning and value of life, he is sick, since objectively neither has any existence; by asking this question one is merely admitting to a store of unsatisfied libido to which something else must have happened, a kind of fermentation leading to sadness and depression. I am afraid these explanations of mine are not very wonderful. Perhaps because I am too pessimistic. I have an advertisement floating

about in my head which I consider the boldest and most successful piece of American publicity: "Why live, if you can be buried for ten dollars?"

Lün has taken refuge with me after having been given a bath. If I understand her right, she wants me to thank you warmly for the greeting. Does Topsy realize she is being translated?

Write again soon.

Affectionately

Your

Freud

Here Freud spoke directly about death and even joked about funerals. Yet he must also have been responding to Marie Bonaparte's preoccupations, her meditations on the meaning and value of life, in *Topsy* which he was translating. Schur (1972) speculated that Freud's correspondence with Marie Bonaparte had a particular—perhaps not fully conscious—aim. By giving Freud "an outlet for the expression of certain pessimistic, or more accurately, realistic thoughts, it enabled him to turn back to work, enjoyment, wit" (p. 491).

At the bottom of a letter from Freud (December 6, 1936), Marie Bonaparte made a notation about an earlier discussion with him about the fleeting nature of life:

Notebook V, October 22, 1925

M.: How beautiful everything is that you say, but how sad!

Fr.: Why sad? That's what life is. It is precisely the eternal transitoriness which makes life so beautiful (Schur, 1972, p. 485).

Edelson (1963, pp. 23-25), in his discussion of Freud's 1916 paper, "On Transience," pointed out Freud's recognition of these issues. Ironically, in this paper Freud had recorded a conversation that had taken place during another war:

Transience value is scarcity value in time. Limitation in the possibility of an enjoyment raises the value of the enjoyment.

> It was incomprehensible . . . that the thought of the transience of beauty should interfere with our joy in it. As regards the beauty of Nature, each time it is destroyed by winter it comes again next year, so that in relation to the length of our lives it can in fact be regarded as eternal. The beauty of the human form and face vanish for ever in the course of our own lives, but their evanescence only lends them a fresh charm. . . . since the value of all this beauty and perfection is determined only by its significance for our own emotional lives, it has no need to survive us and is therefore independent of absolute duration (Freud, 1916, pp. 305-306).

In 1916, more than twenty years before he read *Topsy*, Freud himself helped to answer the conundrum which the history of *Topsy* presents. He noted that it was hard for human beings to confront transience; that "some powerful emotional factor was at work which was disturbing their judgement. . . ." He believed he had discovered what it was: a revolt against mourning: ". . . since the mind instinctively recoils from anything that is painful, . . . [the] enjoyment of beauty [is] interfered with by thoughts of its transience" (p. 306).

Marie Bonaparte, in *Topsy*, addressed the beauty in the transience of life and the difficulty in directly confronting mourning. She wrote about Topsy: "Yet, if the unavoidable alternative, because of you, moves me so deeply, that is because it is also my own" (p. 51). Crying for her pet dog, Marie Bonaparte was clearly crying for herself, for Freud, and for humankind.

Yet, Marie Bonaparte sidestepped a final confrontation with death and mourning. Topsy recovered and was transformed into the "magical dog." The happy ending of *Topsy: The Story of a Golden-Haired Chow* must have expressed, both for Marie Bonaparte and for the Freuds, the wish that Freud, like Topsy, would yet recover and become again Marie's (and Anna's) immortal guardian in a world untroubled by political turmoil and persecution.

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Reaction to the End of the Analytic Hour as a Derivative of an Early Childhood Experience: Couch or Crib.

Muriel Chaves Winestine

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REACTION TO THE END OF THE ANALYTIC HOUR AS A DERIVATIVE OF AN EARLY CHILDHOOD EXPERIENCE: COUCH OR CRIB.

BY MURIEL CHAVES WINESTINE, PH.D.

Reactions to the end of an analytic session serve as fertile ground for transference manifestations. The following, from the analysis of a man in his early thirties, shows with unusual specificity how his characteristic way of behaving at the end of each session was derived from an early childhood experience. The level of affective and cognitive regression reflected at such times was in sharp contrast to his otherwise sophisticated level of perceptiveness and intelligence. It exposed an intrapsychic conflict around which his neurosis was organized and which contributed to his failure in pursuing a profession.

Mr. P always responded to the end of the hour as though it was a surprise and had occurred abruptly: he lingered on the couch, raised his eyebrows, finally sat up, looked disgruntled, amazed, gave me a woebegone, reproachful gaze as he dragged himself to the door, hesitated before opening it, and finally left. He reported that once on the street, he felt bewildered, and he described mild feelings of agoraphobia.

During one session, he recalled that after the previous day's hour, he dined at a nearby restaurant counter. Although his order was taken ahead of a man sitting next to him, the latter was served first. Mr. P felt a surge of rage and irritation and yelled to the waitress, "Where is *my* food?" She admonished him to wait a minute and then presented his meal, which had taken a bit longer to prepare. His associations led to feelings that he thought he had had when he was a small child and his mother had to feed "the baby" ahead of him. In the transference this

was represented by his wish to compose himself before leaving his session and re-entering the waiting room so that he would not have to *abruptly* confront the next patient. Clearly, the latter was experienced as "the baby" and a deterrent to Mr. P's wished-for interminable session with me.

So far, this is not an unusual transference sequence derived from a patient's recall of early experiences in connection with an infant sibling. My trying to lessen the blow by adding a few minutes at the end of sessions, or by changing my voice as the end approached, did not alleviate my uneasiness (countertransference) over his reproach that, indeed, I ended the sessions too abruptly. I told Mr. P that no matter how much I tried to cue him to the end of the session, it seemed that he responded each time anew, as though there had been no preparation for or anticipation of the end. The following analytic work ensued.

Mr. P had already reported that when he was two and a half years of age, a newborn infant girl had been suddenly given over to his mother to care for by her brother. The brother's wife had become too emotionally ill to take her infant daughter home from the hospital and could not assume responsibility for her care. The baby remained in Mr. P's family for seven months, and he recalled accompanying his mother when they returned the baby to her father. Immediately upon reunion, the uncle and his family moved to a faraway city, and Mr. P did not see his cousin again until many years later. The over-determined role that this baby girl and her disappearance played in the formation of Mr. P's identifications goes beyond the scope of this communication.

The following is pertinent. Mr. P, a university graduate who had delved into and comprehended the most obscure and profound levels of philosophy, continued to behave as if he believed that the infant had "been left on the doorstep," although his uncle, the infant's father, was himself a highly responsible university professor of considerable renown. This cognitive anomaly was congruous with the patient's recalling that his own father had told him that the infant (i.e., all babies) was found in

a cabbage patch. As already stated, this culturally sophisticated man maintained an air of naïveté and bewilderment over how to go about leading his life.

Reconstruction suggested that the traumatic nature of this early childhood experience was not based merely on his displacement by the baby, but on the *abruptness* with which it had occurred. The arrival of the infant had lacked for him (as well as for his mother) the preparation and anticipation and visual cuing that is normally provided by a pregnant mother. Mr. P then pronounced that his entire childhood had ended abruptly the night of the infant's arrival: she replaced him in his room and crib, and he was put to sleep on the living room couch where he remained throughout the seven months the baby had been present. He recalled that a rubber sheet had been placed on the couch, and he was convinced that, as of that night, he never again wet his bed (although he retained a symptom, which eventually yielded to analysis, of having to urinate several times before leaving his house). He was *returned* to his crib in his room upon the departure of the baby seven months later. He continued to sleep in his crib for one more year until the family moved to a new neighborhood and he was again shifted from the crib, this time to a junior bed. He described this move and the surrounding circumstances as traumatic and as a break in the continuity of his life. Initially in his analysis he tended to attribute all his problems to this move. This was eventually understood as a screen for the trauma that had preceded it, the abrupt arrival of the infant girl.

The analytic couch represented the crib as long as Mr. P maintained the illusion that the session would not come to an end. After each session, he felt as though he was being peremptorily removed to make way for the next patient (the infant). Following these abrupt evictions, he faced the street with bewilderment, a defense which also blocked his irritation and rage. Mr. P added that having been *placed back* in his crib left him with a feeling throughout his life that he would always get a "second chance." I interpreted this as perhaps contributing to his belief

that nothing he did mattered, that it did not count and was not the real thing. He gained further insight into the unconscious equation of each session representing a "second chance" in which the analytic couch was converted into the crib while he remained fixated on his infantile illusions and his wish for an interminable session. Eventually, the oscillation from couch to crib became attenuated, as each session assumed greater differentiation and became "the real thing." Mr. P felt more liberated to pursue further psychological development.

The patient had experienced the analytic couch as the crib with its attendant regressive wishes. This experience of the couch also served as a defense against the anxiety mobilized in the transference when the analytic couch represented the living room couch on which he had slept during the seven months that the baby stayed with his family. Mr. P recalled that in contrast to the more sequestered, cozy, protected atmosphere of his small room and crib, the couch in the living room *faced an expanse of open space which frightened him.* The couch was against a wall adjacent to his parents' bedroom, and he recalled hearing plumbing and primal scene noises at night. Overwhelmed and excited by this influx of stimulation, he feared losing control, that is, wetting the upholstered couch. It was possible to connect these memories with those being relived on the analytic couch and in the transference, and I interpreted how they led to the agoraphobic sensations. Working through this material provided Mr. P with a greater sense of reality and mastery with which to further explore his inhibitions regarding the pursuit of a profession.

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Theater of the Mind. Illusion and Truth on the Psychoanalytic Stage. By Joyce McDougall, New York: Basic Books, Inc., 1985. 301 pp.

Bo Larsson

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BOOK REVIEWS

THEATER OF THE MIND. ILLUSION AND TRUTH ON THE PSYCHOANALYTIC STAGE. By Joyce McDougall, New York: Basic Books, Inc., 1985. 301 pp.

The development of an analyst involves not only a lifelong process of internalization of experiences of self and of others but also a continual incorporation of psychoanalytic theories and clinical experiences. Most important, however, is the activity of integration that leads to the creation of what Joyce McDougall might call a neopsychoanalysis, the unique theoretical edifice that every analyst has to build for himself in the same way that every philosopher must build his own philosophy. McDougall's *Theater of the Mind* may be read as a journal of the construction of an impressive psychoanalytic edifice by an extremely creative and passionate analyst. It is difficult to decide what makes reading her book more fascinating: the originality of the edifice, the unconventional use of material, the degree of integration, the author's obvious fascination with the "theaters of the mind," or her talent as a writer.

McDougall explicitly pays homage to her most admired teachers, Melanie Klein and Sigmund Freud. The book is replete with references and allusions to the work of Freud, following Lacan's motto: *back to Freud.* She tends to reinterpret Freud's concepts in a tradition typical of French analysts, although her position rarely conveys the feeling of superficiality which a linguistic reading of Freud often produces. Sometimes you do wonder if she is playing with words, not mainly to deepen her concepts but rather to make links between Freud's mechanistic, biological, and physiological metaphors and her own dramatic ones derived from her personal vision of the unconscious as a theater. Gone is the mental apparatus. What the analyst is watching is a stage, where the *I* is simultaneously the playwright, the director, and the actors, at the same time that it struggles between wishes to conceal and to reveal the dramas of infancy and childhood.

Linking Freud's theory of the stages of the libido with her own theatrical metaphors, McDougall conceives of the categories of neuroses, perversions, psychoses, and "psychosomatoses" as *inventions* by the subject in a *static* or *ec-static* state. She addresses them in

terms of the live experience that is met with in psychoanalytic practice rather than reducing them to nosological entities. Freud could never have put it that way, but dozens of French analysts could. McDougall invites us to look upon psychoanalyses as thrilling dramas—which most of us probably think they are—although without losing sight of analytic rigor or, to use her own words, the austerity of the psychoanalytic protocol. As a matter of fact, this book, perhaps even more than her earlier writings, is exciting reading; it is a belletristic rather than a scientific text.

Freud complained that his case histories read more like novels than like scientific writings, but McDougall does not seem at all uneasy about her metapsychological texts and case histories being profoundly dramatic. To my mind this is an asset. Many contemporary psychoanalytic papers make for rather boring reading. McDougall shows us that it can be otherwise, although her writings are *also* rigorously scientific texts.

A problem with McDougall's way of thinking is that it is not always an easy task to integrate her conceptualizations with ordinary psychoanalytic thought. She has reached a high level of integration in her theoretical thinking, but the way she brings together different concepts is, to say the least, eclectic. If one aims at conceptual rigor, it is problematic to combine the terminology of Freud, Melanie Klein, Charcot, the ego psychologists, Winnicott, Balint, etc., the way she does. For my part, however, I surrender. I leave to the artist the right to choose whatever material she likes, so long as the outcome of her creative work is brilliant, coherent, and full of insights into the human mind.

Through her *mélange* of subtle observations, hard psychoanalytic work, and decision to fit together theories from different psychoanalytic schools, McDougall has created new tools for her fellow analysts. In the words of Novalis, which she quotes in another book, "Hypotheses [are] like nets; he who casts none catches nothing."[1] McDougall has cast quite a few nets, and her draught is both large and delicious.

Let me try to give some examples of McDougall's at times surprising, but always thought-provoking rethinking of psychoana-

[1] McDougall, J. (1980): *Plea for a Measure of Abnormality.* New York: Int. Univ. Press, p. 17.

lytic theory. She defines *libidinal* (object-libidinal, oedipal, neurotic) problems as problems about the Forbidden, e.g., wishes involving parricide or incest, which are possible to fulfill in reality but are forbidden. *Narcissistic* (self-libidinal, pregenital, psychotic) problems, on the other hand, concern the Impossible, e.g., the desire to control other people's thoughts and actions omnipotently, to devour the love object and yet keep it, or to escape the inevitability of death. This distinction is not just a flash of wit, but an ingenious new opening.

According to McDougall, the small child's struggle for the Impossible is alive and very active in all of us, persistently trying to create a scene for its enactment within or without psychoanalysis. In a way, this constitutes a basic human dilemma, insofar as we all desire the Impossible. According to McDougall, you have to acknowledge your own impossible demands before you can help your analysands to give up theirs. As the master theoretician in this field she chooses Melanie Klein.

Neurotic analysands have, to some extent, come to grips with these problems, thus being able to begin to work on other layers of the human dilemma, i.e., the oedipal ones. They have entered the world, or theater, of the Forbidden, where one's wishes can be fulfilled, but not without terrifying or even devastating consequences, at least when one is a child. McDougall considers dealing with such problems to be the field of "classical psychoanalysis." She suggests that understanding and handling the plots of the Forbidden is a prerequisite for grasping the more primitive problems concerning the Impossible. This, to the mind of this reviewer, is a very important point, particularly with regard to the education of candidates. Only after we have learned to understand neurotic problems are we able to deal with more primitive ones.

A real innovation is McDougall's conviction that the psychological mechanisms of patients with "psychosomatoses," including what she calls the "normopaths" and the "antianalysands," is even more primitive than those of the psychoses. According to McDougall, psychotics are not capable of coping with their internal problems and therefore disavow them, after which they try to invent another world to compensate for their loss. Psychosomatic patients do not even feel that anything is missing. They simply deny the existence of what they have lost contact with and leave it to the

"soma" to enact the problems that ensue. This is a thought-provoking formulation of the predicament of certain "intractable" patients. Her formulations about the psychosomatoses have developed out of a critical reading of Sifneos and other students of psychosomatics. She thinks that "operational thinking" is typical of these patients, and she gives the concept "alexithymia" a new, purely psychological meaning, thus making it suitable for psychoanalytic interest.

In a perspicacious and convincing way, McDougall shows that the problems of psychosomatic patients are not necessarily impossible for an analyst to deal with. They involve "impossibles" which the analysand mistakenly tries to handle as "possible." By working out and working through what the analysand stirs up in her or him, the analyst can reconstruct what was banished from psychic reality and can help these patients to realize that they are fighting windmills and using unsuitable weapons.

Between neurosis and pyschosis (i.e., between the Forbidden and the Impossible), each of which she regards as more psychologically creative and inventive than psychosomatosis or "normopathy," McDougall places the pathology of perversions, for which she coins the fitting name of "neosexualities." Perverse, i.e., pregenital, fantasies and/or actions can be found in all of us, at least if we are not too severely disturbed. Perverts, however, produce a special solution to their oedipal conflict. Like psychotics, they *refuse* to deal with their problems, but like neurotics, they are aware that they *should* deal with them. Through perverse activities, they circumvent the challenges they face, which frees them from the need to elaborate them in the compromise formations characteristic of neurotics. Their struggle bears a resemblance to that of psychotics. They fight for their very existence, but, instead of disavowing the problems of the Impossible, they act as though the problems of the Forbidden do not exist. This amounts to proclaiming that there is no difference between the sexes and no distance between the generations.

Freud used the psychology of the pervert to illuminate the psychologies of the neurotic and of the normal, whereas McDougall uses her understanding of the normal, of the neurotic, and especially of the psychotic, to understand the perversions. She offers a penetrating understanding of what the perverts' quest is about,

and she examines the ways in which their mechanisms for circumventing the Forbidden, i.e., the oedipus complex, contribute to their symptomatology.

McDougall's theorizing about the human mind is deeply rooted in psychoanalytic tradition at the same time that it represents a substantial innovation. It is, of course, impossible to predict if a book will become a classic, but I would not be surprised if McDougall's *Theater of the Mind* turned out to be one.

BO LARSSON (NACKA, SWEDEN)

JUNG'S TREATMENT OF CHRISTIANITY. THE PSYCHOTHERAPY OF A RELIGIOUS TRADITION. By Murray Stein. Wilmette, IL: Chiron Publications, 1985. 208 pp.

This volume develops an interesting thesis, one that offers the possibility of shedding light on Jung's religious writings. The author argues, with some conviction, that Jung's religious writings are best understood as an extended effort to cure the ills of Christianity as Jung saw them from his unique perspective, which was rooted in the collective unconscious and the archetypology of symbolism.

The argument is developed in a series of steps, showing first the arguments and divergence of opinion that arose between Jung and his theological commentators over the years, then Jung's views on psychotherapeutic treatment as a background for extending these ideas to his more far-flung efforts in the treatment of Christianity. A critical chapter follows, tracing Jung's life history and development, particularly focusing on his relationship to Freud and his sense of religious mission in the second half of his life. The essential part of the argument is contained in a chapter on Jung's treatment of Christianity, based on an interpretation of his major works on Christianity and its tradition. These include Jung's studies of a psychological understanding of the trinity, his analysis of religious symbols in terms of alchemy, and the three books *Aion, Answer to Job*, and *Mysterium Coniunctionis*. In this analysis, the progressive steps of Jung's analysis of and efforts to cure the illness of the Christian soul are developed in some detail.

To my reading, the most telling chapter in the book is the one about Jung's development and his relationship with Freud. Jung's life seems to have been overshadowed by the figure of his father, a

Swiss Protestant pastor, whose life was a saga of disappointment and resignation, and whose stern, rigid morality seems to have cast a pall over his son's psychic life. Jung described his father as a "sufferer stricken with an Amfortas wound" and himself as a dumb Parsifal, who could only witness this sickness and was helpless to cure it. Jung's hostility is reflected in a fanciful daydream he recounts from these early years. Gazing at the magnificent beauty of the Basel Cathedral, he was overwhelmed by a blasphemous thought which he struggled to suppress, but after several days of anguish he allowed the fantasy to complete itself. He saw the cathedral before him and God sitting on his golden throne high above, when from under the throne a huge turd fell upon the cathedral roof, shattered it, and demolished it. The psychoanalyst would have little difficulty in seeing in this material the residues of an intense anal struggle between Jung and his parents in which Jung's omnipotence has its way, expressing his devastating rage against the church, most likely as a displacement of his rage toward his pastor father.

The need to cure the injured Amfortas and the rage at his inability to do so, or at the parental figures' unwillingness to lend themselves to his curing prowess, carried itself further in Jung's relationship to Freud. The transference that Jung developed toward Freud was based transparently on his relationship to his stern, authoritarian, and restrictive father. Jung finally accused Freud of being rigid, dogmatic, and authoritarian, "thus reducing everyone to the level of sons and daughters who blessingly admit the existence of their faults. Meanwhile you remain on top as the father, sitting pretty. For sheer obsequiousness nobody dares to pluck the prophet by the beard . . ." (p. 92). Jung saw Freud as neurotic and conflicted, and his wish was to confront Freud, analyze his complexes, and thus heal the father-figure's neurosis.

The same transference elements came into play later in Jung's life when he turned his *furor sanandi* on Christianity. It was, after all, in Jung's view, the sickness of Christianity that had crippled and distorted his father's life and had made his own early life experience a torment of guilt and shame. But the spirit of this effort was not merely to cure; it was also in some fashion to master, to overcome, to force into submission and defeat. Thus Jung's treatment of Christianity came to be a distortion and iconoclastic attack

on Christianity and its dogma. The fact that Jung was able to sustain this effort over half a lifetime and at the level of sophistication and penetration that he did is a tribute to his intelligence, but behind it lay the unconscious dynamisms that drove him into inexorable destruction and heresy, and laid the basis for his growing opposition to his theological colleagues.

Thus far, we have before us a tragic tale of a psychological genius gone awry, driven by unresolved unconscious needs and transferential dynamics that caused him to live the best part of his life on the border of psychosis, and introduced a fatal and tragic flaw into his thinking. The very enterprise—the delusion that Jung himself, through his grasp of what he saw as the psychological truth, through the power of his articulation, could transform Christianity—smacks of infantile omnipotence, even to the point of delusion. If he could not remake the church in his own image, he would destroy it with a gigantic turd.

There is much to be learned in these pages, and the overriding thesis lends a new perspective to one's understanding of Jung's career and his obsessional preoccupation with Christianity and its ills. The reader is well advised, however, to keep a perspective, namely, that the entire project is generated out of deep and pervasive unconscious roots and smacks of the omnipotent and the delusional. Unfortunately, the author of the present volume seems to have lost that perspective, at least in part. The final chapter leaves one with the impression not only that the Jungian project has meaning and purpose and possibility, but that, in fact, it has achieved some effect. *Caveat emptor.*

W. W. MEISSNER (CAMBRIDGE, MA)

BLOOMSBURY/FREUD. THE LETTERS OF JAMES AND ALIX STRACHEY, 1924-1925. Edited by Perry Meisel and Walter Kendrick. New York: Basic Books, 1985. 360 pp.

James and Alix Strachey were members of the Bloomsbury set associated with Cambridge University, a group possessed of an intellectual brilliance and leadership, commingled with sexual fluidity, that disposed several of its members to an interest in psychoanalysis. These characteristics were decidedly pronounced in James and in his older brother, Lytton Strachey, whose biogra-

phies of Queen Victoria and of Elizabeth and Essex set a new style and fascinated Freud. James's first description of Alix, in a letter to Lytton, described the American-born young woman as "delightful —an absolute boy" (p. 23). He lamented that, although he had raised a beard, he had not succeeded in convincing anyone that he had "fucked a woman" (p. 21).

James and Alix were a devoted couple for nearly fifty years, with no need, as the letters attest, for pretenses by either of them. They married in June of 1920 (a suicidal threat by Alix seems to have had something to do with this), and their honeymoon proved to be the prelude to James's analysis with Freud. The latter was favorably impressed by James's ambition to become a psychoanalyst himself, though less so by the notion that his ambitions should lead to a reduction in fees.

After James's analysis began, Alix developed "neurotic symptoms," and she asked to be analyzed by Freud too. Though Freud deemed this unusual, he acquiesced. Soon he had an unusual proposal of his own to make: he suggested that they translate one of his works into English. Freud was delighted with their accomplishment and assigned them other works, so that their translations became a regular part of their analyses.

When Alix's analysis had to be interrupted, permanently as it turned out, in February of 1922, because of influenza, she was tended by Freud's own physician, Felix Deutsch. When they left Vienna in June 1922, Freud affirmed that they were both competent to practice psychoanalysis, and he gave them his case histories to take home for translation. This took some years to accomplish, and led to the comprehensive *Standard Edition*, which they arranged to be published by Leonard Woolf, husband of Virginia Woolf and owner of the Hogarth Press. The Woolfs were also members of the Bloomsbury set.

Toward the end of 1924, with the case histories well in hand, Alix felt she should go on with her analysis. On the advice of Freud, she set out for Berlin and an analysis with Karl Abraham. Later she was to regard Abraham, and also others, as superior to Freud as analysts. The result of the separation between James and Alix was a plethora of letters whose value for the history of psychoanalysis can now be recognized. They provide comparative glimpses of analysts in London and Berlin during this period, with

some excursions to the state of affairs in Vienna and New York. While James's reports are rather unexciting, the same cannot be said of Alix's letters. "Decadent Berlin" provided the background for many of the most important figures in analytic history, and its pleasure domes were as frequently their meeting places as were the lecture-halls.

Alix had an entertaining, and frequently unkind, remark to make about virtually everyone. Anna Freud was classified as a "sentimentalist," to which James could respond with a description of A. A. Brill as a "Potash and Perlmutter type." Jews were usually identified as such. The conquest of New York's analysts by the visiting Otto Rank is reported: the local analysts started to send him their cases for mother-analysis as compared to father-analysis. Brill and Oberndorf are mentioned as resisting this tendency. By far the most interesting and important of Alix's reports deal with Melanie Klein. A great friendship developed between the two women, and we see them haunting the dance halls in exotic costumes far into the night. (Melanie favored Cleopatra, and she drew from Alix references to her fading charm and beauty.) Sometimes they encountered male analysts on missions of their own, and then they avoided each other.

Alix grew enthusiastic about her friend's ideas and asserted that only Melanie could analyze a child. When the latter came to London in the middle of 1925, Alix helped her write her lectures, translated them for her, and taught her English. Her translations in some instances found their way into Klein's later books. Alix enlisted James's help in seeing to it that in London Melanie met the right people in the right places. The effort was such a success that she settled there the next year. A sulky Ernest Jones was browbeaten into submission. One gets the impression that perhaps it was Melanie who was manipulating her benefactors. 1925 also saw the end of Alix's analysis with Abraham, because of his fatal illness. Naturally, this ended the correspondence, since she returned to London.

The correspondence ultimately found its way into a Strachey trust and was deposited in the British Library. Perry Meisel of New York University and Walter Kendrick of Fordham University have done a superb job editing it. There are memorable illustrations in the form of photographs and cartoons. An epilogue carries us

some fifty years forward into the productive lives of James and Alix and discusses their subsequent analysts, patients, lovers, and writings. We are provided with a useful glossary of German and French terms that figure in their exchanges.

Two brief letters by Freud call for mention. In one, he reports being shown the bust of a youthful Semite that had been picked up in Alexandria. He seeks aid in matching it with a picture of the young Disraeli. Quite possibly he is on the trail of the hereditary traits he will go on to depict more clearly in future commentaries on Joseph and Moses. In a second letter, addressed to Lytton Strachey, he reveals his propensity to carry on correspondence with writers of the day, not infrequently suggesting themes for them based on his own insights. He reveals his belief that the Earl of Oxford was Shakespeare, and he traces the supposed influence of Elizabeth's remorse for causing the deaths of Mary Queen of Scots and of Essex on the construction of the character of Lady MacBeth.

Current controversies over the Strachey translations do not receive much illumination from this volume. Very relevant is James's remark that the image he had for himself was of Freud as an *English* (gentle-)man of science. The editors add (pp. x-xi) the opinion (with which I concur) that Freud would have looked favorably on this reincarnation. Quite disarming is the dedication of the *Standard Edition*: "To the Thoughts and Words of Sigmund Freud" as seen in their "Blurred Reflection" (p. 321).

MARK KANZER (HARRISON, N.Y.)

OBSERVING THE EROTIC IMAGINATION. By Robert J. Stoller, M.D. New York/London: Yale University Press, 1985. 228 pp.

Stoller prefaces this group of essays with the statement that this book is "part of an ongoing project on gender identity—masculinity and femininity—and a related subject, erotic excitement." His studies of gender identity problems in children led Stoller to study perversions and in time brought him to "understand the dynamics of anyone's erotic excitement, primarily its nonsomatic roots" (p. vii).

This book is divided into two sections. In the first section, "Dynamics of Erotic Behavior," are included the essays: "Perversion

and the Desire to Harm," "Erotics/Aesthetics," "Centerfold," "Functions of Obscenity," "Problems with the Term 'Homosexuality'," "Theories of Origins of Male Homosexuality: A Cross-Cultural Look," "Transvestitism in Women," and "Erotic Vomiting." Section Two is entitled "The Erotic Imagination" and includes the following essays: "Psychoanalytic 'Research' on Homosexuality: The Rules of the Game," "One Homosexual Woman," "Judging Insight Therapy," and "Psychiatry's Mind-Brain Dialectic or the *Mona Lisa* Has No Eyebrows."

Readers who have kept up with Stoller's prolific and provocative publications will find much that has already been published elsewhere, in somewhat different form. For example, "Transvestitism in Women" was first published in *The Archives of Sexual Behavior*,[1] and "Perversion and the Desire To Harm" is abstracted from his book, *Perversion: The Erotic Form of Hatred*.[2] His essay, "Theories of Origins of Male Homosexuality: A Cross-Cultural Look," was part of an article written by Stoller and Herdt in 1982.[3] His disillusionment with psychoanalytic clinical research as a means of understanding human behavior (the word research is always put in quotation marks) appears in "Psychoanalytic 'Research' on Homosexuality: The Rules of the Game." His article on female transvestitism is derived largely from nonclinical material.

While this reviewer found himself in strong disagreement with many of the central themes presented by the author, it should be kept in mind that Stoller's early psychoanalytic research work in gender identity led to an important advance in psychoanalytic theory. His investigation of children with disturbances in gender identity has both wide relevance and clinical usefulness—a usefulness far beyond that to which he himself has put it. That he does not place the problems of disturbance in gender-defined self-identity firmly within a causative series of events leading to the development of sexual perversion (including obligatory homosexuality) indicates a lack of application and a loss of the fruit of his early discoveries. The reason for this may lie in his statement, "I have little experience in treating people in any of these categories" (p.

[1] Stoller, R. J. (1982): Transvestitism in women. *Arch. Sexual Behav.*, 11:99-115.

[2] Stoller, R. J. (1975): *Perversion. The Erotic Form of Hatred.* New York: Pantheon.

[3] Stoller, R. J. & Herdt, G. H. (1982): The development of masculinity: a cross-cultural contribution. *J. Amer. Psychoanal. Assn.*, 30:29-59

93). This is a surprising statement in view of the authoritative position he takes as to the meaning of perversion.

Despite Stoller's lack of clinical "experience," he asserts (1) that the major difference between perverse individuals and "normal" ones is that in perversions individuals are attempting to form a sustained intimacy with another person, and (2) that they are driven by "an erotic form of hatred," i.e., sustained aggression. To differentiate normal sexuality from perverse sexuality by these criteria is incorrect and overly simplistic. To assign such central importance to aggression without clinical evidence from his *own* analysis of many perversions of varying degrees and types seems unwarranted. The "striving for intimacy" is presented by Stoller as if it is not rooted in deep, underlying pathology. As noted by Khan, it is an attempt to master a traumatic internal problem through controlling the actual external object by concocting "active ego-directed, experimental play-action object relations" in which the very "technique of intimacy" plays a major role.[4]

Such misunderstandings can easily be corrected, but in Stoller's elaboration of his theoretical position, he seems not to perceive the abnormality in perversion or the normality of the standard male-female coital pattern. Freud made it clear what was meant by perverse sexual behavior. He stated:

> In the majority of instances the pathological character in the perversion is found to lie not in the *content* of the new sexual aim but in its relation to the normal. If a perversion, instead of appearing merely *alongside* the normal sexual aim and object, and only when circumstances are unfavourable to *them* and favourable to *it*—if, instead of this, it ousts them completely and takes their place in *all* circumstances—if, in short, a perversion has the characteristics of exclusiveness and fixation—then we shall usually be justified in regarding it as a pathological symptom.[5]

In contrast, Stoller belittles the very notion of "normality" in sexual behavior and states that we assume that most people are "abnormal." He argues that "a psychoanalyst, to maintain that a heterosexual behavior is natural, must ignore the discoveries of infant/child development, from Freud's first description of the necessary, universal vicissitudes of development of oedipal conflict to the present" (p. 201). It behooves us, he asserts, to "announce our

[4] Khan, M. M. R. (1965): The function of intimacy and acting out in perversions. In *Sexual Behavior and the Law*, ed. R. Slovenko. Springfield, IL: Thomas, p. 409.

[5] Freud, S. (1905): Three contributions to the theory of sexuality. *S.E.* 7:161.

biases," for the "burden of proof" of our concepts of normality and sexual behavior "has shifted to those who use the heterosexual standard of health, normality, mature genital characterhood, or whatever other ambiguous criterion serves one's philosophy these days" (p. 102).

Kubie's comments are succinct and invaluable on this point. He concluded that stereotypy and automatic repetitiveness are signposts of a neurotic process. Therefore, when we term perversions not simply alternative life styles or normal acts, we are not issuing a value judgment but rather a clinical description of attributes of behavior common to neurotic and perverse actions, and absent from normal ones. The essence of normality is flexibility in contrast to the "freezing of behavior into patterns of unalterability that characterize every manifestation of the neurotic process, whether in impulses, purposes, acts, thoughts or feelings."[6] Since the predominant forces in perverse patients are unconscious, they will not respond to experiences of pleasure or pain, to rewards, punishments, or logical arguments.

Stoller's indictment that we are biased by our own "philosophy" in deciding whether a particular form of sexual behavior is a disorder represents a serious criticism of our psychoanalytic method of inquiry, regarding not only the meaning of sexual perversions but that of all other forms of psychopathology. Furthermore, it is a criticism voiced by those who would place several of the sexual perversions, especially exclusive homosexuality, in the category of "alternative life styles," and it requires a response. The basic principle which answers the question of whether certain sexual activities can be considered perversions or not was supplied by Freud as early as 1916: "Let us once more reach an agreement upon what is to be understood by the 'sense' of a psychical process. We mean nothing other by it than the intention it serves and its position in a psychical continuity."[7]

Thus, whether or not some sexual practices are perversions can be determined by a study of the conscious and/or unconscious motivations from which they issue. Such an approach leaves little room for social/political theorizing or activism. The psychoanalytic

[6] Kubie, L. S. (1978): Distinctions between normality and neurosis. In *Symbol and Neurosis. Selected Papers of Lawrence S. Kubie*, ed. H. J. Schlesinger. New York: Int. Univ. Press, pp. 115-127.

[7] Freud, S. (1916): Introductory lectures on psycho-analysis. *S.E.*, 15:40.

approach leads to the conclusion that the developmental history of individuals suffering from well-structured sexual perversions shows disturbances in the preoedipal phase of development (as well as in the oedipal phase). Object relations conflicts involving anxiety and guilt associated with self-object differentiation predominate. This type of conflict, from which perversion arises, leaves unmistakable signs in the developing personality and its future maturation.

Lastly, Stoller is highly dubious of the veracity of psychoanalysis and its clinical research findings. Psychoanalytic research uses a psychological language instead of the physical language of the biological sciences, and we investigate the private world of a patient through the use of introspection, in contrast to that of inspection in the physical world. Nevertheless, we can only maintain that until such future time when neural mechanisms for psychological aspects of behavior are more clearly defined, both methods of observation will be required, and the latter will not replace the former.

CHARLES W. SOCARIDES (NEW YORK)

THE SUICIDAL CHILD. By Cynthia R. Pfeffer, M.D. New York/London: The Guilford Press, 1986. 318 pp.

This book is clearly written and informative. I agree with the quotation on the book jacket which states that it is "an important book for all medical and mental health professionals . . . pastoral and guidance counselors, [and] teachers concerned with learning how to detect and stem this tragic phenomenon." The book is divided into four sections. The analytic reader will be more interested in the first two sections than in the last two. My comments will therefore be directed primarily to these two sections. The chapters on the definition of suicidal behavior in children, on the changes in ego functioning leading to suicidal behavior, and on outpatient treatment were particularly interesting to me.

The first section, entitled "Clinical Descriptions and Epidemiology of Childhood Suicidal Behavior," contains four chapters. Chapter One is a brief historical review of the literature on child suicide, including the early psychoanalytic formulations on suicidal behavior. The second is "Definition and Classification of Suicidal

Behavior in Children." The author believes that the intent or the wish to die is a basic component in suicidal behavior in children, as it is for adults, but with a modification: it is not necessary for a child to have an understanding of the finality of death but only to have some concept of death, regardless of how idiosyncratic it might be. Later in the book, in another section, there is a chapter in which Pfeffer discusses children's concepts of death more fully.

The third chapter is "The Epidemiology of Childhood Suicidal Behavior" and the fourth is "The Suicidal Episodes of Children." The book is replete with clinical illustrations that are helpful to those readers who are not accustomed to dealing with children or, more specifically, with suicidal children; the clinical examples are less helpful to the more sophisticated clinician and analytic reader.

The second section is entitled "Risk Factors for Childhood Suicidal Behavior." This section's ten chapters cover a wide range of risk factors, including biochemical, social, developmental, and intrapsychic aspects. Pfeffer offers research findings in relation to adult and child affective disorders. Under social risk factors are various family inputs. Pfeffer's hypothesis is that there are five important aspects of family patterns involving these children: lack of generational boundaries, severely conflicted parental relationships, parental feelings projected onto the child, a symbiotic parent-child relationship, and an inflexible family system. These factors interact to produce a family atmosphere that affects the child's personality development and identity. The child's suicidal tendencies arise from failure of the child's ego to maintain a stable balance between forces promoting positive perceptions and those promoting negative perceptions of self and others. The final chapter in this section contains an elaborate examination of the suicidal child's ego functioning.

Pfeffer says, "For a unified theory of suicidal behavior to exist, these [risk] factors must be integrated into the construction of a hypothesis about the interaction of intrapsychic function with the other classes of events" (p. 167). She uses intrapsychic functioning here to refer to mental structural conflict and its resolution via compromise formations. She lists a variety of symptoms, such as obsessions, compulsions, phobias, behavior problems, learning problems, and affective disturbances, and refers to these as Phase I. Other classes of events are included in three subsequent phases

through which the child passes on the way to suicidal behavior. The child in Phase II has superimposed on top of the original stresses of Phase I the added stresses from physiological, developmental, and/or external factors. Two outcomes may occur, depending upon the vulnerabilities of the child. Vulnerabilities are determined by genetic factors, early experience, physical environment, temperament, etc. Children with low vulnerability develop nonsuicidal symptoms or no symptoms, while children with high vulnerability develop feelings of helplessness. In Phase III, the rescue fantasies of a child who is feeling helpless are thwarted. This leads to a feeling of hopelessness, and the hopelessness becomes linked with a preoccupation with death. Finally, in Phase IV, additional stress is the immediate stimulus for the suicidal behavior. This schema may be useful, but it would be helpful to have seen clinical material demonstrating the author's hypothesis. I would conceptualize suicidal behavior as a symptom, a compromise formation. Suicidal behavior is multidetermined.

Pfeffer's illustrations of outpatient psychotherapy are fine examples of good child psychotherapy. The therapists make use of the therapeutic power of the positive transference, play as abreaction of trauma and as catharsis, identifications with the therapist, corrective emotional experience, etc. Interpretations of conflict and of fantasies are made, but they are subordinated to the maintenance of a positive relationship with the patient. For example, we are told, "Samuel experienced any interpretation as a deprivation; in response to this, the therapist made fewer interpretations." (p. 232).

A psychoanalyst interested in this subject will be enlightened by the breadth of coverage in this book. (The well-organized table of contents, with clear one-line descriptions of issues covered in each chapter, make it a fine source book.) But the analytic reader may well be disappointed with the book's lack of depth.

ALLAN JONG (NEW YORK)

DEPRESSION AND CREATIVITY. By André Haynal. New York: International Universities Press, Inc., 1985. 271 pp.

The title of this book is misleading. The author follows a wandering path through a wide sampling of the literature and offers

many original ideas of his own, but this is strictly limited to the subject of depression. There is one brief mention of creativity in the introduction and one short chapter near the end on "Cultural Creativity," which is never defined, but that is all.

The preface contains the clearest piece of writing. In it the author discusses depression as essentially an affective state, its relation to losses and attempts at reparation, and the distinction between depression on the one hand and psychic pain on the other, against which depression is seen as a defense. He explores the difference between these two and between anxiety and guilt. The implication throughout, occasionally overtly stated, is that both depression and anxiety are ubiquitous in psychoanalytic work and play a universal part—to some degree—in painful human experience.

The book is divided into two parts. The first presents the author's own views. The second is devoted to a historical survey of the evolution of psychoanalytic thought on depression, beginning with a summary of Freud's original contributions.

The first part consists of thirteen rather disconnected essays. They move from the subjects of depressive affect, childhood (especially in connection with the *Anlagen* of depressive character structure), and helplessness, to mourning, death, introjection and identification, superego, defenses, and boredom. Then there is the brief chapter on creativity, culture, and civilization.

Throughout the book, the author gives the impression that he is a scholarly, sensitive, highly innovative thinker, who should have written a great deal more than he appears to have done. His ideas are presented in such a fragmented, condensed manner that unifying themes are difficult to find. Badly needed expansion, clarification, and, above all, clinical illustration, are left out. An adequate summary of the author's main conclusions cannot be provided in a brief review. The inviting quality of the writing is shown in the following passages, the first one coming from the Introduction:

> If the present work can lay claim to any originality, I would hope that it is in its concentration on the processes linked to the depressive *affect* (as encountered in psychoanalytic practice) and in its treatment of depressive illness as only one of the possible outcomes of these processes, another being cultural creativity (p. 8).

The second passage comes from the Conclusion:

> It is latent despair and the feeling that one's inner world is crumbling that finally incite the subject to a working through, with all its pain and toil, thus paving the way for a better integration of the inner world and creativity. This work can be accomplished outside psychoanalysis as well, through the cultural process; success in either is creativity (p. 159).

While it is true that a long list of famous "creators" suffered at various times from severe depressive episodes, and this includes the "creative illnesses" of Freud and Jung, there is no evidence that despair and depressive affect are either necessary or sufficient causes for the creative process. In the first place, it is needless, artificial, and indeed confusing to confine our view of creativity to those whose products have achieved public acceptance or renown. Erikson and others who have studied the issue have pointed out that four factors, the epigenesis and current intrapsychic state of the creator and the historical roots and present state of the culture to which the product is presented, all play a part in determining how the product is received. In the second place, attention can be usefully drawn to Kubie's[1] point, made over thirty years ago but still valid, that the creative process involves a preconscious "shuffling about of old bones"—perceptions, memories, ideas, and affects—into new relationships with new (I would call them emergent) qualities, at a preconscious level. These emergent qualities are then organized in relation to external reality by preconscious and conscious, emotional and cognitive work. He makes very clear that neurotic processes, depressive and otherwise, can distort and interfere with this creative work. He cites the familiar psychoanalytic experience of a beginning or prospective analysand fearing the loss of his creative capacity or potential as a result of analysis, a fear which he and I have never found justified.

To be sure, psychic pain, despair, or depressive affect (and I would add plain sadness) can *incite* the painful work of repair and reorganization. Haynal himself points out the ubiquity of depressive affect in analytic cases. But it does not necessarily play an inevitable, major part in creative efforts. That working out personal problems *can* lead to a success in the fields of art or science has been amply demonstrated. That it is a necessary or even facilitating precursor to creativity has by no means been demonstrated, how-

[1] Kubie, L. S. (1958): *Neurotic Distortion of the Creative Process.* Lawrence: Univ. of Kansas Press.

ever, either by this book or by any other I have read. To approach this from a different direction, is not every successful analytic result a creative product, regardless of the reasons for undertaking it?

Haynal has not explicitly limited his concept of creativity to the role of depressive affect and the psychic mechanisms mobilized to deal with it, but he implies this by the absence of discussion of any other aspect of the nature of creativity as process. His non-recognition of the ubiquitousness of depressive feeling as a unique human phenomenon, whether directly observable or blocked by psychosis, neurosis, educational tradition, or cultural-political constrictions also points that way.

In sum, this book is worth reading if one can bear with the difficulties and frustrations of the author's rather involved, fragmented, and in some ways disconnected style and the relative paucity of clinical material, and if one is looking for a fascinating discussion of depression. But this is not a very useful book on the subject of creativity.

BENJAMIN C. RIGGS (CHARLESTON, S.C.)

ON LEARNING FROM THE PATIENT. By Patrick Casement. London/New York: Tavistock Publications, 1985. 244 pp.

Patrick Casement has set out to write a book primarily on technique. However, it is never made quite clear whether the technique he is addressing is psychoanalytic or psychotherapeutic.

The first chapter draws on Matte-Blanco's ideas and models, and the notions of transference and countertransference are related to the concepts of sets, subsets, and symmetry. However, Matte-Blanco's ideas cannot be conveyed in such a short chapter without oversimplification, and this is indeed what occurs. Casement, in this chapter, also introduces the idea of an "internal supervisor," which then forms the major theme of the book. It refers to an internal figure which derives from the experience of supervision. It is an attempt to conceptualize the idea of having one's supervisor inside one, observing oneself reacting and responding to the patient. This is reminiscent of an idea of Bion, who often maintained that it requires at least two analysts to analyze one patient!

The second chapter describes the evolution of the internal supervisor, an important aspect of which is what Casement calls "trial

identification." This is basically a conscious attempt to identify with the patient and the patient's object relationships, including his or her views of the analyst. It is similar to the technique Marino employed in groups when he made participants play the roles of their objects. I suppose we all do this as we examine the patient's transference relationship to us, but Casement makes it much more conscious and explicit. There is also a description of how the therapist learns to use unfocused listening.

Chapter Three focuses on the use of this technique to correct the effects of a technical error through the awakening of the internal supervisor who "had veered away from the patient," thereby causing the error (p. 62). In Chapter Four, Casement talks about interactive communication and the use of projective identification as a form of affective communication. He also mentions work by Pearl King and Joseph Sandler on unconscious communication and makes some comments on countertransference. Casement frequently emphasizes what he calls the interactional viewpoint. The next four chapters deal with the "dynamics of containment" and its failures, and with space and boundaries. They are somewhat repetitious in places.

Casement writes clearly and simply, which is good, but he frequently tends toward the simplistic, despite dealing with subtle and complex subjects. He has clearly gained a great deal from Bion and Winnicott, and he quotes them liberally. The tone and level of his book are demonstrated immediately in the introduction, which I quote in full to illustrate this:

> There is a common myth that the experienced analyst or therapist understands the patient swiftly and unerringly. Although some patients try to oppose this, risking the retort that they are resisting, other patients do expect it. Perhaps it satisfies a wish to find certainty. Some therapists also appear to expect it of themselves, perhaps to gratify an unacknowledged wish to be knowledgeable or powerful. It is not surprising, therefore, how often student therapists imagine that immediate understanding is required of them by patients and supervisors. This creates a pressure to know in order to appear competent. Interpretations offered to patients may then be taken off the peg, culled from the writings or teachings of others, who in turn have accepted such formulations as time-honored, even though over-use rapidly degrades these insights into analytic clichés. (p. xi).

Reading this, it is quite difficult to know who is being talked about, and there certainly is a setting up and knocking down of

straw men. Casement seems to be saying that omnipotent expectations, either in patients or in therapists, can lead to omniscient attitudes, which are antithetical to learning, development, and psychoanalysis. This is certainly an important statement, but is is repeated over and over in different ways and different guises. In fact, apart from the observation about the setting up of the internal supervisor, this is practically the sole message of the book. It is certainly valuable, but one would hope that psychoanalysts would have learned this well very early in their careers. If the book is addressed to beginners as a primer, then it may not be a bad idea to repeat this message over and over, but if it is addressed to experienced analysts, it seems rather patronizing.

At the beginning of the first chapter, Casement says, "There are many different caring professions, but the psychodynamics of any helping relationship may be universal" (p. 1). Here is another example of a rather woolly generalization. Casement does not differentiate "helping relationships" which are essentially transference cures and all those therapies which depend on identification with an idealized object, from psychoanalysis, in which unconscious psychic structure is modified through analysis of transference repetition. He never addresses the essential difference between change in behavior and true psychological development. This is due to the failure to differentiate between psychotherapy and psychoanalysis.

Casement illustrates his ideas with many examples from twice-a-week analytic psychotherapy. The examples depict the results one would expect from psychotherapeutic work, which differs in its accuracy and its effects from psychoanalysis. Much of the book is about dealing with certain mistakes and traumatic situations which occur because of poor technique, which, of course, is somewhat unavoidable in psychotherapy, since one is pressured to do more in the time available than sometimes is possible. Psychotherapy includes much less of the luxury of evidence than does psychoanalysis. I do not mean to infer that psychoanalysts do not make mistakes, but it is difficult for me to believe that many of us would make the kind of technical mistakes described by Casement.

I want to make it clear that I do not believe that psychoanalysts make accurate interpretations quickly or easily. Our work involves a series of approaches to a solution which gradually become more

and more complete and accurate as the analytic relationship develops over months and years. In fact, our work is always "mistaken" or incomplete, because of the very nature of continuing psychoanalytic explorations. We are always modifying, adding, correcting, and subtracting from our ideas and our interpretations as times goes on and we watch the responses of our patients and gather new evidence from them. But the outright mistakes in technique that Casement talks about, sometimes from his own work and sometimes from that of straw man psychoanalysts, are somewhat different. He describes a case in which he obtains a recommendation from a patient to use the patient's dentist, and he borrows a tape from the patient for the purpose of conducting sleep therapy on himself. He talks about mistakes related to changes in session times and mistakes connected to therapists' anxieties, intrusiveness, and premature interpretations. A lot of this is useful for people in training, but I would be surprised if experienced analysts would fit into the "straw man" descriptions Casement provides.

Casement examines the problems of "containment" of the patient's uncontainable feelings and the problems of countertransference, and he also says a bit about projective identification. However, he does not clearly link these three with one another nor does he deal with the anxieties underlying the whole process of projective identification. He frequently tells us that we are doing something wrong, i.e., not containing our patients' feelings, and advises us on how we should be doing this, as though we could achieve this by conscious effort. This misses the vital point that "uncontainable" projections are uncontainable because they are persecutory and overwhelming. This is so because the underlying anxieties presumably are primitive, at times psychotic, and are unconscious.

Containment on our part can only be achieved if we *understand* the anxieties; otherwise we too will be driven to action or evacuation, as is the patient. True containment can never be simulated. It is not the same as holding projections via a conscious effort and refraining from responding to them. Moreover, unless we understand the underlying anxieties that need containment and cause the projective identification, we cannot interpret what they are, i.e., what the patient is defending himself against via the projections. If this is not done eventually, the underlying pathology will never change. Temporary relief may be obtained, but the problem

will recur unless real diminution of anxiety occurs through understanding being conveyed to the patient, especially through analysis of the transference.

While I feel a certain sympathy with Casement and what he is saying in his book, and with the hard work and sincerity which are clearly evident there, I find his depiction of many of the problems oversimplified and somewhat naïve. It seems to me that he seeks to contain therapists' anxieties in a reassuring way rather than helping them to become therapists with a full understanding of the psychodynamics underlying the problems involved. This is a book I would recommend to students, residents, and perhaps to beginning analytic candidates, but I think most practicing analysts would find it rather elementary.

ALBERT MASON (BEVERLY HILLS, CA)

FAMILY DYNAMICS IN INDIVIDUAL PSYCHOTHERAPY. A GUIDE TO CLINICAL STRATEGIES. By Ellen F. Wachtel and Paul L. Wachtel. New York & London: The Guilford Press, 1986. 258 pp.

"Developments in family therapy ought to be useful to the individual therapist," is the first line and main thesis of this book by a wife and husband whose expertise is in the fields of family therapy and individual therapy respectively. They proceed to outline the ways they integrate in their individual psychotherapy cases the various theories of family interactional processes and techniques used by family therapists. It is important to emphasize that they do *not* propose that these approaches be used in psychoanalysis. Psychotherapists whose work is strongly influenced by psychoanalytic concepts will regard some of them with skepticism.

Initially, the authors present their ideas about individual psychodynamics and therapy, which are influenced both by behavioral concepts and by the theories of Erikson, Horney, and Sullivan. They then summarize the principal concepts in the field of family therapy in a clear and concise way. In the remainder of the book they detail ways they have found to apply these family system concepts and techniques to individual therapy. They ask questions about the patient's family system, constructing a genogram or family tree, make interpretations based on what they understand about the family system, give tasks to the patient to carry out, make

paradoxical interpretations, use the technique of reframing, and finally, and perhaps most controversially, bring in members of the patient's family for interviews together with the patient.

Some of these approaches impress this reader as useful and refreshing, but others may present pitfalls for the unwary therapist. An example of the former is the authors' recommendation to ask patients what they do to try to rid themselves of their symptoms. This is done to determine what they might be doing that is exacerbating their problem rather than relieving it. Similarly, constructing a genogram of the patient's family is an exercise frequently used in family therapy that can also be helpful in individual therapy.

Other techniques which they espouse, however, such as paradoxical interpretation, reframing, and bringing family members into sessions with the patient, are questionable at best. Paradoxical interpretation consists of instructing the patient not to try to reduce his symptomatic behavior but rather to observe it closely or even to increase it if possible. This aims at breaking the vicious cycle in which the patient presumably is engaged. The authors are aware that this can be viewed as manipulative and out of place in insight-oriented therapy but they argue the merits of their approach nonetheless. Similarly, they attempt to justify the routine interviewing of family members despite the obvious circumvention of resistance and contamination of transference which that involves. As the Wachtels pursue their goal of integrating family and individual psychotherapy, they fail to distinguish sufficiently those techniques of family therapy which might be utilized appropriately in individual psychodynamic therapy from those which cannot.

MARVIN A. NIERENBERG (NEW YORK)

ART AND PSYCHE. A STUDY IN PSYCHOANALYSIS AND AESTHETICS. By Ellen Handler Spitz. New Haven/London: Yale University Press, 1985. 188 pp.

The general aim of *Art and Psyche* is to contribute to the "ongoing dialogue between psychoanalysis and aesthetics" (p. ix). This aim is, I think, largely realized. Spitz not only summarizes with great clarity an impressive number of the speakers who have contributed to the conversation; she also makes a contribution of her own.

First, she offers us three "paradigms" (p. x) of the relationship between psychoanalysis and art. Second, she puts forward a number of criticisms and speculations, of or based upon the texts from which the paradigms were derived.

Each paradigm consists of an aesthetic problem, a modality of art criticism, and a specific aspect of psychoanalytic theory. In the first, which (following Freud) Spitz terms "pathography" (p. x), the focus is on the relationship between the artist and the work of art. Spitz aligns this problem with classical psychoanalytic theory and with Romantic criticism, "with its emphasis upon the centrality of the artist's experience" (p. x). In the second, the focus is upon the work of art itself, as a microcosm, an autonomous reality which must be understood in its own terms. The correlates here are ego psychology and so-called Objective or New Criticism. In the third, the focus is upon the relationship between a work of art and its audience. Spitz sees object relations and "reader-response" criticism as the related modalities in this instance.

Having announced these three models of interpretive context, Spitz then states that she is "in the odd position of challenging the very models I have set up by showing that any interpretive context is necessarily more extensive and complex than can be consciously known by the interpreter at any given moment." Hence, "all three paradigms may be seen as holding more features in common than is readily apparent" (p. xi).

I shall return in a moment to the odd position into which Spitz has placed herself. But at a minimum, her three paradigms permit her to impose some order upon the world of psycho-aesthetic experience. After an introductory overview chapter, she proceeds to discuss the contributions and limitations of pathography. Romantic criticism and pathography are linked by their view that works of art should be interpreted from the perspective of the artist's intentions, i.e., by an expressive theory of aesthetic experience. Spitz raises two fundamental critical issues concerning this orientation: "one is whether psychoanalysis can adequately account for the artist's intentions, and the other is whether we must allow for aspects of a given work of art that are extraintentional" (p. 39). To the first issue she responds that psychoanalysis widens the field of intentionality, from conscious to conscious *and* unconscious, and so adds to the richness of intentionalist criticism. As to the second,

she acknowledges that the meaning of a work of art is not reducible to the intentions of the artist.

Spitz's general assessment of pathography is sound enough. It is also characterized by an admirable thoughtfulness and absence of dogmatism. I was even more interested, however, in her treatment of three particular examples of pathography: Freud's *Leonardo da Vinci and a Memory of His Childhood*,[1] Liebert's *Michelangelo*,[2] and several works on René Magritte by Martha Wolfenstein. Spitz characterizes Freud's approach as "fictive" in order to "emphasize its special quality as an imaginative piece of interpretive writing that serves to raise, if it does not fully answer, intimate and searching questions about Leonardo and his work" (p. 65). This judgment is, I think, overly generous. Although all interpretation involves a degree of fusion between the interpreter and the object interpreted, on Spitz's own accounting Freud's study tells us little about either Leonardo or his work. Indeed, one could argue that the Leonardo study is actually, if latently, a work of reader response criticism: Freud reports to us what the facts of Leonardo's life and certain paintings mean to *him*, i.e., to Freud, although he then attributes these meanings to the things themselves. Liebert's study of Michelangelo, by contrast, has both a scholarly dimension and a respect for such purely aesthetic issues as artistic tradition and form. Hence, Spitz characterizes it as a "documentary" and as a "genuine critical enterprise" (p. 74).

Spitz views Wolfenstein's work on Magritte as "thematic." Wolfenstein, as she observes, spent many years in clinical exploration of children's reactions to the loss of a parent. She brought this interest and the knowledge acquired in its pursuit to bear upon her studies of Magritte, whose mother committed suicide when he was thirteen years old. Using the painter's reaction to this loss as a locus

[1] Freud, S. (1910): Leonardo da Vinci and a memory of his childhood. *S.E.*, 11.

[2] Liebert, R. S. (1983): *Michelangelo. A Psychoanalytic Study of the Man and His Images*. New Haven/London: Yale Univ. Press. Reviewed in this *Quarterly*, 1985, 44:311-316.

[3] Wolfenstein, M. (1973): The image of the lost parent. *Psychoanal. Study Child*, 28:433-456.

——— (1974): The past recaptured in the work of René Magritte. Unpublished manuscript prepared for the Margaret S. Mahler Symposium, May.

——— (1987): *The Man with the Bowler Hat*. New Haven/London: Yale Univ. Press. (In press.)

of interpretation, Wolfenstein traced its effects in the development of his art. Spitz concludes that "Wolfenstein's brilliant work in reconstructing the psychic reality of Magritte around the theme of maternal loss in childhood has added a new dimension to our perception of . . . [his] paintings and in so doing has contributed substantially to the interdisciplinary dialogue" (p. 90).

The remaining chapters of the book are rather more problematical. With respect to the analysis of works of art as such, I do not see that there is a genuine parallel between the autonomy of ego functions and the autonomy of a text. Ego functions are postulated features of people, which an interpreter might or might not (a) conceive of as relevant to intentionalist criticism or (b) view as immanent in a text. The point of objective criticism, however, is to view the text as a thing-in-itself, so the paradigm does not really hold together. Then when Spitz comes to audience-based criticism, she pretty much runs out of texts to criticize. Instead, she offers a lovely discussion of object relations theory and its possible relevance to the interpretation of aesthetic experience. Moreover, it is evident that object relations theory also has implications for *both* of the other critical paradigms.

This returns me to the earlier point concerning Spitz's challenge to her own models. The problem is that Spitz divides up totalities that are in fact (and which she also really sees as) united. On the one hand, aesthetic experience has three interpenetrating aspects: artist, work of art, and audience. There are a variety of ways in which these aspects interact to constitute art. One may focus upon one of them to bring out its distinctive features, but the interpretive aim is to grasp them in their unity. On the other hand, psychoanalysis offers different ways of interpreting *all* dimensions of aesthetic experience. What Spitz calls classical theory brings out drive-resistance configurations wherever they may be found, ego psychology brings out adaptive and synthetical dimensions, etc. There is no necessary congruence between a particular trend in psychoanalytic theory and a particular aspect of aesthetic experience. Nor, for that matter, do these trends fit together neatly with the various modalities of art criticism. These critical modalities, by the bye, also have the problem of splitting up into mutually exclusive categories what are in fact dimensions of an experiential manifold.

In sum, I think Spitz has created a conceptual problem for herself which she might have avoided. Nonetheless, she focuses upon the appropriate conceptual elements. When these concepts are combined with the wide range of art critical and psychoanalytic knowledge she possesses and articulates, the result is a lively and engaging exchange of insights and perspectives.

EUGENE VICTOR WOLFENSTEIN (LOS ANGELES)

THE NAZI DOCTORS. MEDICAL KILLING AND THE PSYCHOLOGY OF GENOCIDE. By Robert Jay Lifton. New York, Basic Books Inc., 1986. 461 pp.

It is impossible to become inured to the horrors of the Holocaust. It takes a strong stomach to read this book, which examines how and why the German doctors participated in the program to exterminate the Jews and other "enemies of the State." Lifton tries to answer the questions: how did healers become killers? and, why *genocide*? What was the source of the impulse to destroy a human group in its entirety?

The book is divided into three parts. Parts I and II (entitled "Life Unworthy of Life: The Genetic Cure" and "Auschwitz: The Racial Cure") describe the progression from sterilization of the feebleminded to mass murders in the camps. Discussions of how the Nazis deluded themselves into thinking that what they did was for the common good are woven into a historical account.

The methods the Nazi regime used to persuade German doctors to take part in the Holocaust capitalized on the anti-Semitism that had long existed in Germany but was given new impetus after World War I. The pervasive feeling in Germany was that the country had lost the war because it had been betrayed by the Jews and the Communists. Germany's post-war chaos was seen as an Aryan illness caused by the Jews: the agents of racial tuberculosis. Once the medical metaphor was accepted as the truth, the Nazis could adopt a more casual tone: "Anti-Semitism," said Himmler, "is exactly the same as delousing." The bearers of deadly disease who threatened one's own people with extinction had to be eliminated.

Nazi ideology emphasized the concept of the *Volk* and of the State's duty to protect it. The State existed not to safeguard the rights of the individual but to serve the race. The life of the nation

took precedence over any opposing dogma or conflict of conscience.

Prominent scientists subscribed to this view. The ethologist Konrad Lorenz, for example, stated in 1940 that "it must be the duty of racial hygiene to be attentive to . . . elimination of morally inferior human beings. . . . This role must be assumed by a human organization, otherwise, humanity will . . . be annihilated by . . . degenerative phenomena . . ." (p. 134). The doctors were bribed covertly. The elimination of Jewish professionals benefited non-Jewish German doctors materially. No wonder that, of all the professions, medicine was the one with highest percentage of members in the Nazi party (forty-five percent).

The fiction of doctors as protectors of the race was declared everywhere. Doctors who were reluctant to become "racial hygienists" were told that concentration camp duty was the equivalent of front-line duty and that refusal would be considered desertion. Just like the soldiers' work at the front protecting the *Vaterland*, the doctors' work in the concentration camps was a matter of loyalty and sacrifice. That bit of propaganda was but one instance of the fundamental perversion of "duty" invoked by the Nazi regime. A grotesque example was the requirement that each of the "euthanasia" victims had to have a legitimate death certificate signed by a doctor.

Part III explores genocide. It is the weakest part of the book. Lifton's model, a highly idiosyncratic one, is based on the writings of Otto Rank. After criticizing Freud's model as inadequate, Lifton tries to explain the doctors' individual psychodynamics, using Rank's concept of doubling, i.e., the division of the self into two functioning wholes. How doubling compares with the broader Freudian concept of splitting associated with externalization, projection, denial, and reaction formation is not made clear beyond the statement that splitting is not a broad enough concept.

To sum up: this is a comprehensive historical sociological study of one gruesome aspect of the Holocaust. Lifton has dealt with the broad theme of human destructiveness in his previous books on Hiroshima and Vietnam.[1] This book is an extension of that

[1] Lifton, R. J. (1967). *Death in Life: Survivors of Hiroshima.* New York: Random House. Reviewed in this *Quarterly*, 1969, 38:488-491.

Lifton, R. J. (1973). *Home from the War. Vietnam Veterans: Neither Victims nor Executioners.* Reviewed in this *Quarterly*, 1976, 45:325-329.

theme. Regrettably for the psychoanalytic reader, Lifton's explanations seem more philosophical than psychological. The formulations are simplistic, and the concept of doubling does not explain how such a massive perversion could take place. That is unfortunate because the book provides much firsthand information, obtained from direct interviews with Nazi doctors who participated in the killing program.

H. GUNTHER PERDIGÃO (NEW ORLEANS)

THE STRUCTURE OF MIND IN HISTORY: FIVE MAJOR FIGURES IN PSYCHOHISTORY. By Philip Pomper. New York: Columbia University Press, 1985. 192 pp.

Professor Pomper, a historian at Wesleyan University, offers a structural analysis of the psychohistorical formulas developed by Freud, Erik Erikson, Herbert Marcuse, Norman O. Brown, and Robert J. Lifton. He expresses the belief that his analysis is applicable to psychohistorical thought generally. In the chapters devoted to consideration of these writers individually, he provides incisive and comprehensive reviews of their forays into psychohistory. But as Pomper himself acknowledges, and as these five writers demonstrate, the application of Freudian psychodynamics to history has attracted a wide spectrum of authors who differ dramatically in their interests, assumptions, and purpose; and generalizations about their work are likely to be, at best, anemic.

In his introduction, Pomper suggests that contemporary psychohistorians "now see the unconscious mind mainly as the product of external historical forces" and have discounted innate, organic determinants of the unconscious as postulated by Freud. But, in fact, while this is true of some, many writers of psychohistory have no problem with the notion that psychosexual development and, therefore, the development of the unconscious are determined in significant part by organic processes, with only a limited role played by culture and society in the shaping of the unconscious.

In his first chapter, "The Psychohistorical Intelligentsia," Pomper considers the attraction of the intelligentsia to reformist or revolutionary ideologies and the enlistment of Freudian psychodynamics in the service of such ideologies. He notes the tension between, on the one hand, the utopian aspirations of these ideologies

and, on the other, the retort to all utopian schemes implicit in psychoanalysis as well as in Freud's own skepticism with regard to faith in the revolutionary improvability of man's lot. Pomper points out the even greater dissonance between Freud's views and any teleological perspective on history. He suggests that members of "the psychohistorical intelligentsia" are obliged to come to some personal reconciliation of their political aspirations with the contrary implications of their psychoanalytic tools. Yet these statements, too, are relevant to only a particular portion of those who write psychohistory. Likewise, Pomper's caveat regarding "endopsychic anthropomorphism" in history writing, the application of psychodynamic constructs to the characterization of history or societies or particular epochs, is hardly germane to all writers of psychohistory. Insofar as it does have general relevance, it does so only in the sense that all historians might similarly be said to be guilty of some inevitable anthropomorphism in their discussions of history or of political and social entities.

Pomper goes on to consider the "architectonics" of his writers' psychohistory, with architectonics defined as principles for the structuring of processes of development; in particular, genetic, epigenetic, dialectic, systemic (or cybernetic), and catastrophic principles. The structural approach has been used elsewhere to analyze historical models, and Pomper's intent is to apply it to the analysis of the works of his five psychohistorians. However, there are limits to the utility of the approach. As Pomper points out, each of the five invokes at least several of the principles in his work, and structural analysis of itself does not reflect the broad differences in these writers' methods. Moreover, each writer's particular style of psychohistory was shaped by his cultural milieu, his education, his personal dynamics, and the particular concerns generated by these factors, and the structural approach casts very little light on any of these determinants. Pomper is generally sensitive to the limitations of his analysis and does refer to some of the influences determining his writers' perspectives, but such observations do not mitigate the intrinsic weakness of the emphasis on architectonics.

Freud's "genetic" approach to psychohistory, his historical interpretations infused with the assumption that the psychosexual development of the child recapitulates the history of the race, the

analogy of child to primitive, were consistent with the spirit of much evolutionary and anthropological theorizing of his time. Also, insofar as he saw history as offering support for his psychosexual theories, he was following a common medical tradition of bolstering clinical observation with historical arguments. And insofar as he perceived his theories as needing such bolstering, in the wake of his disappointments with regard to deriving from the studies of physiologists the somatic foundations of psychosexual development, surely his historical arguments reflect at least in part a failure—inevitable in his time—to appreciate the power of other sources of support, such as that to be had from organized, large-scale observation of children.

For Herbert Marcuse and Norman O. Brown, psychohistory is primarily the invoking of psychodynamic interpretations of history in support of particular political and social arguments; a far remove from the clinical emphasis of Freud or that of Erikson or Lifton. It is to psychohistorians in the Marcuse/Brown mode that Pomper's observations in his introduction and in his chapter on the psychohistorical intelligentsia, including his caveats, are most relevant. Moreover, the structures of their psychohistory, especially the emphasis on dialectics, reflect the centrality of their political and social programs and are not merely a matter of some independent historical aesthetic. The primary interests of Marcuse and Brown are so far removed from those of Freud or Erikson or Lifton that it is difficult to conceive of any generalizations about the five of them being very substantive.

Despite Erikson's inclination to ascribe to societies the characteristics of individuals and to invoke teleological perspectives, his emphasis on the individual as agent in society in his psychohistorical writings does offer the promise of a path for avoiding many of the pitfalls of psychohistory, such as those noted by Pomper. Stripping away the teleology and the anthropomorphic depictions of community and history in *Young Man Luther*, one can see the possibility of an approach in which the individual's psychosexual and concomitant psychosocial development is conceptualized as the product of both innate, organic factors and the constraints of rearing. There is no need to argue for the exclusive importance of the latter or for the overriding centrality of the former. The ten-

sions derived from the exigencies of development combine in particular ways with the tensions imposed on the person by the social milieu. These then shape the individual's rapport with that society and aspirations within it. Certain people, whether the impetus be conceived as Freudian sublimation or Eriksonian mastery, are drawn to assume roles in their society which—in this social manifestation of the quest to resolve personal tensions—lead to notable changes within that society. This is an analysis that allows for a psychodynamic consideration of the individual in history without any need to ascribe psychodynamic characteristics to the individual's society or culture or to history itself.

It is noteworthy that none of the psychohistorians considered by Pomper is a historian by training and that the primary interest for each is something other than the explication of historical issues. Their interest is, rather, in psychodynamics or political argumentation or both. And their fallacies of anthropomorphism and teleology follow in large part from the nature of their interests and perspectives. But history is neither the sum of the race's psyches—any more than individuals are the sum of their neurons and other cells—nor the race's soul struggling through a long night in search of the ideologue's new morning. Erikson's *Young Man Luther* is illustrative of how far removed these writers are from the writing of history. There is hardly any discomfort on Erikson's part with the paucity of information on which he bases his inferences about Luther's growing up, or with his broadbrush characterization of Luther's epoch. This is because his concern is with elucidating the psyche, and with arguing for particular dynamics to the interplay between psyche and society, not with tracing the events of history.

Much the same can be said of Robert J. Lifton's studies of recent historical events. However, Lifton, in his exploration of psychological responses in the wake of communal catastrophes, such as those responses he labels "psychic numbing," "survivor paranoia," and "desymbolization," often looks closely at a large number of survivors of particular catastrophes to measure both the actual prevalence of these psychological responses and their implications for the individual and the community. Insofar as he employs this method of investigation, he introduces an approach to psychohistorical studies which has the potential to render them more useful

as history: the corroborating of theories about the interplay of psyche and society by historical investigation. One need just imagine the different value qua history of Erikson's work on Luther had Erikson chosen, for example, to look at a large number of Reformation leaders, at the dynamics of their early lives, and to test with historical data the validity of his theses about the correlations between the stresses in Luther's growing up and Luther's responses to the spiritual stresses in society. Perhaps when there are psychohistorians who are more willing to use such tools to test their theories, psychohistory will be less in need of analyses separate from those of historiography in general.

KENNETH LEVIN (BROOKLINE, MA.)

THROUGH A FREUDIAN LENS DEEPLY: A PSYCHOANALYSIS OF CINEMA. By Daniel Dervin. Hillsdale, N.J./London: The Analytic Press, 1985. 244 pp.

In this book, the author takes the reader on a remarkable journey. He explores a host of films with very different plots, analyzing them from one main vantage point, that of the primal scene.

The volume begins with a quotation from Melanie Klein: "In a number of cases it became clear that theaters and concerts, in fact any performance where there is something to be seen or heard, always stand for parental coitus—listening and watching standing for observation in fact or phantasy—while the falling curtain stands for objects which hinder observations, such as bed clothes, the side of a bed, etc." (p. 10).

Dervin then presents a succinct, excellent review of the literature on primal scene trauma and fantasy, from Freud on. He notes that a number of writers have interpreted aspects of literature in terms of the primal scene. However, he also cites Aaron H. Esman's caution against attributing too much to the primal scene, lest "by explaining everything, [it] succeed in explaining nothing" (p. 13). He goes on to discuss Harold P. Blum's suggestion that the primal scene be given precise definition to avoid blurring the boundaries between it and other concepts. Blum noted that primal scene exposure is essentially pathogenic, whereas primal scene fantasy need not be harmful.

Although Dervin does not disagree with these observations, he prefers Henry Edelheit's extension of the definition of the primal scene. Edelheit, describing the "universal mythmaking power of the primal scene," noted that it "antedates the oedipal configuration, determines its form, and provides a framework for understanding its distortion by regressive trends" (p. 15). Dervin finds Edelheit's view "that the concept is structural rather than motivational" most valuable. He states, "Thus to apply the term to far-ranging cultural phenomena, one need not establish an unconscious motive on the part of the agent" (p. 16).

This reasoning allows Dervin to establish five categories which signify primal scene equivalents in films. These include association between sex and danger; plots that turn on the uncovering of secrets; emotions of envy, betrayal, and desertion; an often ambiguous third party as witness; and an interplay between immobility and motion. As a result, science fiction, war dramas, love stories, historical pieces, and horror stories all are interpreted in terms of the primal scene. It follows that the camera acts as a voyeur observing the primal scene. The content of perhaps one hundred films is examined. Primal scene material is seen as the dominant theme in such diverse works as *Alexander Nevsky, Blow-up, The Elephant Man, Fanny and Alexander, Invasion of the Body Snatchers, Moonraker, The Seven Percent Solution, Splash, The Tin Drum, 2001*, and *The Wizard of Oz*. One area of difficulty with this book is that its credibility is based on the author's symbolic interpretation of manifest images. Some of his interpretations seem logical and intriguing. One example is his discussion of *The Seven Percent Solution*, which is frankly organized around a primal scene theme. Dervin, noting that the action is placed in 1892 when Freud was dabbling in hypnosis and catharsis, states:

> For his part, Holmes has been traumatized by a partially repressed memory of childhood, leading him into the dark at the top of the stairs, and he has developed a paranoid delusion that his former mathematics tutor, Dr. Moriarty, is an arch-criminal. Under hypnosis, at the end of the film, Holmes completes the memory: past the darkness is the parental bedroom. However, in bed with mother is not father, but a lover, none other than Dr. Moriarty himself. No sooner is this information absorbed than father appears and murders his adulterous wife. . . . While the novel is reluctant to imply a psychological cure beyond the relinquishing of the cocaine habit . . . , the film suggests that

> Holmes' reliving of the episode is therapeutic. . . . Freud in 1892 must rely on Holmes' recollection of the primal scene, although the real Freud would shortly remark that his patients suffer from reminiscences—some of which are not memories at all, but fantasies (p. 48).

Other of the author's interpretations stretch the imagination excessively, as, for example, his interpretation of *The Wizard of Oz*. The agility of the author's mind notwithstanding, it is difficult to accept the "primal scene" primacy that is claimed in the following assertion:

> Dorothy, having first been terrified of being attacked and overwhelmed by the cyclone, which may well be a remarkably apt representation of the paternal phallus in its swollen, twisting, penetrating state, part of the primal scene. . . . The dream-screen serves Dorothy as the movie screen serves the audience, i.e., as a holding environment or "good breast," while she is inexorably led to the Wizard. . . . Dorothy's sharing with the dethroned Wizard in the comical figures' humanizing process is tantamount to having children with him: She and the Wizard are making babies from her dolls, and the shift from dream to play is from the greater to the lesser mode of regression. By acting as a partner to the man, Dorothy relives and masters the primal scene trauma (p. 62).

More often than not, the author's views are based on a symbolic reading of manifest content. As with dreams, symbol interpretation involves dangers and serious limitations. Furthermore, we have no way of confirming Dervin's speculations, and we can reasonably question his characterizing the oedipus complex, castration fears, etc., as subordinates of the primal scene.

The problem of the book is one of the tail wagging the dog. The author subscribes to the idea that "the primal scene which antedates the oedipus complex determines its form" (p. 15). Primal scene is thus placed in a primary position, to the exclusion of all other dynamic events in childhood.

It seems to me that many factors determine the meaning of the primal scene for the child. These include the psychic structure of the child, autonomous ego functions, the delicate interplay that Annemarie P. Weil, for example, has described between the incorporation of autonomous ego functions into the defensive ego and the influence of the latter on those autonomous functions, the overall structure of the personality, the age and developmental stage of the child, the child's emotional state, the degree of resolution of the oedipus complex, the capacity to sublimate, etc. That is,

the effect of any trauma and/or fantasy is determined by the existent psychic structure. Primal scene exposure may influence structure, but that it necessarily creates or has the most decisive influence on that structure would seem to be a very debatable issue.

The book is imaginative and stimulating. Particularly for those interested in the cinema, it can provide enjoyable reading, but serious questions have to be raised about the author's theoretical perspectives.

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ABSTRACTS

Contemporary Psychoanalysis. XXI, 1985.

Abstracted by Steven H. Goldberg.

The Primary Data of Psychoanalysis. Stanley L. Olinick. Pp. 492-500.

"The primary data of psychoanalysis are not words, nor language as such . . . but representations or signifiers of process." Process is changing and connecting, and imparts meaning through language, intonation, and gesture. Examples of the "processes" to which the author refers are free association, transference, resistance, conflicts, defenses, and "what the patient is doing with himself and others, often in contrast to the words and language per se." Analysts are advised to pay close attention to paradox, irony, grammatical shifts, and other stylistic features of language in order to derive meaning from the patient's communication. A clinical vignette is offered, in which careful attention to process, as opposed to the contents of the words themselves, yielded unanticipated and important meanings.

Toward a Reconceptualization of Guilt. Michael Friedman. Pp. 501-547.

This paper begins with a review and critique of Freud's understanding of guilt as fear of an internalized threat of loss of love and loss of protection from danger. According to this formulation, guilt is a function of egoistic motives, and concerns about harm done to others are of secondary importance. The author feels that this foundation fails to capture the experience of guilt, and argues that Freud was describing superego anxiety instead. Friedman reformulates guilt as "an appraisal, conscious or unconscious, of one's plans, thoughts, actions, etc., as damaging, through commission or omission, to someone for whom one feels responsible." In this view, concern for others is not seen as secondary or defensive, but as deriving from primary, nondefensive, and biologically based motivational systems. The author reviews evidence from the fields of ethology, evolutionary biology, and cognitive psychology purporting to demonstrate the existence of "prosocial instincts" mediated by the capacity for empathy, which underlie the experience of guilt. Precursors of these ideas within the psychoanalytic literature are traced to the work of Klein, Modell, Searles, Weiss and Sampson, and others. Finally, Harry Guntrip's central pathology, as portrayed in his account of his analyses with Fairbairn and Winnicott, is seen as a form of survivor guilt based on his beliefs that he had not adequately helped his depressed mother and his baby brother, who died, and that he might have harmed them by his very surviving.

Secret Bearer or Secret Barer? Countertransference and the Gossiping Therapist. Elaine G. Caruth. Pp. 548-562.

The frequent phenomenon of informal communication to a third party of information disclosed by a patient in treatment is explored, with emphasis on the dynamic and countertransference aspects involved. Gossiping is seen as expressive of libidinal and aggressive conflicts and of disturbances in both object relations and narcissism. The gossiper is seeking intimacy with the recipient of his gossip, and

distance from the patient who is the subject of it. Certain transference situations, particularly those deriving from more archaic needs and fears, are most likely to place an unbearable burden on the therapist, who seeks relief by diluting the dyadic situation to a triadic one including the person gossiped to. The therapist is thus able to break away from the intensity of the connection, while at the same time betraying his preoccupation with the patient. Gossiping may also represent an attempt on the part of the therapist to bolster self-esteem, and is likely to occur when the circumstances of the therapy place the therapist's self-esteem under attack. Patients gossip about their therapists, which also may have important meanings and functions, such as the re-enactment of infantile curiosity about secrets of the parental bedroom. The therapist's experience involves both intimacy and loneliness, and gossiping may be used by the therapist to deal with both. When patient, transference, and countertransference are better understood, the need for gossiping is reduced.

Countertransference Resistance. Darlene Bregman Ehrenberg. Pp. 563-576.

Countertransference potentially constitutes an important source of analytic data and can serve to facilitate or to hinder the analytic task. Particularly when unrecognized, countertransference can pose difficulties. The author describes both the resistance to awareness of countertransference and the use of countertransference as resistance as entities roughly analogous to the more familiar concepts of resistance to awareness of *transference* and use of the *transference* for purposes of resistance. Unconscious identification with the patient and with the patient's projections is discussed as countertransference resistance which impedes analysis of underlying fantasies and interactions. Analysts should be highly attuned to subtle indications of countertransference and its use as resistance. A case example illustrates several instances of the analyst's defensive use of countertransference, in collusion with particular transference wishes of the patient. The author views such occurrences as inevitable in any analysis, and suggests that the collusion and subsequent efforts to unravel what occurred may be central to the analytic work. An additional suggestion is that attentiveness to one set of transference-countertransference feelings may serve to obscure awareness of other, more threatening sets of transference-countertransference feelings.

Discussion of Papers by Drs. Caruth and Ehrenberg. Arthur Feiner. Pp. 577-590.

Feiner briefly surveys the development of psychoanalytic thinking about countertransference. For Freud, countertransference was seen as a hindrance, as the "fogging of the analytic mirror." The technical injunction was to eliminate it. The notion of projective identification added a new dimension to the understanding of countertransference, since it suggested that the patient's feelings could be evoked in the analyst for adaptive and communicative as well as for defensive purposes. Sandler's concept of role-responsiveness was a further step in clarifying the nature of the contribution from patient and analyst to the analyst's experience of countertransference. Feiner discusses the papers by Caruth and Ehrenberg from a vantage point on countertransference informed by the interpersonal view of the psychoanalytic process, in which patient and analyst are constantly influencing each other in

complex ways. Overall he feels that both papers make significant contributions to our understanding of countertransference and to our being able to use it in the service of analytic work.

On Supervisory Parataxis and Dialogue. John Fiscalini. Pp. 591-608.

Supervisory parataxis involves transference-countertransference of supervisee and supervisor to each other, and inevitably has an impact on the relationship between supervisee and patient. The author argues that open discussion of these aspects of the supervisory relationship will lead to enhanced understanding by the supervisee of both his patient and himself. Moreover, to the extent that identification with the analytic functions of the supervisor is an important component of learning in supervision, an open, curious, and non-authoritarian attitude on the part of the supervisor will foster like qualities in the supervisee. An example is furnished, from the author's experience as a supervisee, which illustrates the enhanced effectiveness of a supervisory stance characterized by a willingness to explore the supervisory process itself. The author feels that supervisory attention to transference-countertransference issues in the supervision will have salutary effects not only on the analytic work being supervised, but also on the supervisee's personal analysis and on the development of his own unique style as an analyst. The environment in which the supervision takes place, particularly when it is a requirement of training, contributes to the resistances of both supervisee and supervisor to the open exploration of their own interaction.

Hitler's "Table Talk" as Psychoanalytic Source Material. Stanley A. Leavy. Pp. 609-616.

Dr. Henry Picker, one of the dutiful underlings of Hitler during his military operations of 1941-1942, kept a stenotyped record of the Führer's comments, which he labeled *"Tischgespräche,"* or "table talk," and subsequently published. An attempt is made by Leavy to examine this text from a psychoanalytic point of view, in order to gain insight into Hitler's mind. The assumption is made that the passages recorded in a given evening were linked to each other in a manner similar to free association, thus rendering them amenable to analytic inquiry. Two passages are analyzed in this manner, involving a variety of postulated unconscious fantasies, ranging from omnipotence to world destruction and self-destruction. Leavy concludes that, although there is nothing uniquely "Hitlerian" about these fantasies, the fantasy of omnipotence was realized in fact, and the hidden intentions could be enacted.

Self Knowledge through Immediate Experience. Benjamin Wolstein. Pp. 617-625.

In response to "The Psychotherapy of Rage," an article by Jeffrey Nason published in a previous issue of this journal, Wolstein advances another point of view on this topic, namely that rage, anger, and aggression derive from the experience of "failing individuation and therefore unlived uniqueness." Wolstein feels that the analyst's attempts to interpret this rage compound the patient's problem, since they superimpose "yet another layer of an attitudinized façade over the still unworked-

through rage that continues to smolder within." Only through the direct experience of the unique, personal roots of his rage does the patient begin to work through the rage. The patient needs "to understand the privately inflected rage arising within himself, and move it through his immediate experience into conscious awareness with his analyst." If the analyst interrupts this process through his efforts to become the interpretative source for understanding the rage, he "appropriately earns this increment of the patient's therapeutic hostility." Wolstein takes Nason to task for allegedly having done just this in the clinical material cited in his paper.

A Communicative Critique: A Response to Emanuel Peterfreund. Robert Langs. Pp. 626-636.

The "heuristic approach" to classical psychoanalysis articulated by Peterfreund in his recent study, *The Process of Psychoanalytic Therapy,* is criticized from the point of view of Langs's "communicative approach." The major aspects of Langs's critique involve: 1) Peterfreund's focus on the manifest surface of the patient's associations and failure to decode these communications into their latent meanings; 2) his inadequate attention to the spiraling conscious and unconscious communicative interaction which is the center point of the analytic process; and 3) Peterfreund's acceptance of manifest as opposed to decoded, latent meanings as criteria for validation of the analyst's interpretations. Langs proceeds to summarize the main tenets of his own "communicative approach." He views the communicative interaction as central to the analytic process, and as the main stimulus to the patient's encoded, adaptive communications, which illuminate the meanings of the underlying psychopathology. He argues that the unconscious meanings of the patient's pathology are always communicated in encoded, derivative forms, and can be understood only by undoing the encoding processes of displacement and symbolization. These encoded derivatives cluster around the patient's valid but limited view of the implications of the analyst's efforts. Finally, Langs asserts that validation of interventions can only be assessed through attention to encoded, derivative, unconscious expressions.

Journal of the American Academy of Psychoanalysis. XIII, 1985.

Abstracted by Roderick Gilkey.

Thinking as a Narcissistic Resistance. Jonathan Cohen. Pp. 77-92.

Verbal communication is the medium that makes psychoanalysis possible. However, for some patients, verbal thought is linked to early traumatic experience so that it is difficult for them to use speech to reveal their inner needs. As a form of resistance, their communication obscures rather than facilitates an understanding of their inner experience. The patient's unimaginative use of speech and the need to maintain the gap between thought and experience are clinical signs of this defensive organization. Such resistance presents a serious challenge to the analyst who must help the patient achieve an integration of experience and thought amid the shifting flow of free association and objectifying ideas characteristic of the analytic process.

Resistance and Primitive Anxiety. James B. McCarthy. Pp. 181-189.

Resistance is described as arising from both intrapsychic and interpersonal events that convey fears of growth and change. Such growth, when equated with death, provokes "death anxiety," the feared loss of a sense of an individuated self. Unconscious fears of change, primitive anxieties associated with such fears, and the resistance that results, can be overcome through the psychoanalytic process, which helps the patient attain greater emotional freedom.

Omnipotence and Self-Fulfillment: Key Issues in Analytically-Oriented Psychotherapy with Older Persons. Roman Anshin. Pp. 245-258.

This paper examines the evolution of self-concept and personal meaning through mid-life and old age as described by a number of influential thinkers. It focuses on the narcissistic issues associated with aging, while summarizing the most broadly conceived theories of adult development including those of Erikson, Gould, Jacques, Kernberg, Lifton, Marmor, Pollock, Neugarten, and Vaillant.

Bulimia: Theoretical Conceptualizations and Therapies. E. L. Lowenkopf and J. D. Wallach. Pp. 489-504.

The increased incidence of bulimia has spurred considerable research but little consensus on the etiology, definition, and treatment of the disorder. Investigators have cited numerous etiological factors associated with bulimia, including epileptic disorders, social/cultural factors, and psychopathological conditions. Affective disorders, depression, and anorexia nervosa have all been explored as potential causes of bulimia. Bulimia has also been conceptualized as a variant of obesity. While there is some evidence to suggest that each model has some explanatory power, no single approach or understanding has been proved superior. Bulimia takes on multiple forms, from a relatively benign social bingeing followed by vomiting, to more severe forms that are long-term and out of control. Different categories of bulimia have been proposed, such as neurotic, anorexic, and borderline schizophrenic types. Multiple approaches to intervention are advocated, including psychopharmacological treatment, psychoanalytic and behavioral psychotherapies, and various combinations of these. Mixing treatment approaches makes it extremely difficult to assess treatment outcomes. However, the optimal psychotherapeutic treatment appears to be a combination of behavioral interventions (to bring symptoms under control) and psychoanalytic treatment (to maintain symptom-free functioning and to facilitate further growth).

Boundary and Intimacy. Joel Paris. Pp. 505-510.

Personal boundaries are necessary for psychological stability. Such boundaries must be at once impermeable enough to provide a person with a consistent sense of self-sameness, and porous enough to incorporate new experiences that contribute to growth. A developmental model is proposed that suggests that neglect in early life produces porous boundaries, such as those of the borderline personality. Conversely, intrusiveness can lead to the establishment of overly rigid boundaries, typically found in paranoid and narcissistically disturbed individuals. The author dis-

cusses two cases in which patients who grew up with an overly controlling mother and an absent father later experienced inability to tolerate intimacy in adult relationships. "The transference of both patients reflected their extreme sensitivity to impingement on their boundaries." These cases demonstrate that boundary rigidity interferes with the ability to incorporate positive experiences, which can lead to the chronic experience of emptiness.

International Journal of Psychoanalytic Psychotherapy. XI, 1985-1986.

Abstracted by Luke F. Grande.

Child Analysis with a Severely Disturbed Adopted Child. Paulina F. Kernberg. Pp. 277-299.

Kernberg presents the analysis of an adopted child, with emphasis on the effect that being adopted had on such issues as the transference, separation, and termination. She presents some ideas about adoption in general and discusses the technical issues surrounding the child's feeling of rejection, the matter of secrecy and its effects on learning, problems with identity and superego formation, the adoptive parents' sense of inadequacy and guilt, and variations on the family romance as experienced by child and parents. She stresses the need to deal with the adoption and to help both child and parents to accept their belonging to one another.

Discussion: Adoptive Anxiety, Adoptive Rage, and Adoptive Guilt. Martin A. Silverman. Pp. 301-307.

In this discussion of Kernberg's paper, Silverman notes that adoption is only one factor in personality development. He focuses on the child's anxiety and rage over abandonment and on various factors that lead to reactions of guilt. He stresses the importance of facilitating attachment between adoptive parents and child, and of informing the child about the adoption at an appropriate phase of development.

Discussion: The Adopted Child's Self and Object Representations. Jules Glenn. Pp. 309-313.

Glenn focuses on how adoption may affect adopted children's representation of themselves and their biological and adoptive parents, in this discussion of Kernberg's paper. While cautioning against assuming that all adopted children have similar fantasies, he presents ideas on why they might see parents and selves as deserters, deceitful, deficient, and castrated, and why they may have split self-representations. He offers additional insights into the case presented by Kernberg.

Conjoint Treatment of a Mother and Her 16-Month-Old Toddler. Michelle Ascher. Pp. 315-330.

Ascher discusses a case of intergenerational pathology, in which she treated the mother and her sixteen-month-old daughter conjointly and met with the mother and father as needed. She describes the unfolding process, the dynamics involved, and her interventions and their effects. She demonstrates the therapeutic effect of resolving the symbiotic tie between the child and her mother, and, concomitantly,

between the latter and *her* mother. She focuses not only on the emerging sense of self in mother and child, but also on the child's developing sense of gender identity and the conflicts related to it.

Discussion: A Case of Inter-Generational Early Psychopathology. Eleanor Galenson. Pp. 331-333.

In this brief discussion of the paper by Ascher, Galenson lauds her work, stresses the importance of such early intervention, highlights some of the dynamics involved, and raises some questions about the case.

Discussion: Infant Psychotherapy. James M. Herzog. Pp. 335-337.

Herzog focuses on the approach adopted by Ascher. He notes that the case is an excellent example of successful infant psychotherapy, in which Ascher intervened quickly and actively, thereby structuring the case from her own particular theoretical viewpoint. Herzog wonders why infant analysis would not have been indicated.

Collaboration between Therapists in the Simultaneous Treatments of a Father and Son with Disorders of Masculine Identity Formation. Gerald S. Stein and Cora Lea Chittenden. Pp. 339-368.

A detailed account of the history, dynamics, and treatments of a chronically and severely troubled man and his eleven-year-old son is presented. This was the father's first experience of psychoanalytic psychotherapy; he had previously undergone four courses of supportive therapy. Father and son were enmeshed in intense maternal dyadic relationships that prevented their developing adequate paternal and masculine identifications. The father's resistance to therapy and to the development of a useful paternal transference was not resolved until his son entered therapy. The authors decided to collaborate by discussing their respective cases with one another. The article discusses the potential transference and countertransference difficulties of such a course of action. The authors believe it enhanced their understanding of the interlocking pathology and facilitated the separation and growth of father, son, and mother, which is depicted as the authors describe transference reactions and their management, family interactions, identity formation, and conflict resolution. At some point the mother also sought therapy for herself.

Discussion: Shedding Light on Paternal and Filial Identity: The Use of Collaboration. Samuel Wagonfeld. Pp. 369-372.

Discussing the paper by Stein and Chittendon, Wagonfeld comments on and commends their collaboration. He cites instances in which such collaboration is indicated. He also offers his observations on the dynamics and treatment of the cases presented.

The Resolution of Impasses in Long-Term Intensive, Inpatient Psychotherapy. Monica Carsky. Pp. 435-454.

Carsky presents details from a case to illustrate the problems encountered in the treatment of a severely disturbed psychotic young woman in an inpatient setting.

She describes the dynamics involved in the impasses that developed, and how the hospital staff helped her and the patient resolve them, particularly by helping them experience and deal with the severe and primitive rage reactions being stirred up in the treatment. Carsky reviews some of the literature and offers ideas about negative therapeutic reactions and interactions, not only as they occur in the patient-therapist dyad, but in the larger social system of the hospital setting.

Discussion: Therapeutic Impasses and the Inner World. W. W. Meissner. Pp. 455-458.

In this discussion of Carsky's paper, Meissner writes of the inner turmoil of borderline and psychotic patients. He notes how aggression and narcissism are particularly disturbed. Thus the rapid shifts in the projection and introjection of the aggression and the alternation between narcissistic superiority and inferiority lead to chaos and confusion in patient and therapist. Meissner questions some aspects of the treatment as described by Carsky, especially the apparent non-use of medication and the seeming lack of work on the therapeutic alliance. He cites the value in the collaboration between staff and therapist in resolving the transference-countertransference difficulties, as well as Carsky's inherent capacity to deal with the problems involved.

Psychoanalytic Study of Society. XI, 1985.

Abstracted by John J. Hartman.

The Taming of the Deviants and Beyond: An Analysis of Dybbuk Possession and Exorcism in Judaism. Yoram Bilu. Pp. 1-32.

Dybbuk refers to spirit possession among Jews and has been reported since the sixteenth century. This study was based on the analysis of sixty-three cases over four hundred years. The author discusses spirit possession in terms of individual motivation and societal restraints. He found that the *dybbuk* idiom provided a means by which forbidden sexual wishes could be symbolized and expressed in a way that decreased their threat both to the individual and to the community. The author also found non-sexual forbidden desires expressed by *dybbuk*. Exorcism is discussed in terms of strengthening social conformity and reinforcing social control over deviance. *Dybbuk* phenomena appear in traditional communities which exert extensive control over their members. Those individuals who fill the social role of the one possessed are probably hysterics, he concludes. *Dybbuk* should be considered an example of a culture-specific syndrome.

After the Death of the Primal Father. Géza Róheim. Pp. 33-61.

Róheim's paper, first published in 1923, was a response to *Totem and Taboo* as well as to Freud's subsequent papers on melancholia, group psychology, and the pleasure principle. Róheim's purpose was to extend Freud's ideas about the primal horde and the origin of totemism. His thesis was that all death rites involve repetitions of the events after the murder of the primal father by the primal horde. Róheim uses the legend of the murder and castration of Osiris, the Egyptian god of life and fertility, to demonstrate his thesis. Fratricidal war and psychological upset oc-

curred after the death of the primal father and became the phylogenetic source of conflict in the ego. Róheim, like Freud, tied together phylogeny, myth, and neurosis in the psychoanalytic language of his time.

Crisis and Continuity in the Personality of an Apache Shaman. L. Bryce Boyer; George A. DeVos; Ruth M. Boyer, Pp. 63-113.

This paper deals with an Apache woman who became a shaman, a rare event in her culture. A Rorschach protocol was obtained two days after her first shamanistic performance, and a follow-up Rorschach was obtained two years later. Previous findings have been mixed regarding the role of psychopathology in shamans. In this case the first Rorschach indicated a preoccupation with homosexual conflict in an otherwise unusually rich and productive record. The test indicated both the positive and negative meanings of assuming the role of shaman for this woman. The second protocol indicated that the woman was now dealing with anxiety by emotional constriction, and the homosexual conflict had been repressed. Her shamanistic activity had gone well, but psychologically she was worse. She had assumed a social role which no woman had performed, and she ran the risk of supernatural retribution, social censure, and now repressed homosexual conflicts. Hers was now a more paranoid clinical picture. Since the woman was not psychotic before becoming a shaman, the authors view her as having experienced a "success psychosis."

Sakulambei—A Hermaphrodite's Secret: An Example of Clinical Ethnography. Gilbert H. Herdt and Robert J. Stoller. Pp. 115-156.

The authors, an anthropologist and a psychoanalyst, offer this study of a hermaphrodite of the Sambia tribe of New Guinea as an experiment in ethnography. Their task was to study subjective experiences across cultural boundaries. This case illustrates an empathic eliciting of information on thoughts and feelings through the use of clinical skills and concepts. The psychoanalyst served as consultant to the ethnographer. During a visit to the field, he participated in the interviews, which enriched the results. The paper presents a verbatim transcript of a crucial interview during which previously suppressed material emerged. At age ten the hermaphrodite had been photographed nude by a European man. This had been a trauma which the hermaphrodite had never discussed and which played a part in a guarded relationship with the ethnographer. Through his clinical knowledge of resistance, the psychoanalyst was able to help the ethnographer in the crucial session. The authors recommend a team approach when dealing with areas of fantasy and feeling as reported in this paper.

"Culture Shock" and the Inability to Mourn. Howard F. Stein. Pp. 157-172.

Stein denotes "culture shock" as the painful disruption of the "identity of perceptions" between an inner representational world and the externalized outer world. This estrangement occurs as if culture were an object representation. The author uses Volkan's concept of the "linking object" to illustrate that nativistic responses involve the denial of loss and an inability to mourn. The author's work with people who have migrated from the north and northeast United States to the sun belt is used to illustrate this thesis. A case is presented to highlight the author's view that

interpretation of the clinging to internal symbols of a romantic past is the preferable therapeutic strategy in dealing with "culture shock." Stein also applies this view—of repairing a broken symbiosis with internal object representations—to indigenous peoples and anthropologists as well.

The Charismatically Led Group: The Mental Processes of Its Members. Leon Balter. Pp. 173-215.

According to Balter, the fact that the charismatic leader is extraordinary in comparison with members of the group distinguishes this type of group from others. In other groups identification with the leader is important in the group formation process. For the charismatically led group, Balter cites as evidence Redl's description of a youth group, Freud's description of ceremonials of veneration in West Africa, Deutsch's clinical description of a marriage, and Redl's description of a grade school class. The author concludes that the essential ingredients in these various charismatically led groups are viewing the leader as extraordinary and idealized, using the leader to externalize one or more superego functions, adopting a submissive, masochistic attitude toward the leader as authority, and using this member-leader relationship to resolve inner conflict.

On Telephoning, Compulsive Telephoning, and Perverse Telephoning: Psychoanalytic and Social Aspects. Renato J. Almansi. Pp. 217-235.

This paper deals with some general aspects of the psychology of telephoning. The author discusses the magical character that telephoning may have for certain people in their quest for mastery. He also discusses the telephone in relation to aggression, object relations, the oedipus complex, and superego structures. Extensive case material documenting a voyeuristic perversion involving the telephone illustrates the author's views. Finally, telephone hotline social services are discussed in terms of psychodynamics.

British Journal of Medical Psychology. LVIII, 1985.

Abstracted by James E. Storm.

Cognitive Theory, Object Relations, and the Self. Anthony Ryle. Pp. 1-7.

Cognitive theory uses a hierarchical series of "schemes" to describe mental functioning. A scheme is an organized series of operations serving to regulate and structure experience and behavior. For example, Reciprocal Role Procedures (RRP's) are schemes governing a person's interactions with others, and they incorporate the capacity to predict and adapt to the reciprocating acts of others. The language, terminology, and formulations of this cognitive theory may be used to describe theories and concepts which originated in psychoanalysis, such as object relations theory, resistance, transference, splitting, and projection. Ryle gives examples using the concept of RRP's to explain these psychoanalytic concepts. This approach is said to 1) overcome the confusing, isolated, idiosyncratic, inconsistent, arcane, metaphorical language of psychoanalysis and 2) state the clinical concepts of psychoanalysis in a clear, scientific language for the purpose of science.

Advantages of Cognitive Defenses and Stress Management. Alfred B. Heilbrun, Jr. and Victoria Pepe. Pp. 9-17.

In a laboratory setting (with student subjects) a series of word-selection tests was utilized to evaluate 1) the use of four defenses: projection, rationalization, repression, and denial; 2) the conscious awareness of use of defensive maneuvers; and 3) the general level of stress experienced by the subject. The authors observed that subjects using projection and rationalization were unaware of their use of these defenses, and that they reported the lowest level of stress. The authors concluded therefore that these defenses were unconscious and were used to protect the subjects from painful material. This is consistent with the Freudian view of defense. Subjects using repression also were unaware of their use of defenses, but reported a higher level of stress. The authors concluded that repression is an unconscious defense which protects the individual from painful material but does so at severe cost, preventing the effective reduction of stress. Subjects using denial were more conscious of their use of it and reported a very low level of stress. The authors concluded that this defense is a conscious, deliberate style of coping with a problem, not an unconscious process, as were the other defenses. Denial is considered a primitive defense, and it was therefore surprising that it was associated with low stress. The study reports only associative links between reported stress, defense use, and awareness of defense use, and does not claim that causal links have been proven.

Delusions: Problems in Definition and Assessment. Philippa Garety. Pp. 25-34.

A brief historical review of the concept of delusions illustrates the complexity of the issues involved, and the difficulty in obtaining consensus on the concept. Five characteristics of delusions are cited. Of these, the author selected the qualities of fixity and intensity of belief to examine in detail by use of a formal psychological protocol. Both intensity and fixity of belief were observed to fluctuate in subjects who were considered clearly delusional from a clinical point of view, suggesting that delusions should be considered phenomena at one end of a spectrum, rather than as discrete entities. The protocols allowed formal measurement of two aspects of delusions, thus making them accessible to systematic investigation.

Staff Countertransference in the Therapeutic Milieu: Creating an Average Expectable Environment. Nathan Szajnberg. Pp. 331-336.

Szajnberg believes that a milieu setting magnifies those facets of the countertransference related to (1) "evoked feelings" and (2) the interaction of the mutual needs of patient and therapist. Reasons for this magnification include the use of action as a communication by regressed patients and the continuous interaction of patients and therapist in a therapeutic milieu. In Szajnberg's clinical example, the mutual needs of patient and therapist interacted and allowed the patient to progress. A therapist spent long hours sitting with a regressed incontinent patient. The therapist felt concern for the patient's comfort. This was formulated as a feeling of caring evoked in the therapist, who then changed the sheets in a non-demanding way. The patient improved and said that she could feel the caring which she sought. The therapist's feelings as perceived by the patient met her needs, whereas during previous changes of sheets the patient had perceived a demanding, critical staff

reaction of disgust, to which she had reacted by withdrawing further. The predictability of the milieu setting is said to foster this process. Szajnberg uses the term "moment of illusion" to describe the patient's feeling that she had created this situation, although "illusion" thus seems to be used inconsistently. A second vignette is provided in which a therapist's countertransference feelings were acted out in the milieu. When a colleague interpreted and the therapist examined the countertransference feelings openly in the milieu, the patient's observation of this led to insight and improvement. The therapeutic milieu is said to facilitate this process. Exploration of the patient's psychological processes could not be made, however, so any conclusions are speculative. In a final vignette, therapist and staff's multiple observations of each others' countertransference reactions to patients provided a more thorough understanding of these reactions than would be possible outside of the "milieu" setting.

Dangers of the Vagina. Benjamin Beit-Hallahmi. Pp. 351-356.

The author provides many citations and examples of fantasies about the dangers of the vagina. He emphasizes that these fantasies "do not represent just individual anxieties but are also cultural products transmitted and distributed through cultural ways." Dramatic, literary, and scientific publications, oral traditions and myths, and a published case by the author are cited as illustrations of how such fantasies are transmitted. The intrapsychic origins of the fantasies are not discussed. One senses that the author may wish to convey that men have such fantasies because they heard them or read about them.

Inversion of Parent-Child Relationships: A Contribution to Attachment Theory. Mario Bacciagaluppi. Pp. 369-373.

Parenting is described as an innate tendency of humans. Anthropological, psychological, and psychoanalytic writings are cited in support of this idea. A case of agoraphobia is presented in which the patient's fears could be traced to her concerns for the safety and welfare of her parents. This was induced by their own dependent behavior and by unconscious frustration of her drive toward independence. The patient's phobia is thus understood as related to pathological, premature stimulation of the innate parenting tendency. The author discusses the extension and consequences of this point of view. One consequence may be severe, intractable resistance to analysis.

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Meeting of the Psychoanalytic Association of New York

Ronald Schenendorf

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NOTES

MEETING OF THE PSYCHOANALYTIC ASSOCIATION OF NEW YORK

January 21, 1985. REFLECTIONS IN THE MIRROR. MOTHER-CHILD INTERACTIONS, SELF-AWARENESS, AND SELF-REFLECTIONS. Paulina F. Kernberg, M.D.

Dr. Kernberg discussed aspects of the development of self-awareness, its relationship to mother-child interactions, and its correlates involving the mirror. She presented the case of a five-year-old autistic-like boy. During the first month of therapy, he would lie on the floor and never make eye contact with her. At first Dr. Kernberg did exactly what he did. If he looked at her, she would promptly return his gaze. Once he acknowledged her presence and looked at her with interest and eye contact, she moved from strictly parallel, mirror-like feedback to more sequential, reciprocal exchange. As his responses became more complex, his reaction to his actual mirror image also changed. This change followed a course parallel to that of his reaction to Dr. Kernberg as a real person. His initial blank look into the mirror gave way to avoidance-like behavior and then to symbolic play. With increasing pleasure, he transferred to the mirror her mirroring of him. In the fourth year of treatment, he would look at himself, smile, and arrange his hair. At times he would comment on her reflection. This child's mirror behavior between five and nine years of age, according to Dr. Kernberg, was a recapitulation of what would normally be observed in children between six and thirty-six months of age. The first experience of oneself may be linked to the recognition of the way one is perceived and integrated by another human being who looks and behaves as much as possible like oneself. An outgrowth of this phenomenon is that the first object is a picture of oneself as object, reflecting more the self than the object. Following Abelin's observations of early "triangulation," Dr. Kernberg postulated that an infant's emerging self-awareness depends on both the intactness of cognitive functions and on the attachment to the mother. Dr. Kernberg stated that an infant's response to the mirror has both affective and behavioral components.

In discussing the mother as mirror, Dr. Kernberg first cited the work of Winnicott, who said that the mirroring function of the mother's face can either aid or disrupt the development of the child's self, as well as providing his or her first significant exchange with the external world. Brazelton showed that the infant's behavior can become disorganized if the mother does not synchronously mirror her baby. To underscore the importance of attachment in this process, Dr. Kernberg cited Bowlby, who stressed the mother's or mother substitute's "mothering way," in which she engages the child's signals and approaches. "It is the person who gazes at, talks with, and smiles at the baby who becomes the most important attachment figure," said Dr. Kernberg. She suggested that the more secure the tie to the mother, the greater the exploratory behavior on the part of the child. This results in an enhanced sense of self. The animating, integrating function of the mother brings meaning to the object world and thus meaning to the sense of self, as the infant perceives the mother perceiving her or him.

Dr. Kernberg then discussed self-recognition in the mirror. Because the mirror reproduces the child's actions simultaneously, it helps the child to realize what he or she is doing, as opposed to what the other is doing. In other words, one can learn about the uniqueness of oneself. Dr. Kernberg pointed out that the visual recognition of the face and the concept of the self are not identical, but it would hardly be possible to recogize oneself without a concept of self. Self-directed behavior in front of the mirror appears to be related to self-recognition. This begins early and thus can be detected in nonverbal behavior. She traced a developmental sequence that is observable during the first two years of life. In the beginning, the child has little or no interest in the mirror image, preferring to look at the mother instead. Then the child begins to smile, vocalize, and interact with the image. The next step is the comparison stage, during which the child focuses on itself and its image, then on the object and its image. This is followed by manipulation of the image, with close observation of both the child's real body parts and their reflected image. Then search behavior begins. The last two stages are, first, an avoidance reaction, in which the child hides or withdraws, and, lastly, a period of more self-conscious behavior with much more self-recognition. Dr. Kernberg then reminded us that most of the child's behaviors in front of the mirror echo the attachment phenomena between child and mother; thus the child's reaction includes the reaction to mother also. In trying to understand the avoidance reaction, Dr. Kernberg assumes that the child becomes aware that the reflecting mirror is not the mother; the child then displays a stranger reaction to the image. This reveals the child's stable sense of self.

Integrating her observations with Mahler's work, Dr. Kernberg stated that at eight months, during the differentiation phase, the child's mirror response is similar to that of reacting to a twin. This is followed by the practicing phase, in which the searching behavior coincides with experiencing mother and child as interchangeable. During the months of rapprochement, the mirror behavior is one of avoidance, with self-consciousness and/or recognition, as well as reactions of fascination with the mirror image of the good mother, and avoidance of the mirror image of the bad mother of separation. The infant can be found looking for mother in the mirror. During the last period on the way to object constancy, the mirror behavior is that of self-consciousness, in that the child shows embarrassment in some form, or self-admiration. The mother-infant relationship is one of introjection and identification, the child containing the mirroring function, self-constancy. The mirror reaction during this phase consists of the ability to look at oneself as mother had looked at one and an increased ability to play in front of the mirror.

In the last section of her paper, Dr. Kernberg spoke about the diagnostic and therapeutic applications of these findings. She quoted Dr. John McDevitt, who stated, "Mirror reactions are most relevant for following the process of building self-representation and differentiating these from object representation."

DISCUSSION: Dr. Anni Bergman noted that Dr. Kernberg had used herself as a mirror in the treatment of a child with poor self/object differentiation. The child had used the mirroring in the process of self-integration. Children develop their first image of themselves by way of how the mother perceives and mirrors them. The mother creates a symbiotic orbit by protecting the baby from seeing her as different or separate too early. At this stage, the baby, when looking at mother, does

not see mother but sees itself as perceived by mother. This is the foundation on which the sense of self will rest. Here the self/other similarity is the prime feature and is connected with the forming of early attachments. Dr. Kernberg had, of course, pointed out that this early similarity experience can also decrease the individual's sense of self. Dr. Bergman then asked what optimal mirroring consists of. No mirroring by a mother can be exact because it always adds the perception of the mother. Dr. Bergman stated that there are other factors that contribute to an emerging sense of self. She cited two children from Mahler's work. In one case, the mirroring was first viewed as perfect, but it resulted in a child with rather insecure attachment and exaggerated separation and stranger reactions. In another case, in which the mirroring was judged to be excessive, the child was not overly attached to the mother, but instead avoided her. Dr. Bergman suggested that this may be an area for primary prevention and for further research.

Dr. Alan Eisnitz discussed his concept of the self as based on the organization of a stable system for the maintenance of the self-representation, a function of the ego, with contributions from superego and id. It includes many aspects which must be organized and maintained as a cohesive whole. It is a dynamic structure that matures and develops with instinctual and structural advances. The sense of self evolves from two main sources. First is the inner source, which includes conceptual and cognitive ability, the capacity to establish a body ego, and the capacity to integrate affective tone from experience and from instinctually derived wishes and fantasies. The second source is initially the mother-child unit, but also involves later phases of development, especially from oedipal and postoedipal identifications, including adolescent and adult phases. Dr. Eisnitz questioned Dr. Kernberg's formulation about her patient's recapitulating, between ages five and nine, the stages normally traversed between six and thirty-six months. He wondered whether she literally meant that he lived through them as they had originally occurred. For Dr. Eisnitz, the conflicts from earlier stages of self/object differentiation are experienced later in development only in highly derivative form. Dr. Eisnitz maintained that Dr. Kernberg overestimates the importance of mother as mirror, as opposed to other aspects of the mother-infant relationship, and underestimates the input from the child in the development of the self. While he agreed that there are many mirroring aspects in mothering behavior, there is also much more. He felt it was a mistake to view the mother solely as mirror in anything but a metaphorical sense. We now know that the infant is capable of a greater degree of perceptual and cognitive distinction than was formerly believed. While infants probably do experience the mother as part of the self, they also experience her as a steady, gratifying, stabilizing, organizing, and at least partly separate presence, a kind of omnipotent protective capsule. Dr. Eisnitz agreed with Dr. Kernberg that reaction to the mirror image would be a fruitful area for research on problems in the mother-child unit and in self-development. He also agreed that self-recognition in the mirror is dependent on an already existent self concept. However, he felt that Dr. Kernberg's views seemed somewhat one-sided, slighting drives and wishes, as well as conflicts from later developmental phases.

RONALD SCHENENDORF

MEETINGS OF THE NEW YORK PSYCHOANALYTIC SOCIETY

February 25, 1986. PRE-OEDIPAL DETERMINANTS OF AN INFANTILE GENDER DISORDER. (The Margaret S. Mahler Memorial Meeting.) John B. McDevitt, M.D.

The paucity of analytic data about children with disturbances in sexual identity is frequently mentioned in the analytic literature. Dr. McDevitt presented data from and formulations based on four times weekly analysis with a four-year-old boy who wanted to be a girl. His presentation was organized in three sections: first, the history as given by the mother; second, the child's concerns as revealed in the analysis; and finally, the analyst's efforts, utilizing this data and the findings of observational research to examine the determinants of the child's disorder. The most essential determinants of the child's feminine identification included the mother's need to shape the boy in a feminine direction because of her own anxieties over sexual and aggressive impulses, along with the boy's passive willingness to be shaped during his first eighteen months. Also involved was his need to actively defend himself against his own anxieties over aggressive and sexual wishes by taking over the shaping of himself in an active form, in other words by actively identifying with his mother, beginning as early as eighteen months of age.

DISCUSSION: Dr. Eleanor Galenson pointed out the three themes emphasized in Dr. McDevitt's case material. (1) The sense of gender identity begins to emerge only very gradually at the end of the second year of life and becomes more complex in the next several years even before the oedipal period. (2) This gradual development of gender identity is shaped in large part by the mother's unconscious fantasies that are activated by the child's drive-directed sexual and aggressive behavior, which normally begins to emerge at the end of the second year. (3) The child feels anxiety over possible maternal loss, which motivates him to maintain attachment to his mother, even at the cost of compromised drive and ego development. Dr. McDevitt utilized the analytic material from his treatment of a young boy to illustrate these three themes in an unusually clear manner. He offered convincing evidence that gender identity is established to a marked degree during the preoedipal period and that the mother's unconscious fantasies do indeed influence the direction as well as the form of the child's sense of gender identity.

Dr. Ernest Kafka noted that the child's mother had early suppressed his assertive behavior. The boy began to behave in a feminine way, evidently to comply with his mother's wishes and to maintain a playful relationship with her. He feared his mother's abandoning him (as she had done during his toddler period). His fear and anxiety were followed by anger, which was expressed in feminine identification with mother via castrating fantasies and games in which the child played his mother's part. This was an identification with the aggressor that converted passivity into a form of activity; it also expressed the child's wish to appropriate his mother's power and to rival her. Study of adult patients shows that as development proceeds, femininity can be used in numerous other ways—for instance, to assuage guilt when femininity is employed as masochistic provocation, as well as in the service of so-

cially adaptive functioning. One can conclude that the concepts "identification" and "gender identity" are terms that refer to the complicated constructions people create to organize wishes, defenses, and adaptive and maladaptive gratifications.

March 11, 1986. ASPECTS OF EGO DEVELOPMENT. SIX WEEKS TO SIX YEARS: INDIVIDUAL DIFFERENCES IN THE GROWTH OF COMPETENCE. Sylvia Brody, Ph.D.

Dr. Brody presented a forty-minute teaching film of several children whose levels of competent behavior appeared to have been acquired from the first year of life. The footage was selected from film data gathered in the course of a longitudinal project in which one hundred and twenty-one children and their parents were studied from the children's birth through age seven. The quality of the child's object cathexis for people and things was seen to be intimately related to the quality of the mutual cathexis of mother and infant at the infants' ages of six weeks, six months, and one year. Films of test sessions from ages one to six showed that the children's readiness to understand directions and to carry them out effectively and with satisfaction appeared to be an important result of their trust in the mother's attentiveness and care during infancy, as had been seen in feeding situations. Many styles of competence that reflect drive development are observable in the amount and kind of energy the children invest in a task, the maintenance of their interest in it, and the pleasure they derive from it. The richer and more stable their investment in the environment generally, the more likely they are to develop spontaneous opportunities for able and rewarding activity. Work and pleasure can therefore come to have reciprocal values at an early age, thus facilitating a firm move into the period of formal learning in latency. Competence as an ego strength that involves reality testing, concentration, capacity for delay, cognition, and pleasure in accomplishment (setting aside the effects of unknown constitutional differences) is influenced by the quality of experiences at the hands of the mother or her regular surrogate, from the earliest weeks of life. As a follow-up, ninety-one of the children were located at age eighteen and were interviewed and given a battery of psychological tests. Dr. Brody made brief comments about the children in the film, as they were at age eighteen.

DISCUSSION: Dr. James M. Herzog noted that Dr. Brody's film drew on the admirable longitudinal research project which she and her husband, Dr. Sidney Axelrad, launched several decades ago. Two fundamental hypotheses guided their work. (1) Optimal object relations development requires experiencing in the first year of life a regular sequence of positive cathexes of need-satisfying (part) objects—of people, things, and beginning ideas. (2) Children whose pattern of object relations at the end of their first year reflects an age-adequate balance of cathexes of these need satisfactions will, in their seventh year, show a balance of sound object relations in general and a superior cathexis of ideas or abstract thinking in particular. Conversely, children whose pattern of object relations in the first year is poor, deficient, or imbalanced will show poorer object relations and poorer capacity for abstract thinking in their seventh year. Dr. Herzog stated that Dr. Brody had discussed

competence as it relates to character, coherence, continuity, and discontinuity. As she moves from the level of videotaped and interrogative reality to the domain of personal meaning (terms which Dr. Herzog employed to describe various levels of experience), Dr. Brody's work can be useful to analysts as they try to understand and reconstruct the unique experience of each analysand.

The Sigmund Freud Professorship of Psychoanalysis, an endowed chair at the HEBREW UNIVERSITY OF JERUSALEM, will become available for the 1989-1990 academic year and subsequent years. The University is pleased to announce that this professorship has been awarded to Professor Rafael Moses of Jerusalem for 1987-1988, and to Professor Sidney J. Blatt of Yale University for the year 1988-1989. The Freud Professor is also Director of the Sigmund Freud Center for Psychoanalytic Study and Research. The Hebrew University wishes to make a tenured appointment, but applications for interim appointments will be seriously considered. Inquiries should be sent before February 1, 1988, to Professor S. Kugelmass, Department of Psychology, Hebrew University of Jerusalem, Mount Scopus, Jerusalem 91905, Israel.

The 65th Annual Meeting of THE AMERICAN ORTHOPSYCHIATRIC ASSOCIATION will be held March 27-31, 1988, at the Hilton Square, San Francisco, Calif. This year's theme is "Adapting to Social Change, Therapy, Technology and Services." For further information, contact: ORTHO, 19 West 44th St., Suite 1616, New York, N.Y. 10036, or phone 212-354-5770.

The 45th Annual Meeting of the AMERICAN PSYCHOSOMATIC SOCIETY will be held March 24–26, 1988, at the Four Seasons Hotel, Toronto, Canada. The theme will be "A New Look at Psychosomatic Medicine." For further information, contact: Program Committee, American Psychosomatic Society, 6728 Old McLean Village Drive, McLean, VA 22101.

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SUBJECT INDEX

KEY: (A) Abstract from other journal
(N) Note of paper presented at scientific meeting
(R) Book review