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Martin H. Stein

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DREAMS, CONSCIENCE, AND MEMORY

BY MARTIN H. STEIN, M.D.

The interpretation of certain dreams, as opposed to the direct examination of behavior, makes it possible to explore the conscience of the dreamer, detect hidden sources of guilt, and interpret them with less likelihood of arousing intractable resistances. Through the recovery of memories and the establishment of an intimate familiarity with one's personal history, it becomes possible to resolve problems of "neurotic" guilt, based ultimately on distortions of repressed childhood memories. The resolution of these conflicts allows a greater role for the operation of "appropriate" guilt, based on genuine transgressions, and the establishment of a more mature ethical structure.

> . . . a degree of familiarity with history, in the absence of ecclesiastical teaching, is our only available source for an ethical education.
>
> JOSEPH BRODSKY (1987)

The most familiar manifestation of superego functioning, "conscience," may be defined as "the internal acknowledgement or recognition of the moral quality of one's motives and actions: the sense of right and wrong as regards things for which one is responsible: the faculty or principle which pronounces upon the moral quality of one's actions or motives, approving the right and condemning the wrong" (*Oxford English Dictionary*, 1971, p. 522).

I intend to show how the systematic interpretation of certain dreams and the consequent recovery of memories make it possible to explore the conscience of the dreamer, and thus put

moral conflict into a perspective in which it can be more satisfactorily understood and resolved. This is an important step in the analysis of the neurotic sense of guilt, the alleviation of symptoms, and the stabilization of an autonomous, well-integrated and effective set of ethical standards.

It is hardly to be questioned that moral conflict and the sense of guilt play a prominent role in the development of character, not always for the better, and that they contribute to the formation of symptoms. We accept as a matter of course that we must pay constant attention to these issues. Yet in practice, perhaps out of concern that we may be accused by our patients, or ourselves, of being moralistic or judgmental, we are too often tempted to phrase our interpretations diffidently and in ambiguous terms. This cautious approach is understandable, but our obligation as psychoanalysts to withhold moral judgment in no way permits us to evade significant moral issues. We are required therefore to explore thoroughly not only the dynamics, but the historical sources of the sense of guilt as well, and convey these to our patients in the course of interpretation.

It is my contention that this task may be made easier by the analysis of certain dreams. A major advantage lies in the role of dreams as pathways to long-forgotten yet highly significant affect-laden memories, making it possible to trace guilt to its distant and often obscure origins. Furthermore, the dream's operation in sleep permits evidence of the most painful, heretofore repressed conflicts to reach consciousness more readily, albeit in distorted fashion. The dreamer feels only partly responsible for his or her dreams; they have some of the quality of play, of "let's suppose." As a consequence, it becomes easier to discuss them in the same spirit, as if we were talking about another person, the sleeper as opposed to the waker. Only later must we face the essential, admittedly difficult task of bringing the two together in an effective interpretation (Goldberger, 1989).

Moreover, it is relatively easy to maintain an atmosphere of moral neutrality in analyzing a dream. When interpreting behavior directly, on the other hand, it is far more difficult to

maintain neutrality. Faced with an account of some real action about which the analysand feels defiant, ashamed, or remorseful, it may be difficult to avoid conveying the impression of moral repugnance on the one hand, or exculpation on the other. Whether or not such judgments are in fact experienced by us (they are, after all, not always avoidable), our patients are all too ready to delegate their twinges of conscience by projecting them on to us. They are likely to respond by concealment or by self-imposed controls of behavior, which have the effect of driving the issue underground, thus impeding or altogether preventing the analysis of the moral conflict. Like well-behaved prisoners, some patients become "good" for the duration, but are left with a high probability of eventual relapse. Even worse, in the special category of those who are prone to acting out, any but the most tactful attempts to interpret behavior directly may result not in suppression, but rather in exacerbation of the very patterns of action we are attempting to understand. Interpreting a dream, on the other hand, has the advantage of being less likely to precipitate such undesired consequences; it should in fact make it possible to deal with the symptom more directly at a later time, with less risk to the continuation of the analysis (Greenacre, 1963; Stein, 1986, 1987).

I shall relate a dream reported by a very intelligent woman in her forties, whom Freud, in his old-fashioned way, might have described as being "of the highest moral character." She was also, under an attractive and cheerful exterior, guilty and depressed and was sleeping very poorly. One day I commented that she had almost never reported her dreams and suggested that she was afraid of the emotions they seemed to engender.

The following morning upon entering my office, she exclaimed, "I've finally remembered a dream!—My husband and I were sleeping in a hotel last night, out of town, and I dreamed that I woke up, and tried to arouse him, but I couldn't. I thought he might be dead, and I became frightened and left the hotel in a panic. Once outside, I found myself in a foreign city, I'm not sure which, but it was strange, entirely unfamiliar. I had

forgotten the name of our hotel too, so I walked the streets, unable to find my way back. I felt lost and terrified. . . . I'm sure I've had this dream before. . . ." She woke up feeling panicky and discovered that even awake she could not recall the name of the hotel in which they were staying. She continued, "I was so disturbed that I got out of bed and made my way to the bathroom and found the name by reading it on the wrapper of a cake of soap." She felt frightened and guilty, a mood which persisted until now.

By nature thoughtful, she had nevertheless always done her best to avoid introspection, suppressing not only dreams but imagination as well, and had spent all of her leisure time in frenzied activity, seeing friends, telephoning, and exercising. The one major exception to this inhibition of imagination was to be found in her work as an artist, but even here her production was confined entirely to the abstract. It was at first very difficult for her to sign her work, and although it was generally recognized to be of very high quality, only after much discussion could she bring herself to exhibit and sell it. She felt it was like appearing naked, and might reveal secrets that even she was unaware of. Understandably, to remember and put a dream into words was a new and disturbing experience.

It was easy to conclude that her dream expressed a wish to be rid of her husband, with whom she had had a number of quarrels. At the time, they were in fact concerned about his health. How much simpler it would be for her if he were to develop a fatal illness! She was actually devoted to him, but her dreams took less account of that than of her hostile fantasies. She soon experienced her punishment, however, finding herself lost in an unknown city, unable to remember where she was or where she was staying, an impression so powerful that it persisted well after she awoke. She had not only cast herself into the wilderness, but was truly lost. She had become a "streetwalker," literally. This fate was equivalent to losing her own personality, her psyche or "soul." The idea that she might imagine her husband's death was not entirely unfamiliar, for

hints of this had surfaced before. But there was more to be found in the dream. Why the peculiar punishment of becoming a wanderer who had lost even the memory of where she lived? Why should her expressions of guilt take this form?

Exploring her associations further led to memories of the childhood circumstances which had contributed to the persistence of her guilt and masochistic life pattern. Her father, now dead, had been an intelligent and sensitive man who suffered from severe attacks of psychosis, condemning the family to poverty and social isolation. In the course of his psychotic episodes, he would leave home and disappear for weeks at a time, eventually to return looking like a derelict, dirty and unshaven. The patient's perpetually enraged mother could never accept the fact that her husband was really ill. She insisted that he was bad and irresponsible, in her word, "disgusting." Even worse for the child, her mother maintained that it was her birth that had made her father the way he was. The child found it impossible not to share her mother's attitude, and suffered from an overwhelming sense of guilt and persistent embarrassment that made her feel like an outsider among her schoolmates. She had been a bright, well-behaved little girl, but inevitably a very angry one, who found the conflict intolerable. Often she became aware of thoughts that things would be so much simpler if her father were never to return! Her anger with her parents, her wishes for her father's death and later guilt over misjudging and rejecting him, all contributed to her attitude toward her sick husband, so graphically portrayed in her dream. Her attempt to reject completely her personal history, especially everything her parents represented, gave her the sense of being "nobody," an artificial person who could not be recognized by others who met her in the street. Distinctive enough in appearance, she nevertheless felt that whenever she met an acquaintance, she had to introduce herself anew.

It became clear that she punished herself by identifying with her father as the runaway, the wanderer, the lost soul. (There was no evidence that her own symptoms were of a psychotic

character.) She also became more clearly aware of the disturbing parallels between father and husband who, while unlike in so many respects, shared a tendency to emotional instability and behaved in a way which could cause her painful embarrassment. A loyal and considerate wife, she was horrified by the sense that she might be tempted to behave like her angry, scolding mother. While the idea that she wished for her husband's death was not altogether new to her, it had never been discussed so directly, nor supported by such vivid and convincing evidence of links to parallel memories of childhood.

Her reaction to this interpretation was a remarkable one: it became a valuable clue to her characteristic defenses. The following day she entered my office smiling, appearing almost triumphant. She began by saying that she had had a dream and had forgotten it, but upon greeting me she recalled an image she experienced upon wakening: "I saw in front of me the musical chord, C-E-G-B flat, the dominant seventh. I felt wonderful! This chord is one which can always be resolved." She added, "The first dream was for you, this one is for me!" Her triumph was emphasized by her knowledge that she was a practiced musician, while I was, by comparison, a musical illiterate. In effect, she announced that she had no need of me to resolve her guilt; she could do so by herself. She had not only gotten rid of husband and father, but disposed of me as well, in a characteristically disarming and graceful fashion. Thus by creating the image of the self-resolving musical chord, she had dealt with me and my disturbing interpretation cleverly and effectively.

In the course of her treatment, bringing in a dream was itself an unusual event. But why the fear of dreaming in the first place? In her case it was clear that guilt was the issue. If she were to have dreams which revealed such evil thoughts and fearsome punishment, she would rather ignore them altogether. It was most painful for her to recognize that she had been unjust in siding with her embittered mother and rejecting her father so completely, especially as she began to recognize

the degree to which, in spite of his recurrent illness, he had contributed to her remarkable intellectual and artistic development. It was easier to deal with such painful conflicts while she was wide awake in my office, where she could express them in measured language, quite removed from the raw brutality of the dream thoughts. Through words, her desires could be denatured and pushed aside. The frenzied activity of her waking life permitted virtually no opportunity for introspection, but during unguarded sleep, she was subject to the full force of her terrible rage and guilt. By understanding the influence of her history, she was now able to achieve a measure of analytic understanding of the nature of her conscience, and take a vital step in moral development. She could begin, little by little, to lead her life in a less masochistic and self-denying fashion, and acquired more effective control of angry and provocative outbursts toward her troubled husband. Her capacity for understanding and sympathy could be more successfully manifested, and things became rather better all around.

Possessed as she was of a highly developed conscience, the guilt experienced by this patient, and so vividly portrayed in her dream, was an example of one of the more pervasive emotional responses experienced by human beings. "Neurotic guilt," as I have chosen to call it, may be defined as that affect based on the memories of offenses associated with childhood, generally forgotten, and recalled (if at all) only in distorted fashion. These memories have become reified during development, remaining dormant until triggered by some current experience, perhaps unimportant in itself, but to which they attach themselves. A frequent consequence is the infantilization and blunting of the conscience, manifested by failure to react with the guilt which should be attached to a genuine transgression. It is a prominent symptom in obsessional neuroses and depressive reactions, constituting a source of great suffering to the individual who is afflicted not only by disturbances of affect, but also by substantial confusion of moral values and defects in judgment. Its contri-

bution to a viable ethical system is, if anything, negative; the sole value of neurotic guilt may be in its role as a clue to previously unrecognized conflicts within the psyche.

In 1900 Freud, in an almost offhand way, suggested that "character" is based upon the accumulation of memory traces of impressions (p. 539). If we add the contribution of genetic endowment, we may follow him in thinking of "character," including its moral aspect, as being acquired through an accumulation of memories. It would follow that the recovery of memory traces, correction of their distortions, and their integration into ego and superego structures (especially the latter) would be vital steps in a treatment which has as one of its goals the establishment of a well-integrated system of ethics. Such a system must include an active conscience which operates as an appropriate and useful signal of transgression, free of the confusion engendered by guilt of neurotic origin. I have pointed out elsewhere (Stein, 1966) that when acuteness of moral evaluation is impaired, depending as it does upon accuracy of self-observation, we may expect serious disturbances in the individual's capacity to make judgments about external reality as well. This is hardly surprising when we reflect that children do not at first distinguish very sharply between what is bad (morally wrong) and what is incorrect (wrong in logic). Some people never do make the distinction. The maxim, "Honesty is the best policy," is therefore not a meaningless cliché, at least when applied to mental life.

It may be accepted that the psychoanalytic method possesses a morality of its own, the principles of which are invariable in its field of operation. Both parties who agree to honor the analytic contract bind themselves to tell the truth as well as they can, to conceal as little as possible, to face issues however painful, and to respect the other's integrity, this last condition applying most forcibly to the role of the analyst. While the analysand is necessarily influenced by the implicit ethical structure of the analytic situation, it should go without saying that there is no place for the imposition upon him or her of the personal standards of the

analyst, those which the latter applies to life outside the analytic situation. Nor does it by any means imply unquestioning conformity to society at large.

Among the goals of analytic treatment, therefore, is the maturation and integration of conscience as an active moral sense which is autonomous without being isolated or inaccessible to further education. The analyzed individual should be capable of being more honest than before, at least with him/herself, to develop a conscience based not on unresolved transference conflicts and anxieties, but rather on an increased capacity for self-observation and understanding of his or her dynamics and history. In this respect the individual will have identified with the analyst *as analyst*, or perhaps more accurately, with what the analysand has perceived as the analytic stance, the maintenance of curiosity about the workings of the mind and most other matters as well, and the rejection of self-deception. But the conscience of the analysand will have become his or her own, not the analyst's—and it will be an *educated* conscience. The analysand will be able to take away what he or she wants and needs, and to modify that system when appropriate, rather as the pupil of an experienced artist retains what the pupil has found useful, discarding what is no longer needed, in order to develop his or her own style. It is by this means that the transference will have established its most profound and lasting influence, in an open, not a rigid system. One of the ways of approaching this ideal state is through an understanding of the moral implications of dreams.

The dream I have related with its associations and historical context reveals the presence of neurotic guilt clearly enough: the dreamer had little enough to reproach herself with in the context of adult behavior. It is not always the case that matters appear so clearly, for individuals vary just as much in how they express themselves in dreaming as they do while awake. There are people who have the greatest difficulty in ever expressing a hostile thought, or becoming aware of a vengeful fantasy, yet experience and report dreams which seem wildly at variance

with their overt personalities. In their sleep, they murder their siblings, cut up animals, and indulge in the most extreme acts of sadism. In waking life, they may be eminently reasonable, kindly to a fault, at the same time inclined to be depressed and masochistic, and subject to unexplained sensations of guilt.

It takes a great deal of patience and analytic work to demonstrate to these patients the role sadism plays in their lives, especially since their capacity for reaction formation is so effective in preventing behavioral manifestations of such impulses. Their twinges of guilt are likely to be intermittent; but their capacity to lead lives of unnecessary suffering seems unlimited. Their sadistic impulses are manifested most irritatingly in their ability to provoke guilt in others. Here dealing with their dream life may be the only immediate clue to those unconscious memories and fantasies that have contributed to the distortions of conscience which account for such behavior. Ultimately, these elements can be integrated with relevant memories of early experience and become part of the analytic process. It is not easy, but more often than not, it can be done.

We may turn now to the consideration of certain classes of "typical" dreams, those which share a common form and are repetitive enough to be quite familiar, like old friends—or enemies. The classic traumatic dream, in which the sleeper relives over and over again an accident or a narrow escape, has long been considered an attempt to master a situation in which one had felt helpless and overwhelmed. While Freud was inclined to ascribe the wish fulfillment of such dreams to the death instinct, I have argued elsewhere that the relief experienced upon waking contains the wish to be restored to life and sanity (Stein, 1965, 1989).

In the present context we may see traumatic dreams from yet another aspect. Upon awakening, they are generally accompanied by terror and a sense of relief that the danger is really past, that the dreamer is still *alive*. They are, in addition, often marked by an intense sense of guilt not readily relieved by reassurance. This was a conspicuous feature of the traumatic

dreams of soldiers in frontline combat and a distressing aspect of the stubborn neuroses which afflicted so many of them. It was frequently possible to establish that the guilt was engendered by the sense that the dreamers had survived at the expense of others who had died. They were indeed trying to reject part of themselves, the self-interested part they saw as capable of sacrificing others to save themselves. Their persistent guilt expressed the reaction to the idea, "If I were even to *dream* of such an action, I couldn't accept that part of myself which harbors the desire to survive while others die. I would be a lost soul." It is expressed most succinctly as, "If I were to do such a thing, I couldn't live with myself."

An even more familiar example is the examination dream, which seems for the most part to afflict those who, in their school days, were superior students. The dreamer is to take an important examination, but finds him/herself altogether unprepared, or perhaps shows up a day late, or cannot remember the room in which the test is to be administered. Still in the dream, the individual suffers the most intense anxiety and guilt over the lapse. Upon awakening, the dreamer recalls with great relief having long ago passed that particular examination. The conventional interpretation of such dreams emphasizes the person's need for reassurance in facing some trial in the near future. The dreamer has been through it before and did not fail; quite the contrary, he or she had passed it and can do it again. This interpretation is correct, so far as it goes, but it fails to deal with other aspects of the dream's meaning. Both dreamer and interpreter are likely to be left with a vaguely defined sense of discomfort, accompanied by the impression that there is something more.

Freud (1900) had written, with feeling based, I am sure, on personal experience, "The ineradicable memories of the punishments that we suffered for our evil deeds in childhood become active within us once more and attach themselves to the two crucial points in our studies—the *'dies irae, dies illa'* of our stiffest examinations. The 'examination anxiety' of neurotics

owes its intensification to these same childhood fears [of wishes]" (p. 274). It is implied that these dreams were derived from memories of exhibiting one's sexual charms, a common and sometimes engaging activity of little children who, at first free of self-consciousness, later become aware of their role as seductive beings, especially when they have been discouraged, if not openly rebuked, by their parents.

A striking example of a closely related phenomenon was afforded recently during the course of a newspaper interview with Alec Guinness (1987). He reported a dream which has recurred once a month during his highly successful career on the stage. He finds himself before the footlights, "not knowing a single line, dressed in the wrong costume, with both audience and fellow artists reacting in total, total astonished silence." Finally, he breaks into a desperate little tap dance. He continued, "My inadequacy nightmares are always about theater, never about film. . . . I prefer the life of the theater. . . . I was equally attracted and repelled by the limelight. . . . when an adolescent, I envisaged thunderous applause for my every gesture."

This led me to recall a patient who dreamed over and over again of appearing at the concert hall, only to find that she was hours late, had prepared the wrong music, or forgotten it altogether. She would awaken in a panic, consumed with guilt, and only slowly experience the relief of recognizing that the performance was still ahead of her and that she was in fact perfectly prepared. An unusually conscientious performer, she had never been late for rehearsal nor forgotten a note. There was indeed no shortage of guilt-laden memories related to adolescent and adult sexual experiences, but we found other factors that were relevant to her performance guilt.

Each time she gave a particularly good concert and was rewarded by the enthusiastic response of the audience, she reacted with pleasurable excitement, followed almost immediately by a feeling of depression which included a profound and unexplained sense of guilt. We arrived at the explanation by an event which resulted in considerable embarrassment on my

part, if not on hers. During a session in which she described, in moving fashion, an emotionally charged sexual experience, I found myself irresistibly impelled toward sleep. She became aware of my lapse, and so did I. It was not that I was bored; on the contrary, I was *overcome*; her superb performance had charmed me to sleep. This gave us the clue to what she strove to do with her larger audiences. She desired to overwhelm them, to put them into a charmed state, or, as it is so often expressed by performers, to "kill" the audience—the ultimate goal of every virtuoso, as epitomized by Alec Guinness. There is no harm in that, unless it is taken literally by the unconscious ego, which transmits the message unchanged to the superego. If this occurs, which is far from uncommon, guilt strikes in the form of an examination dream or stage fright.

My patient's examination dreams had become transference dreams, now re-enacted during the analytic session: she had become excited by and afraid of her wish to seduce and destroy *me*. She recalled that as a very little girl, she had been an enthusiastic performer who did her best to charm her parents, who were too self-absorbed to appreciate her efforts. She was deeply hurt and, for this and other reasons, was enraged enough to have fantasied their deaths, as mine was now no doubt intended, in a kind of *Liebestod*. Overwhelming charm is one way to bring about such a result; it conveys not only love, but the wish to dominate and destroy by magic the objects toward whom it is directed, including the analyst (Rittenberg, 1987). The dream of being examined, i.e., of exhibiting oneself, therefore includes the desire to impress, to charm and dominate, even to kill; hence its association with guilt. Such dreams, while not always easy to analyze in depth, are still more accessible than the symptom alone, particularly when the interpretation can be correlated with transferential exchange and historical reconstruction, as in this instance.

It is hardly necessary to mention that we come across guilty reactions based on the knowledge that one has committed actual transgressions serious enough to justify them. For that

matter, hardly any of us are so virtuous as to have *no* genuine reason to experience a sense of guilt now and then. It is vital to be able to distinguish between "normal" guilt, evoked by the conscious or preconscious knowledge that we have committed a real offense, and the "neurotic," founded on (generally repressed) memories of the past.

In psychoanalytic practice, we do not very often come across truly corrupt individuals, the sociopaths and habitual criminals; if we do, we are not likely to get a successful analysis going. There are, however, those patients on the borderline who are worth a try, and here again, the analysis of dreams may furnish a view into analyzable elements of inner conflict.

Neurotic individuals, not as a rule inclined toward serious crime, nevertheless often carry within themselves the consciousness of guilty secrets based on episodes of lying, petty larceny, or minor frauds. During analysis, the first hint of such secrets may appear in a dream, which, if picked up and interpreted, will result in confirmation in the form of a confession. This in turn makes it possible to analyze the underlying conflicts and to demonstrate to the patient the role of repressed memories, unconscious fantasies, and the need for punishment which have resulted in symptom formation, along with an uneasy and unreliable conscience.

Freud was explicit on the moral implications of dreaming: "If we look at unconscious wishes reduced to their most fundamental and truest shape, we shall have to conclude, no doubt, that *psychical* reality is a particular form of existence not to be confused with *material* reality. Thus there seems to be no justification for people's reluctance in accepting responsibility for the immorality of their dreams. . . . It is in any case instructive to get to know the much trampled soil from which our virtues proudly spring" (1900, pp. 620-621). A moral statement, not a moralistic one, making no concession to those who assume, mistakenly, that psychoanalysis does away with guilt; rather, it attempts to trace it to its sources and subject it to scrutiny by the observing ego.

It is not only the strange, "crazy" quality of so many dreams that troubles us, but what they reveal on an even deeper level about those profound desires which disturb the conscience. Freud did not claim to be the first to point out the role of forbidden wishes in the genesis of dreams. He cited Plato, to whom he gave credit in spite of his reservations about philosophers (1900, pp. 67, 620). Plato had Socrates say, "What we wish to recognize is the following: surely some terrible, savage and lawless form of desires is in every man, even in some of us who seem to be ever so measured. And surely this becomes plain in dreams" (IX, 572b). Of the tyrant, the truly evil man, he says, ". . . what he had rarely been in dreams, he became continuously while awake. He will stick at no terrible murder, or food or deed" (574e, 575a). The worst man "is awake, presumably, what we describe a dreaming man to be" (576b) (Plato, translated by A. Bloom, 1968). (Was he in some uncanny way anticipating Caligula, or more plausibly, reflecting on some past or contemporary tyrant?)[1]

I have remarked elsewhere (Stein, 1984) that aside from Plato (who was not altogether consistent), there were, in the ancient world, only occasional interpreters who, rather than ascribing dreams to supernatural sources, tried to explain them in terms of human memory and daily concerns, the role of wish fulfillment being at least implicitly recognized. Some striking examples are to be found in the works of Homer and others. During modern times it has become no longer fashionable to view dreams as coming from God, but there still remains a stubborn tendency to seek ways of evading their moral and other personal implications, especially the role of wish fulfillment. New advances in brain neurophysiology, which are certainly relevant to our understanding of dream formation, have, for example, been employed by such investigators as Hobson and McCarley (1977) and Crick and Mitchison (1983), not so much

[1] Plato regarded dreams as indicative of a man's ethical attitude, believing, however, that they registered a stage in his education, rather than his morality per se (van Lieshout, 1980).

to supplement and clarify the psychological understanding of dreams as to trivialize or discount it altogether. Such reductive approaches fail to take into account the multiple determinants of psychological phenomena, rather as if one were to account for blushing by describing the complex physiology of changes in the blood supply to the cheeks, while ignoring the role of embarrassment. Hobson's recent publication, *The Dreaming Brain* (1989), in which he again discounts the psychoanalytic understanding of dreams, has been subjected to a sophisticated and critical review by the philosopher, Brian Farrell (1989), who points out the simplistic and reductive nature of Hobson's arguments.[2]

But questioning the ubiquity and central importance of wish fulfillment and the moral implications of dreams, with more relevance to problems of interpretation, has come from psychiatry and psychoanalysis as well. Kuper and Stone (1982), employing the theories of Lévi-Strauss to examine Freud's analysis of the dream of Irma's injection, suggest that the structural analysis of dreams may furnish "an alternative to psychoanalytic dream interpretation, focusing particularly on the internal dialectic of the dream—the movement from the initial premise to the resolution" (p. 1225). While this is an interesting way of looking at the manifest dream, essentially from an ego-psychological view, the authors impair their argument by ignoring Freud's concept of secondary revision, which dealt with this very issue at greater depth and with more subtlety by allowing the unconscious dream work its proper role (Stein, 1989). Moreover, their argument skirts the issues of wish fulfillment and moral conflict, treating the dream as if it were a purely intellectual exercise.

The Irma dream, which has been exposed to so much critical scrutiny by these and other authors, contains a description of Freud's attempts to deal with a series of painful moral conflicts.

[2] Hobson's work had previously been subjected to criticism by Vogel on physiological grounds, and by Labruzza and Reiser on the conceptual level (reported by McDonald, 1981).

He accused himself of lapses in clinical judgment, envy of friends and colleagues, disloyalty to his wife, improper sexual interest in his patients, and much else of which he found reason to be ashamed. These charges he answered very inadequately, leaving himself with a persistent burden of guilt and, fortunately for us, a pressing need to understand his dream. Concern about his moral deficiencies also appears in several other dreams, e.g., "Uncle with the yellow beard," "Undressed, running upstairs," and *"Non vixit,"* to select only a few (1900). By analyzing these, he learned to face some of the darker aspects of his own character and to relate them to memories of childhood. Somehow he was courageous enough to describe these painful moral conflicts in his writings. It is not too much to claim that, among many other sources, psychoanalysis arose out of one man's attempt to deal with his sense of guilt, not by self-punishment, nor by confession, but by the active exploration of his dreams and thereby his memories as part of an unsparing self-analysis (Stein, 1987).

A very different view of unconscious conflict and the role of guilt was advanced by Heinz Kohut in 1977. Referring to the present day as the age of "Tragic Man," as opposed to the age of "Guilty Man," which encompassed Freud's lifetime, Kohut minimized the role of moral conflict in psychopathology and in modern life generally. He made relatively few references to dreaming in his later works (e.g., 1977, as opposed to 1971), and was for the most part inclined to downgrade the significance of psychic conflict, the use of free association, and the latent dream in the understanding of personality. This was consistent with his advice to rely upon the analyst's empathic introspection, at the expense of the thorough exploration and evaluation of memories of those events and fantasies which are part of the individual's history and are re-enacted in the transference (Stein, 1979). Kohut's approach was essentially ahistorical, a trend very much in line with the temper of the period during which he wrote, the late '60's and the '70's.

It is true that the *content* of the manifest dream has changed,

for it is above all culture-bound. All dreamers employ the images, myths, and prejudices of their period and society in the construction of their dreams. Modern humans no longer picture Father Zeus, the avenger, in their manifest dreams; they are more inclined to bring in their Chief Executive Officer or their analyst. Yet the underlying dream thoughts and unconscious desires have been far more uniform over the ages. The basic conflicts we detect in the dreams reported by ancient Greeks are altogether familiar, and we come across parallels daily in our experience with patients (Stein, 1984, 1986). Sophocles has the power to move us today; the conflicts he described are very much with us, even though we express them in different terms. The question of fundamental changes in the principles of interpretation can be answered only with the aid of a long view; it cannot be taken for granted or decided on the basis of generalizations over a half-century or so, which is, after all, a relatively brief period of history. It is too early therefore to sound the knell of "Guilty Man," the dreamer troubled by the power of desires, fearful of punishment by the reigning deities or the personal conscience, however portrayed. "Guilty Man" can and does coexist with "Tragic Man."

To return to Joseph Brodsky: the brief passage I cited at the beginning of this paper referred to morality in relation to society, and to a knowledge of history in the broadest sense. Brodsky claims that great immorality in politics, e.g., treason, is fostered by an ignorance (or gross misunderstanding and denigration) of history, a condition predisposing to major distortions of the content and meaning of past events and the uncritical acceptance of doctrinaire accounts. When distortion is officially cultivated, as is so often done to justify betrayals by individuals and genocide by groups, it is often called the "rewriting of history," in itself a disingenuous term employed to conceal its dishonest purpose and tendentious quality. (It is not to be confused with "revisionist" history, based on the discovery of new sources and methods of research, which attempts to

undo past omissions and distortions. It too, needs to be "revised" every few years.)

Herodotus, one of the founders of Western history, although by no means a moralist, approached his task with the hope that it would hold lessons for his readers. Called by some "the father of history," others called him "the father of lies." There is no real contradiction. By recording all the myths and folk tales he could collect, the "lies" so-called, as well as stories and personal recollections of contemporary events, he furnished us with a view of history which is closer to our own "psychoanalytic anamnesis" (Schafer, 1980) than is the more "factual" history of Thucydides. Each has its virtues, but when Herodotus records some fantastic tale, which he follows by the phrase, "at least so the Persians say," we hear the echo of our own inner response when we are told a somewhat improbable tale by a patient who had reported a screen memory as if it were fact. Whether literally true or not, it is significant that those who relate it believe it and have been influenced by their belief; they have constructed a "personal myth" of their own, by which they have regulated their lives (Kris, 1956). Herodotus knew that the behavior of individuals and societies was as profoundly affected by their folk tales, daydreams, and even their night dreams, the "lies" they believed, as it was by their experience of events (Stein, 1984). The dominance of Athenian culture and power, and its ultimate fall, for example, was not only a function of economic, political, and military factors, but was profoundly influenced by the Homeric myths, the "lies," which pervaded Greek political and cultural life for better and worse.

That familiarity with history would ultimately be of social benefit has been an age-old ideal, infrequently realized in practice, but worthy for all that. Although it is reasonable to assume that ignorance constitutes a substantial threat, it would not do to claim that a *knowledge* of history, social or personal, by itself ensures the presence of a sound ethical structure. Like any knowledge, or ecclesiastical teaching for that matter, an ac-

quaintance with even the most unbiased history can be misused. It is worth noting that Brodsky uses not the term "knowledge," but *"familiarity"*—"the state of being very friendly or intimate" (*Oxford English Dictionary*)—thus emphasizing that history, presumably a corrected and reasonably honest history, must be integrated and become part of political human beings in the most fundamental sense, allowing them to think and react historically. Only then, as I read Brodsky, may history contribute to moral education. Ignorance, in any case, does not. To quote the historian, Michael Howard, "The historical process, through the very challenges it poses and the responses it evokes, itself creates the morality of mankind. That seems to me a very good reason for studying it" (1989, p. 689).

The parallel with the analytic process is striking. The ideal "analyzed" individuals have more than just a knowledge of their personal history; they have worked it out in the transference, they feel at home with it, it is part of them; they have attained not simply knowledge but *familiarity* with their past. They have it to use or misuse, but at least it is there, at their disposal.

I do not wish to leave you with the impression that every dream is accompanied by sensations of guilt, or that it must contain a significant confession, to be winkled out by persistent analysis. Even if guilty conflict were ubiquitous on some level, it need not be the predominant theme of every dream, or the one which requires interpretation. If the dreamer is successful in resolving the conflict, no guilt at all may be experienced; sleep is undisturbed and the conscience remains clear. But the kinds of decisions which have to be made in the course of the dream work, about how to gratify archaic desires unacceptable to the waking conscience, are likely to result in conflicts that are imperfectly resolved and leave their residue of guilt.

By dealing with the issue of personal guilt the analyst becomes not the conscience of the patient but, to appropriate Calef and Weinshel's (1980) term, "the conscience of the analysis." Analysts are equipped by training and, we hope, by temperament, to face the disturbing nature of the forces revealed

by the analysis of their patients. (We should remind ourselves that these forces are not unleashed by analysis—life has taken care of that.) Analysts must be able to look upon them with clarity and a sufficient degree of detachment—not to explain them away, but to put them in context and to evaluate their significance. By refraining from condoning or collusion on the one hand, or punitive interference on the other, we can aid the working through of neurotic guilt, the kind revealed in dreams, fantasies, and symptoms. On the part of the dreamer, it takes energy and courage to look through the window offered by the dream and to understand how forgotten memories of forbidden desires have contributed to his or her unreliable conscience and unexplained burden of guilt. Will the recovery and correction of memories lead to a more discriminating, less punitive and more effective conscience, one which is less troublesome, but more troubling? If analysis can accomplish *that*, it has done a great deal for the individual and for those around him or her.

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8 East 96th St.
New York, NY 10128

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Pregnancy During Analysis — Help or Hindrance?

Marianne Goldberger

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PREGNANCY DURING ANALYSIS—HELP OR HINDRANCE?

BY MARIANNE GOLDBERGER, M.D.

This paper challenges the technical precept that during pregnancy a woman is less accessible to analytic treatment. The precept, which originated more than fifty years ago, has remained with us despite significant changes in our knowledge about pregnancy; despite fundamental changes in analytic theory with attendant changes in technique; and despite a large body of clinical evidence to which this paper contributes further information from four analytic cases. All of these developments support the view that pregnancy is not a contraindication for analysis but, on the contrary, can facilitate analytic progress.

This paper reassesses the technical precept that a pregnant woman is not a particularly suitable subject for psychoanalytic treatment. In doing so, it follows Brenner's (1969) advice "that technical precepts must be firmly based on theory, just as theories must be continually tested against the data available; particularly against those data which are available through the application of the psychoanalytic method—that is, through our clinical work with patients" (p. 351). When this technical precept originated, analysts did not have the conceptual tools of the structural theory and the new theory of anxiety. However, the precept is sometimes still invoked today, long after these theoretical advances.

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Early in my training, a colleague of mine was accepted as a candidate at an analytic institute and made arrangements to begin analysis. Before actually starting, she discovered that she was pregnant and was then strongly urged by her prospective training analyst to postpone beginning her analysis until some time after the birth of her baby. Since then, I have heard of other analysts cautioning against analysis during pregnancy. I have heard about experienced supervising analysts who advised candidates not to begin a supervised analysis with a pregnant woman. On several occasions I have even heard the opinion that analysis should be interrupted during a patient's pregnancy. The reason usually given for advice of this kind is that the patient will not be sufficiently "available" for involvement in the transference because she will be narcissistically absorbed by her pregnant state.

It will not come as a surprise that the dictum about pregnancy is said to originate with Freud.[1] According to Benedek (1970),

> Freud, impressed by the emotional calmness of pregnant women, considered pregnancy as a period during which the woman lives in the bliss of her basic wish being gratified; therefore, he assumed that pregnant women are not in need of *or accessible to* psychoanalytic therapy (p. 137, italics added).

Since Benedek was well aware that views about pregnancy had changed, being a significant contributor herself in this area, she went on to say,

> Since then psychoanalytic investigations have revealed the two opposing poles which account for pregnancy as a critical phase. One is rooted in the drive organization of the female procreative function, the other in the emotional disequilibrium caused by the stresses of pregnancy and the danger of parturition (p. 137).

I would like to draw attention to the fact that Benedek ques-

[1] A search of the literature (including all references in *The Concordance to The Standard Edition of the Complete Psychological Works of Sigmund Freud*), as well as inquiries made to those familiar with the Freud Archives, failed to provide any reference to a written statement on this subject by Freud himself.

tioned (as many others have done) one part of Freud's imputed attitude—the calmness of the pregnant woman—but did not comment on the other part—the inappropriateness of psychoanalysis for a woman while she is pregnant. The view of the early analysts was confirmed by Helene Deutsch in 1945 when she said that she "considered the libido 'turned inward' . . . in pregnancy and that the woman's narcissistic investment in her body and self interfered with transference and investment in analytic work" (as quoted in Notman and Lester, 1988, p. 140).

In Grete Bibring's initial report in 1959 about her group's landmark study of a population of pregnant women at the prenatal clinic of a hospital, she noted that therapeutic results could be achieved during pregnancy "with relative ease" (p. 115). In view of this finding, it is noteworthy that she did not address the issue of *analytic* treatment during pregnancy.

In 1982, E. Loewald wondered about the advisability of beginning intensive, psychoanalytically oriented psychotherapy when a woman was pregnant. She said, "To undertake intensive therapy and plan a pregnancy at the same time might often be a suspect plan . . ." and even added that "often . . . occurrence of a pregnancy during therapy might be a signal for postponement or termination of the treatment" (p. 383). As recently as 1988, "a few senior analysts expressed surprise at the abundance of material relating to the pregnancy" during a presentation by Lester and Notman (1988) of their analytic cases of pregnant women. In fact, one of these senior analysts said, "A woman I analyzed recently sailed through her pregnancy and barely talked about it" (p. 197). Notman and Lester (1988) have also stated:

> It was a *prevailing* idea among early analysts that being pregnant was not compatible with being in analysis, considering the intrapsychic changes brought about by pregnancy, although once begun, analysis was not *necessarily* interrupted when pregnancy occurred (p. 140, italics added).

The technical precept that analysis is not fruitful during

pregnancy does not appear to have been explicitly challenged, although there are a number of reports of analyses of pregnant women. Inasmuch as my own clinical experience and that of many colleagues do not support this impression, it seems to me that the time for such a challenge is long overdue.

In the 1940's and '50's detailed descriptions of the experiential and developmental aspects of pregnancy were expanded and reformulated by a number of researchers, including Benedek (1952, 1959), H. Deutsch (1945), Erikson (1950), Kestenberg (1956), and Klein, Potter, and Dyk (1950). Bibring's group (1959, 1961) was largely responsible for promulgating the view of pregnancy as a maturational crisis: "Pregnancy, like puberty or menopause, is a period of crisis involving profound psychological as well as somatic changes" (1959, p. 116). In support of this view, Bibring and her colleagues noted "the revival and simultaneous emergence of unsettled conflicts from earlier developmental phases and . . . the loosening of partial or inadequate solutions of the past" (1959, p. 116). Nowadays one would think of this phenomenon as a loosening of previous compromise formations. Bibring, *et al.* (1961), emphasized that puberty, pregnancy, and menopause have to be singled out as different from other developmental crises because of "the intense and specific interdependence between the psychological and biophysiological changes in this group of fundamentally biologically determined maturational crises. It is this factor which adds to the adaptive process the quality of the inevitable, emphasizing it as the point from which there is no return" (p. 13).

Lester and Notman (1986), noting that "little had been written on the internal shifts and realignments in the mental organization of the woman during pregnancy" (p. 365), described material from the analyses of three women during their first pregnancy. These three patients had sought analysis because of neurotic symptoms, not because of conflicts over childbearing. The authors stated that "[t]he most remarkable finding in the analytic material is the preoccupation of the three women

with their pregnancy and the presence of anxiety" (p. 362). They concluded that "the course of pregnancy is above all determined by factors pointing to the woman's earliest experiences with the maternal object. . . . A second conclusion may be that narcissistic valuation of the body and a poorly integrated bodily ego . . . may become the source of serious anxiety during pregnancy" (p. 363). Their richly detailed description of the three analyses demonstrated the analytic work on the patients' relationships to their mothers, including the re-emergence of "unresolved conflicts over separation-individuation" (p. 364). Unfortunately, they did not specifically mention whether they thought the pregnancies interfered with or enhanced the analytic work.

Applebaum (1988) described a woman who had previously benefitted considerably from extended psychotherapy and who later requested brief, intensive psychotherapy during her third pregnancy, "in order to take advantage of the openness of her inner life that she was experiencing" (p. 178). The twenty sessions of this course of treatment were compressed "into four weeks of intensive psychoanalytic work focusing upon her conflicts about the pregnancy" (p. 178). Applebaum called the treatment "an episode of analysis . . . [since] one can discern the events ordinarily expected to transpire within an analysis conducted without the constraints of a predetermined termination" (p. 193). On the basis of convincing clinical evidence, Applebaum concluded that "pregnancy, for some women, may be a time of increased self-reflectiveness particularly conducive to the work of psychoanalysis" (p. 194).

In my experience, pregnancy usually is a particularly fruitful time in a woman's analysis. I will illustrate this finding with clinical examples; I will propose that it is exactly because pregnancy is a time of emotional disequilibrium that it facilitates accessibility to some of a woman's deepest conflicts; and I will offer some views to explain this phenomenon in terms of current analytic theory.

CLINICAL ILLUSTRATIONS

I have selected brief clinical illustrations from four patients who came for analysis for neurotic symptoms not specifically related to conflicts over childbearing. I would like to stress that these four women all felt an enhanced sense of well-being and of importance during their pregnancies. They felt special in a way that was not present at other times. In my experience, women with major conflicts about pregnancy and having a child differ from this picture, in keeping with the severity and extent of their conflicts. The analyses of women from the latter group were more like two of the three cases described by Lester and Notman (1986; Notman and Lester, 1988), in whom anxiety and regression were prominent.

My first patient, Ms. A, was a thirty-four-year-old tax accountant, the mother of two children, who sought analysis because of severe and pervasive anxiety that she referred to as her "death fear." She had an obsessional character, and while she got along well with most people, she displayed a marked isolation of affect. About fifteen years earlier she had had a four-year analysis, which she had found very useful, but about which she remembered very little. It revolved mostly around her conflicted relationship with her parents. I had the impression that it was helpful mainly in the resolution of issues of late adolescence.

One very striking aspect of this patient was her childhood amnesia, which extended far beyond the usual, so that almost all the major work of the analysis was done in the area of the transference. Another aspect of the treatment was the emergence of certain reactions to separation, of which she had not been aware in her previous analysis. To give one example of the latter phenomenon, every Monday when she arrived for her analytic hour, she experienced me as a total stranger. Even my face seemed unfamiliar. It took until Wednesday or Thursday before she felt that she "knew" me again. Later it became clear

that such reactions to separation were partly related to the "loss" of her mother when her sister was born.

Ms. A was the older of two girls, her sister having been born when she was three. She remembered almost nothing about the birth or early years of her sister, except one vague recurring memory of watching her mother change the baby's diaper. Historically, we knew that she had stayed with her grandparents when her sister was born and for some time thereafter, but she had no actual memory of this. Her adult relationship with her sister was cordial but distant.

After about four years of analysis with me, Ms. A became pregnant for the third time. The pregnancy was planned and the patient hoped that she would have more freedom with her pleasurable feelings this time, now that the analysis had enabled her to be less fearful and rigid. She described her experience of this pregnancy as completely different from the first two, the distinction deriving mostly from her access to a wide variety of affects and fantasies. To her great surprise, she felt increasingly "connected" to all kinds of bodily sensations. This phenomenon became more pronounced with quickening, as would be expected. However, with the earliest hints of sensing fetal movements, she became very disturbed when she could not be sure whether her sensations were uterine or intestinal. At those moments she felt "loathsome" for not being able to differentiate between the two sensations, and she also had upsetting fantasies about her baby's being "disgusting and repulsive." During this period the old vague recollection of her mother changing her sister's diaper kept recurring in her associations with progressively increasing detail. She finally experienced it as a vivid memory and described the sister's diaper full of soft feces which made her feel so nauseated that she had to run out of the room. She thought this might have happened more than once, and she remembered being afraid that she would vomit. After this recollection she began to talk about oral incorporative and expulsive fantasies that are so frequently experienced during

pregnancy. The many motives for the repression of memories about the baby sister continued to emerge after her baby was born and led to more analysis of related conflicts during the rest of her analysis. This vignette serves as one example of the important impetus that a patient's pregnancy can provide to analytic progress.

My second case, Ms. B, was a lawyer in her thirties with a one-year-old daughter. She began analysis because of depression and her continued sexual inhibitions. Her early years had been chaotic, with a stepfather who was sexually involved with her until she was about ten. The childhood incest was clearly a major factor in her current sexual problems; the patient even reported that her husband reminded her of her stepfather. In the fourth year of her analysis the patient was exploring the incest problems productively, when her husband persuaded her to have another child. While she realized that she did want a second child, she was also fearful of not being able to "give" enough to two children and was apprehensive about the prospect of not having enough time for herself.

As soon as she became pregnant the analysis was taken up with issues relating to the pregnancy, and the incest issue was temporarily put aside. She was determined to be a better mother this time and also determined not to repeat the experience with her own mother. She had always felt that her mother had no time for her at all.

For the first time Ms. B was now able to feel close to me. Previously, her strong need to keep her distance had prevented her from being willing to even consider anything about her involvement with me. In the course of her pregnancy she began to feel very "cozy" on the couch in my presence, and this atmosphere led to her feeling that we were going through her pregnancy together. Along with this more comfortable and intimate relationship with me came her realization that she had been unable to have much understanding for her first child—something she had denied before because it would have been too great a blow to her self-esteem.

An important part of the analytic work then centered on Ms. B's relationship with her daughter. The patient had been the oldest of four girls, and she was shamefully aware that her rage at having been required to take care of her stepsisters had emerged in the relationship with her first child. Much of the care of this daughter had been turned over to a full-time housekeeper. Her wish to be a better mother to the new baby was an important factor in her being able to analyze the painful reality of her problems in mothering. This source of motivation to work hard in analysis—to be a better mother than one's own mother—will be discussed in the last section of the paper.

A conspicuous feature of the analysis during the gestation was Ms. B's ability to look not only at her problems in mothering, but also at other aspects of herself that had been much too painful before. The results of this work were dramatically apparent after the birth of her second child, when she was able to deal with two children much better than she had done previously with one. In this case, work on her incest experiences did have to be postponed to a later phase in the treatment, but working in the transference only really began when she became pregnant.

A third illustration comes from the analysis of a phobic woman who was a fraternal twin. Ms. C was fairly satisfied with her marriage and delighted with her three-year-old son. She had been in psychotherapy before her marriage and her worst phobias had been significantly ameliorated. She sought analysis with me because she experienced little sexual pleasure and because she still suffered from phobias severe enough to cause her frequent painful anxiety.

Ms. C realized how incompletely she understood her complex feelings about her twin sister. She had always felt extremely close to her sister and also was aware of ambivalence toward her. But it was not until she became pregnant (after about three years of analysis) that progress in this area began to increase markedly. The shifting sense of self in complete union with the fetus, yet also separate from it, led to increasingly rich associa-

tions about her experiences of confusion between self- and twin-representations. This more detailed knowledge about her very complicated relationship with her twin made it possible for her to gradually experience the same issues in the transference —something that had not occurred prior to her pregnancy. (She had not been in therapy during her first pregnancy.) One example of the twin issue in the transference was her focus on whether or not we were alike; she was dismayed when she thought I was very similar to her, and was equally dismayed when she thought I was very different. In this case again, the new insights gained during pregnancy had an enduring effect on later analytic work.

My fourth case, Dr. D, was a married thirty-five-year-old mental health professional who had had five years of helpful analysis in her twenties which she had sought because of several unhappy relationships with men, and because of her inability to use her full capacities in her graduate training. Her work inhibitions had largely disappeared, and she had made a good marriage. She now sought analysis because of continued inability to achieve orgasm during intercourse, and because she still felt a lack of confidence in her work. She also was convinced that anyone in the mental health field should have personal treatment.

Dr. D thought that women had to transfer their main sexual pleasure from the clitoris to the vagina, and was convinced that intercourse should result in simultaneous orgasms for both partners. After two years of analysis she was thrilled when her plan to become pregnant was successful "on the second try."

Dr. D had little awareness of her passive longings and of her considerable conflicts over separation. She was a person whose independence (achieved in reality) was very important to her self-esteem. The first glimmerings of her understanding about these issues came as a result of analyzing the intensity of her pleasure when having intercourse "in order to make a baby." Her new-found sense of openness and receptivity during intercourse made her realize that for the first time she experienced

sex as really *giving* her something. She had genuinely enjoyed sex since her late 'teens, but she now knew that having intercourse had always had strong components of an "accomplishment" and of pleasing her partner. With much hesitation and difficulty, she began to have fantasies of how she "drank" and "sucked in" the semen in order to conceive. Even more defended were her feelings connected with what she disparagingly called her "clinging self." She eventually was able to talk about her wishes to hold on to the man during intercourse "forever," to take him in "all the way" and to keep him. Thus it was because of her pregnancy that Dr. D was first able to gain access to long-repressed conflicts and to begin to analyze issues of separation-individuation. In fact, this progress began with the anticipation of becoming pregnant, flourished during her pregnancy, and then continued throughout her analysis.

From these clinical examples it should be clear that the conflicts that came to light for the first time during the patients' pregnancies began to be analyzed, but the analytic work on those issues was not completed before the end of the pregnancies. Once these newly emerged conflicts had begun to be analyzed, they then remained part of the material for the rest of the patients' analyses.

DISCUSSION

Freud and his early followers had two main reasons for considering a pregnant woman unsuitable for analysis. The first reason was that her libido was turned inward and this narcissistic investment would prevent her involvement in the transference; the second was that she was not accessible to analytic treatment because of the emotional calmness resulting from gratification of her basic wish.

As for the first reason—the narcissism of the pregnant woman—the development of psychoanalytic theory and practice over the last forty years has changed our views of transfer-

ence. We now recognize that, as Brenner pointed out, "There is no such thing as a patient who has 'no transference,' or in whom transference 'fails to develop' " (1976, p. 131). He stressed that the important issue is whether or not transference reactions are eventually analyzable. The clinical data from the analyses of the pregnant women reported here demonstrate that transference reactions are analyzable during pregnancy in patients who did not seek analysis primarily for deep-seated conflicts about childbearing. It is true that the analyst may at times feel left out during a patient's pregnancy, but this does not mean that transference manifestations are not actually present. Kohut (1971) described a group of narcissistic patients with whom the analyst frequently felt left out. He described ways to understand the transference phenomena in these patients—patients in whom the so-called "lack of availability for transference" had been thought to seriously interfere with analytic work, as if there were "no transference." I would like to suggest that during pregnancy the transference may similarly, though temporarily, take on a different quality.

Changes in the transference during pregnancy result partly from the fact that a new and unique "object" has entered the patient's life—the fetus, who plays a role as a transference object. This phenomenon of the fetus as transference object will be familiar to any analyst who has worked with a pregnant patient. Recently, Stack (1987) wrote explicitly about the fetus as a transference object, although his examples did not derive from *analytic* work. Similarly, Lieberman (1983) described a patient whose psychotherapy began at thirty weeks of gestation, and who unconsciously equated her fetus with her hated younger sibling. Reports of cases of pregnant women in analysis contain a variety of examples of the changing transference meanings of the fetus.

I would like to emphasize that an important advantage of the fetus as transference object in the analytic process is that, like the analyst, it is an object *within* the analytic work space. The patient brings the fetus with her to every analytic hour! Even

though it may deflect affects and fantasies away from the analyst, it still remains very much within the analytic setting.

Another important aspect of the fetus as transference object is that it prompts the pregnant woman to vividly identify with both sides of the mother-child relationship. This is one reason why the pregnant patient has an enhanced opportunity to analyze her relationship with her mother and why some of a woman's most primitive affective experiences and self-representations may become meaningfully available for the first time during her pregnancy. Lester and Notman (1986) have already described these phenomena clearly in their paper detailing the analyses of three women. Asch's (1966) report of the dramatic case of a very regressed woman he saw in therapy demonstrates "extreme confusion of the identities of herself, daughter, fetus and mother" (p. 168).

The absorption of the pregnant woman with her unborn baby has sometimes been thought to undermine motivation for analytic work. Actually, the opposite can also be true. Applebaum (1988), in discussing the case described above, suggested an important impetus for greater self-understanding during pregnancy:

> *Motivation to change* ingrained relationship patterns becomes sharpened in the face of an anticipated new relationship. To the extent one senses that those ingrained patterns may be dominated, to one's detriment, by identification with one's own mother, and by a compulsion to repeat with the new baby patterns of mothering seen as damaging to the self, there can be an *urgent need to reexamine one's own infancy* (pp. 194-195, italics added).

This motivation for working in the analysis is also illustrated by the case of Ms. B (above) who was determined not to repeat her experience with her own mother in raising her second child.

Now I want to return to the nature of the transference during pregnancy. As described above, the patient's investment in the new object (the fetus) may temporarily lessen the intensity of

investment in the analytic relationship, but this does not do away with the significance of the analyst as transference object. On the contrary, I would like to suggest that one meaning of the patient's apparent "leaving out" of the analyst can be a replay of the battle with her mother over autonomy.

This phenomenon is illustrated by the situation of a professional woman who was pregnant for the second time when she sought consultation with me about her four-year analysis with a male analyst. Overall, she was satisfied with the progress of her treatment, but now that she was again pregnant, she had the feeling that her analyst was no longer interested in her in the same way as before when the transference had put him "at the center" of the analytic work. It reminded her of her doubts about his understanding during her first pregnancy. In the course of exploring the current complaint about her analyst, her reluctance "to let him in" on all that she was experiencing soon became clear. She was convinced that only women are interested in such "trivial" details and that she would become interesting to her analyst again only when her concerns returned to her professional work and to her relationship with him.

She then began to tell me in a pleased and confidential tone about some details concerning her pregnancy. After a while, I reminded her of her reluctance to share such details with her analyst, and asked if she might also be pleased to have something he could not really share. She agreed and added that she'd been aware of a certain unusual sense of self-sufficiency. Her associations then went to recollections of ambivalent feelings toward her mother. She spoke of her fury at her mother's intrusive comments about her budding breasts at age eleven and her own withdrawal from her mother at that time. Yet, her mother had been quite helpful when her periods began. By the end of the consultation, the patient said she realized that she had been contributing to the recent distance from her analyst, and she seemed eager to continue with him.

Need I say that this vignette demonstrates that there was an added dimension in the transference—the patient was re-

peating her struggle for independence, casting the analyst in the role of intrusive mother. My guess is that due to the transient nature of a consultation, she experienced me as the helpful mother-confidante.

A girl's battle with her mother for independence is just one possible transference constellation among many. Numerous other aspects of a pregnant patient's early relationship with her mother appear in transference reactions to the analyst, and the specific coloration of the transference manifestations will, of course, depend on the conflicts of each patient.

The second reason why Freud and his co-workers doubted the suitability of a pregnant woman for analysis was her emotional calmness resulting from the gratification of her basic wish. Women who are not deeply conflicted about pregnancy do quite frequently have a special sense of satisfaction and importance while they are pregnant. Their contentment can at times border on smugness. Arlow (1957) quoted a patient describing such women as looking "like the cat that swallowed the canary" (p. 7). This sense of satisfaction has many determinants, not the least of which is the pregnant woman's feeling that she has achieved, and keeps on achieving, something of unique importance, completely effortlessly, just by *being*. The case of Dr. D illustrates this feeling. She described an intense awareness of having a marvelous special secret, long before anyone else knew she was pregnant. From the clinical material described, we know that she felt she had swallowed something fabulous.

The early analysts who assumed that such a gratified state meant a lack of drive energy for investment outside oneself did not apply the new theory of anxiety. For this reason they failed to understand, as Brenner (1982) has so convincingly emphasized, that conflict is always present and that there is always a dynamic equilibrium among the elements of any compromise formation. An increased feeling of satisfaction would be expected to shift the usual pattern of compromise formations due to changes in the components of conflict.

In regard to the drives, both libidinal and aggressive drive

derivatives are stimulated during pregnancy in many complex ways. Analytic data consistently show that pregnant women in analysis are deeply involved in multiple aspects of their relationships with their mothers at every developmental level. In Ms. B, for example, pregnancy reactivated competitive urges toward her mother as well as wishes for close union with her (the latter mainly manifested in the transference). Had she not been in analysis, she might have experienced only an increase in anxiety, and probably would have developed added defenses. The ongoing analysis provided her the opportunity for using the increased drive derivatives to gain more self knowledge.

Another common source of stimulation of drive derivatives during pregnancy is feelings toward siblings which were formerly defended against. This is clearly illustrated in the analysis of Ms. A, who recovered memories of feelings from the time of her sister's birth. The analytic work with Ms. C, the fraternal twin, also exemplified important wishes and fantasies connected with her early relationship to her sister that had largely been emotionally unavailable before her pregnancy.

Another circumstance of pregnancy that may allow a compromise with greater expression of aggressive aims than would have been tolerable previously is that wanting something for the fetus is experienced as altruistic—a mother can demand all that is best for her infant. If a woman can go beyond this altruism and experience herself also as the infant, thereby acknowledging her aggression as a direct expression of her own wishes, she can make important headway in the analytic work.

Changes in defenses during pregnancy can be as important as the changes in drive expression. Since heightened self-esteem is an important component of the sense of satisfaction, the pregnant woman's need for certain defenses can diminish. Because of their increased sense of worth, my analytic patients had less anxiety about the possibility of being incapable or defective. This sometimes permitted self-observations that they had previously avoided. Evidence for this from the clinical cases presented here includes Dr. D's newfound ability to bear knowing

about her separation anxiety and her passive longings, and Ms. B's ability to analyze the painful reality of her problems in mothering.

On the other hand, the analysis of Ms. B demonstrates that certain defenses may increase during pregnancy. Her defenses against the incest material were heightened enough to make it impossible for her to consider that issue while she was pregnant (though her defenses against her wishes for closeness with me were diminished during the same period). The sense of well-being experienced by many pregnant women may simultaneously serve the purpose of defending against the bodily anxieties regularly found in varying intensity during pregnancy. Feeling especially competent helps to preserve a sense of safety in the face of the anticipated dangers of parturition.

Another determinant for shifts in a woman's compromise formations is a diminution of superego pressure. During pregnancy she often feels that she is permitted to be more self-absorbed than usual. Our culture supports the idea of pampering the pregnant woman, allowing her to feel less urgent about maintaining her usual ego ideal of being selfless, caring, and concerned with those around her. Consequently, she may feel freer to explore in detail her changing inner physical self as well as the workings of her mental self. In this instance the apparent increased narcissism of a pregnant woman can become an asset to the analysis.

Decreased superego demand was a factor in the ability of Ms. B to consciously strive to be better than her own mother. Her conflict was altered by the presence of a fantasied permissive mother (the analyst). Such an alteration was, of course, due to transference during her pregnancy. It became an analytic result only when Ms. B became conscious of putting the analyst into an affectionate, permissive role, and was eventually able to achieve some modification of her own superego attitudes.

The validity of the studies demonstrating that pregnancy is a time of physiological and psychological disequilibrium is now widely accepted. In my experience this disequilibrium is often a

facilitator of the analytic process. The theoretical basis for this finding is that certain compromise formations become less fixed under these conditions and therefore can be more available to analytic observation. If the new insights gained during pregnancy achieve some stability, as they did in my cases, then they remain available for analytic work even after parturition, and the progress of the analysis continues to be enhanced.[2]

SUMMARY

This paper has re-examined the clinical precept that during pregnancy women are less accessible to psychoanalytic treatment. Although many analysts seem to be aware that this old dictum is not clinically supportable, the precept does continue to be invoked. There are numerous examples in the literature that demonstrate the usefulness of psychotherapy during pregnancy, yet the studies specifically based on analytic treatment have not challenged the precept directly.

My own experience with women in analysis during their pregnancies has repeatedly demonstrated that useful analytic work often occurs at this time. I have presented illustrative vignettes from the analyses of four women for whom pregnancy in itself did not represent a major conflict.

For the purpose of discussion I divided the old dictum into two parts—narcissistic self-absorption and emotional calmness due to gratification, although admittedly they overlap. I have pointed out that the development of psychoanalytic theory and practice over the last few decades has led to a very different view of the analyzability of narcissistic issues. My cases show that workable transference manifestations are far from absent during pregnancy and that maternal transferences sometimes

[2] I want to thank Dr. Rita Clark for a point she made when this paper was presented at the Psychoanalytic Association of New York—namely, that another motivating force activated by pregnancy is the sense of an inherent time limit which provides many women with an impetus to accomplish as much as possible in the analysis before giving birth.

emerge with special clarity. The fetus as transference object is frequently an important locus of analytic work. Thus, narcissistic self-absorption is not a valid reason for refusing to accept a pregnant woman for analysis.

In the early years of this century when the old precept originated, no detailed studies were available concerning pregnancy as a major developmental phase in the life of women. The important studies that have appeared over the past fifty years have revealed the inadequacy of the old view of pregnancy as a period of emotional calmness, thereby undermining the other concept on which the precept was based. Even more important is the way that pregnancy demonstrates the ubiquitous presence of conflict in every individual and that compromise formations can always fluctuate. My discussion illustrates some ways that changes in the components of conflict can result in shifts in the various patterns of compromise formation.

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1130 Park Ave.
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Arnold H. Modell

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A CONFUSION OF TONGUES OR WHOSE REALITY IS IT?

BY ARNOLD H. MODELL, M.D.

In a 1933 paper Ferenczi implied that conflict between the adult's and the child's construction of reality is traumatic for the child. As all individuals construct their own view of reality, it is inevitable that there will be conflicting constructions between child and adult—and between analyst and analysand. This may be biologically rooted; recent ethological studies suggest that parent-child conflict is ubiquitous because of a divergence of needs. When a child perceives a marked divergence between his or her construction of reality and that of the caretaker, the child may tend to reject the information proffered by the caretaker. This may appear later as a resistance to learning from the analyst. The divergence of needs between child and caretaker may have a profound influence on the child's cognitive development. The capacity to share other constructions of reality is a developmental achievement which may be facilitated by the psychoanalytic process.

In this presentation I shall develop certain issues raised by Ferenczi (1933) in his historically important but largely neglected paper, "Confusion of Tongues between Adults and the Child." That paper, presented at the International Psycho-Analytical Congress in Wiesbaden in 1932, reflected Ferenczi's growing estrangement from Freud, in that he revived the theory of the traumatic etiology of the neuroses which Freud had abandoned (see Dupont, 1985). Before presenting the paper, he read it to Freud, who expressed the opinion to his colleague, Eitingon, that it was harmless, but stupid and inadequate. Freud at-

tempted to persuade Ferenczi not to present it (Gay, 1988, p. 583).

The confusion of tongues refers to the child who is sexually seduced by an adult and is confused by the conflict and contradiction between his or her own language of tenderness and the adult's language of passion, lust, and hypocrisy. Ferenczi sensed a principle that goes beyond the specific issue of sexual seduction. I would restate "the confusion of tongues" as the conflict between the adult's construction of reality and that of the child. It is a conflict that represents their different desires and needs. My focus in this paper will therefore not be on the specific problem of the adult's sexual seduction of the child, but on the traumatic effects that ensue when there is a marked divergence between the child's construction of reality and the construction of reality that is communicated to the child by the caretakers.

Ferenczi described one such typical reaction to trauma: children compliantly identify with the adult construction of reality, which results in a loss of trust in their own judgment of reality. This compliance does not reflect a true internalization, as it is frequently accompanied by the very opposite attitude: a permanent distrust of knowledge that is obtained from others. I recall, for example, a patient, who would repeat exactly what I said to her, never altering my choice of words. This puzzled me until we discovered that she never accepted anything that I said to her: her compliant, parroting repetition masked the opposite attitude of absolute defiance and rejection. Some individuals become quite adept at compliant learning of this sort. Divining what the situation requires may lead to successful social adaptation, but it does not represent knowledge that becomes part of the self.

Ferenczi described how the seduced child identifies with the aggressor's hypocritical and false interpretation of reality—that nothing, in fact, had really happened. As a consequence, the child's confidence in the testimony of her or his senses is broken. Ferenczi (1933) noted that he understood why his pa-

tients refused so obstinately to follow his advice (p. 163). This inability to assimilate what is presented from without may be accompanied by a paradoxically overly credulous gullibility. Calef and Weinshel (1981) described a syndrome that they called "gaslighting," a term they borrowed from the movie, *Gaslight*, which was based on the play, *Angel Street*. In the story, a newly married young woman is convinced by her husband that she is going crazy. This syndrome, in which one partner uncritically assimilates the other partner's wildly divergent interpretation of reality is more common, I believe, than has been acknowledged. From the foregoing discussion it is clear that when there is a marked divergence between the caretaker's and the child's construction of reality, the child will have good reasons for not accepting the parent's instruction and guidance. This impairment in the capacity to learn from others will undoubtedly extend to the psychoanalytic situation as well.

Whether to believe in the environmental or in the intrapsychic origin of the neuroses, which in part formed the content of Freud's controversy with Ferenczi, has been a continuing dialectic since the beginning of psychoanalysis. Currently, the balance is tipping in the direction of a traumatic etiology. This is not only due to the recognition that sexual abuse of children by adults is widespread and not a fantasy; we have also learned to recognize the far-reaching traumatic effects of the caretaker's affective unresponsiveness or affective hypocrisy. That is to say, we have learned to recognize the traumatic effects not of a single event, but of the chronic influence upon the child of certain elements within the caretaker's personality.

Ferenczi's paper was several generations ahead of its time, in that it proposed a constructionist view of reality. Such ideas were not systematically recognized in psychology until the monumental researches of Piaget. As important as Piaget's contribution to cognitive science is, its application to psychoanalysis has been somewhat limited by the fact that Piaget observed the child's cognitive development in an average expectable environ-

ment. The influence of the child's caretakers was not a subject that he investigated. Although Winnicott did not use the term *construction of reality*, this is essentially what he described under the heading of creativity. Winnicott, unlike Piaget, was not interested in the development of cognitive structures, but was fascinated by the problem of the border between subjective and objective reality. In contrast to Piaget, Winnicott believed that the child's creative construction of reality could not be separated from the facilitating maternal environment.

Before I discuss Winnicott's contribution, I hope to demonstrate that the question—whose reality is it?—is not just a question for philosophers but one that has direct clinical relevance. The question has been implicit since the beginning of psychoanalysis. When Freud transformed himself from a hypnotist into a psychoanalyst, he was confronted with the difference between the analyst's interpretation and the hypnotist's suggestion. The hypnotic suggestion, the authoritarian hypnotic command, is a product of the hypnotist's mind that is then "suggested" or placed into the mind of the subject, whereas an analytic interpretation, Freud believed, is based upon what the analyst observes in the analysand's mind by means of the process of free association. Freud believed that through the method of free association, as applied especially to the dream and to the transference, the analyst has access to the patient's unconscious mind and reflects this insight back to the patient in the form of an interpretation. Although Freud never doubted that the analyst interpreted what was in the patient's mind, he acknowledged that the patient's acceptance of the analyst's interpretation depended on some measure of suggestion. He stated:

> Thus our therapeutic work falls into two phases. In the first, all the libido is forced from the symptoms into the transference and concentrated there; in the second, the struggle is waged around this new object and the libido is liberated from it. The change which is decisive for favourable outcome is the elimination of repression in the renewed conflict, so that the

> libido cannot withdraw once more from the ego by a flight into the unconscious. This is made possible by the alteration of the ego which is accomplished under the influence of the doctor's suggestion (1917, p. 455).

Although we do not exactly know what Freud meant by the term *suggestion*, it does connote a compliant, uncritical submission to a reality external to the self.

Freud's unquestioned assumption that the analyst interprets what is in the patient's mind has been challenged by Schafer (1983) and Spence (1982). They have asserted that an interpretation is merely the analyst's narrative construction. Psychoanalytic interpretations, according to these authors, are analogous to the interpretation of a text: they both speak of the interpretation as achieving a certain "narrative fit." Schafer calls it the "analyst's story line," and Spence asserts that interpretations depend more on their power to persuade, on their linguistic characteristics, than on their "truthfulness." Schafer believes, a priori, that the analysand "can never have direct access to [past] events" and that his or her "experience of these events is always subjective" (Panel, 1983, p. 240) and therefore open to further, interminable, interpretation. The analyst's interpretations are "acts of retelling or narrative revision" (pp. 239-240). An "accurate" interpretation is an impossibility, for the analyst is only offering the patient an alternative "story line"; the analyst is merely substituting *his or her* narrative for that of the patient.

Freud did not deal with the question, whose reality is it?, head on, but he did make an important distinction between the analyst's insight and the patient's insight. The analyst's insight is a step ahead of the patient's insight, but the analysand only becomes convinced of the truth of the analyst's interpretation after it has been demonstrated directly through the experience of transference. Freud implied that in the act of interpretation, there is an interplay between the analyst's and the analysand's construction of reality.

The Interplay between the Child's and the Mother's Construction of Reality

When there has been a persistent divergence between the child's reality and the adult's, the individual will, as Ferenczi observed, either develop a cynical distrust of the knowledge proffered by others or a naïve and uncritical acceptance in which the individual abdicates his or her own critical judgment. It is not uncommon to find both attitudes co-existing in the same person. Infants and children construct their own realities, but at the same time they are totally dependent upon their caretaker's construction of reality for their safety in the world. There comes a time when children begin to discover discrepancies between their construction of reality and that of their caretakers. Winnicott suggests how this conflict might be normally resolved.

Winnicott, as mentioned before, did not speak of the child's construction of reality, but referred instead to creativity, which he believed begins at birth: "At the first feed the baby is ready to create, and the mother makes it possible for the baby to have the illusion that the breast has been created by impulse out of need" (1988, p. 101). This illusion is made possible if the mother responds synchronously to the baby's desire. A "good enough mother," with a sensitivity based upon her identification with the baby, will reinforce the baby's illusion of omnipotent magical control of the breast. Winnicott asserted that the importance of the mother's sensitive adaptation to the baby's needs can hardly be overestimated, in that it provides a core that remains the foundation for a continuing positive attitude toward external reality. The infant needs the mother, yet the infant has the illusion of creating the breast out of need. There is a paradox here: the mother provides the necessary environment so that the baby can have the illusion of self-creation, but it is the mother's perception of the world that will insure the baby's safety. We know that for the young child the mother is an alternative environment interposed between the child and the dangers of the real world. The child's safety in the world de-

pends upon the caretakers who provide the child with those signals of danger that are the instinctive endowment of other species. In a certain sense the mother *is* reality, in that she is the source of vital information concerning the real world. As Freud (1926) observed, "Man seems not to have been endowed, or to have been endowed to only a very small degree, with an instinctive recognition of the dangers that threaten him from without. Small children are constantly doing things which endanger their lives, and that is precisely why they cannot afford to be without a protecting object" (p. 168).

I have often referred to the observations that Anna Freud and Dorothy Burlingham (1943) made regarding young children during the bombing of London in World War II. These children remained calm during a raid if their mothers were not unduly anxious. In this way the mother functions as a transcendent reality interposed between the child and a dangerous world. When the mothers or other caretakers provide what has been called a background of safety, children are allowed to live within a self-created world of fantasy and magical action which neither mothers nor children question. In the absence of such parental protection, the self-created world may take on a very different function, a function essential for children's psychic survival, for then children must construct a substitute world in which they are their own caretakers. In those instances the self-created world is likely to have at its center fantasies of omnipotent self-sufficiency.

Winnicott's theory of the transitional object indicates how, in health, these two constructions of reality, that of the child and that of the mother, might interact with each other. It is a theory of shared constructed realities. It is here that Winnicott posited the formation of a third area of reality that he called a *potential space* between the child and the mother. It is an illusory world that belongs neither to the subject nor to the object; it is neither inner reality nor external fact.

As is characteristic for Winnicott (1971), the center of his thought rests on a paradox:

> Of the transitional object it can be said that it is a matter of agreement between us and the baby that we will never ask the question "Did you conceive of this or was it presented to you from without?" The important point is that no decision on this point is expected. The question is not to be formulated (p. 100).

Within the illusion of the potential space the mother accepts and does not challenge the child's construction of reality: the question, whose reality is it?, does not arise. Winnicott generalized from the observation of infants to suggest that this potential space characterizes the mental process that underlies the shared illusions of aesthetic and cultural experiences. From the standpoint of an outside observer, this potential space is a space that belongs neither entirely to the subject's inner world nor to objective external reality; it represents the subject's creative transformation of the external world. From the standpoint of the subject, this potential space symbolizes the interplay of separateness and union. Playful merging requires a sense of sureness regarding the self, which means that the autonomy of the self is preserved. This is in contrast to those who fear being merged or swallowed up by the object.

Winnicott further suggested that this creative apperception should be distinguished from compliant learning that is characteristic of a false self. For when the self enters into the object, one can in this way make learning truly one's own. This interplay of separateness and union with the other person permits one to learn from others while maintaining the autonomy of the self. The most effective interpretations are those made when we do not know whose construction it is, ours or the patient's. The importance of this process can be observed in the negative, that is, by its absence, which results in a relative inability to learn from others.

We all know of some patients who cannot take in anything that they have not already thought of themselves. I described elsewhere (Modell, 1985) a case of a professional man, who, in-

stead of taking something in and making it his own, learned in a fashion that was quick, superficial, and shallow. He picked up information from the air, so to speak; he was *au courant* with all the latest stylish professional jargon, catchwords that he picked up from conversations and from skimming professional journals. He achieved his professional credentials by cramming for examinations and was very skillful at multiple choice questions. But he rightly felt himself to be an impostor, for nothing stuck to him. Early in the analysis he informed me that he never read a book that was not required as a school assignment; I dismissed this at first as an exaggeration but later learned that it was literally true. Confrontation with other constructions of reality produced anxiety. Such individuals may act as if they are learning from the analysis, but one discovers that one has been writing in the sand, that nothing has been truly taken in. As far as it could be determined, in this particular case there was a major failure of the early holding environment: his mother had left him at the age of two in the care of an elderly, nearly blind grandfather who spoke only Yiddish, which the patient did not understand.

Winnicott believed that primary creativity is supported by the mother's intuitive response to the infant's desire—a response that arises out of identification with the infant based upon the mother's love; but he also believed that the child's acceptance of the externality, the separateness, of the object is supported by the mother's acceptance of the baby's *hatred*. Extrapolating from his experience with adult patients in psychoanalysis, Winnicott claimed that in order to accept both the limitation of personal omnipotence and the separateness of others, the child must also have experienced both intense hatred toward the mother and the mother's acceptance of that hatred. To know that they have both survived hatred, Winnicott (1971, p. 92) thought, was essential for the capacity to playfully merge. Looked at from this point of view, the sharing of constructed realities may require this developmental step. There is some support for this theory: in some analyses the capacity to learn from the analyst begins

only after both analyst and analysand have survived a point of maximum destructiveness in the transference.

Divergence in the Constructed Realities of Children and Their Caretakers

The divergence of constructed realities must also reflect the enormous variability of our central nervous systems. Recent advances in neuroscience (Edelman, 1987) indicate that the nervous system is not as genetically hard-wired as had been previously supposed; that even within the constraints of genetic instruction, the embryological development of the nervous system shows a remarkable degree of variability from the level of the cell to the level of global functioning. This variability results from a dynamic interaction with the environment. Not only do significant variations in morphology arise in this manner, but the functional organization of the central nervous system is also dynamically responsive to the environment at every level of organization. This means that genetically identical twins, even at birth, do not perceive the world identically; each person perceives the world uniquely, that is to say, all individuals construct their own reality. Modern science has confirmed what William Blake apprehended intuitively: "A fool sees not the same tree that a wise man sees."

We must assume, as I noted earlier, that at a certain point in development, children will begin to observe the differences between their own construction of the world and that of their parents. I suspect that children perceive a great deal more about their caretaker's construction of reality than they are able to articulate. Growing children may find their parent's judgment of the real world eccentric and, in a sense, crazy. Not infrequently, intelligent children correctly judge that a parent's view of reality is off. For example, one patient who was, in fact, intellectually precocious perceived at the age of two or three

that his mother was mad, although the extent of her madness was hidden and not acknowledged by her family or by her neighbors. This child knew that his mother's judgment was unreliable and could not assure his safety in the world. Another patient, during latency, correctly observed that his mother was flighty, childish, and fatuous. This is not to say that children articulate their observations as I am doing now, but these perceptions are taken in, whether consciously or not, and have profound consequences for further development. Such a recognition will result in the child's turning away from the caretaker as a source of information and knowledge and may lead to a distrust of the judgment of others.

Something analogous but less serious may occur with extremely intelligent children or with those who are brighter than their parents. It can also be found in immigrants' children who have a greater mastery of the language and local culture than their parents. These children learn that their world view is apt to be more dependable than that of their parents. The loss of their parents as protective objects induces a precocious yet fragile maturation supported by grandiose illusions regarding the self, illusions that prove to be necessary for the child's psychic survival. In addition to the need to retain omnipotent and grandiose illusions regarding the self, such individuals, whose parents' construction of reality is markedly divergent, may suffer from a subtle cognitive impairment. Although in some cases they may appear to be competent students, they recognize that their knowledge is facile and shallow, and they fear that they will be discovered to be impostors. They doubt whether they know anything.

Kinship Theory and the Divergent Construction of Reality

I noted earlier that divergent constructions of reality between parent and offspring may be attributed simply to differences in

their nervous systems, a biological given. Another "biological given" that may contribute to this divergence is the ubiquity of parent-offspring conflict (Trivers, 1985). Ethologists and evolutionary behaviorists have recently observed what appears to them to be the nearly ubiquitous occurrence of parent-offspring conflict in a variety of mammals and birds. They understand this conflict to be the consequence of the divergent needs of parents and their offspring. Such observations are seen to support the belief that the altruistic behavior observed in many species is correlated with the degree of kinship—the extent to which there is shared genetic material. From this point of view, altruism may be a disguised form of self-interest, as one could argue teleologically that from an evolutionary point of view, the ultimate self-interest is the preservation of one's own genetic material. Altruism is greatest toward offspring, but offspring share in only one-half of each parent's genetic material and in terms of evolutionary forces are competing with yet unborn siblings. Some evolutionary biologists believe that parent-child conflict follows from these genetic differences.

Older ethological studies have focused upon the mutuality of need between parent and offspring, such as seen in nursing behavior. These studies contributed to Bowlby's (1969) theory of attachment behavior. Kinship theory, on the other hand, has resulted in the positing of a nearly universal existence of parent-offspring conflict based on the divergence of needs between the two. The foremost exponent of this point of view is the evolutionary biologist, Trivers (1985). He describes a cost/benefit ratio in the weaning behavior of many species. Consider the example of a newborn caribou and its mother. For the mother, the benefits of nursing the calf compared to the cost, the danger to the calf from predators, decreases rapidly with the increase in size of the calf. Continued nursing may be beneficial for the calf's survival, but it places the mother's survival at greater risk. There is therefore an inevitable divergence of self-interest. For the evolutionary biologist, self-interest is equated with reproductive success expressed as *inclusive fitness*. Trivers

says that "conflict results from an underlying difference in the way each party maximizes its inclusive fitness" (p. 149). For other species as well as humans, this divergence of self-interest affects the capacity of the offspring to learn from its parents. Trivers states: "Although [the offspring] is expected to learn useful information . . . [it] cannot rely on its parents for disinterested guidance. . . . Thus from the offspring's standpoint, an important distinction ought to be made between reinforcement schedules that are imposed by a disinterested environment and ones that are imposed by other organisms, which may be attempting to manipulate it against its own best interests" (p. 159).

Malcolm Slavin (1985) was the first to note the relevance of Trivers's work for psychoanalytic theory. He states that "overlapping yet distinct interests in parent and offspring [have] the following major implication: that on virtually every crucial psychological issue in the course of development . . . the parent as a functioning biological organism will tend to hold a view of reality which is consistent with its own interests, derived from its own experience and biased toward those individuals . . . to whom it is most closely, reciprocally tied" (p. 418).

The Parent's Self-Interest

In cases of the sexual seduction of the child by an adult, the divergence between the needs of the adult and those of the child is all too painfully obvious. But if we assume that even in the best regulated and happiest of families, there is an inevitable conflict between the needs of parent and child, which the child recognizes, how do we distinguish normative from pathologic development? A commonsense answer is that under the best of circumstances the parents will see to it that the child's needs take precedence over their own.

The subject of parental self-interest may be hidden within the too inclusive term *narcissism*. What is usually meant is that the

parent is unable to perceive the child's separateness and accordingly treats the child as an extension of the self; the child then becomes the recipient of the parent's self-love and self-hatred. A banal example is seen in parents who have an explicit agenda for the child based on their own needs and not their child's needs. We are all familiar with those patients who believe that they were not loved for themselves but felt that their parents' love was contingent on their living up to certain expectations. When such individuals first encounter an analyst, they may need to test the analyst in order to discover whether he or she is committed to them or to his or her own hidden agenda. This is especially true when the analyst or therapist does, in fact, have another tacit agenda for the patient's treatment.

For example, I treated a patient in psychotherapy behind a one-way mirror in a teaching exercise. This clinic patient was informed about the project and agreed to this intrusive arrangement as a trade-off so that he could obtain the services of an experienced therapist for a possibly long-term treatment. As therapy proceeded, it became apparent that the patient felt he had not been loved for himself as a child, that he had been loved only when he performed in a manner that provided pleasure to his parents. Predictably, this man did everything in his power to demonstrate to the class that he was a "bad" patient and that I was an ineffectual therapist. It was essential for him to discover whether I was committed to him and to his treatment or whether my primary intent was to demonstrate to the class my therapeutic prowess. It was crucial for him to learn the extent to which I was motivated by my own self-interest. I recall another instance when a prospective analysand, in the initial interview, peremptorily demanded that I refrain from smoking during *her* analysis. At that time I smoked small cigars, and although I did not know the meaning of this woman's demand, I assented to her request. Later, during the course of the analysis, I learned that it was absolutely necessary that this patient discover whether I could forgo my own pleasures in favor of her needs. She had experienced both parents as self-indulgent,

selfish people who were incapable of giving up anything for their children. Both of these patients were understandably distrustful of my formulations.

Therapeutic Implications

This quasi-philosophical excursion into questions concerning divergent constructions of reality does have some practical consequences for the therapist, inasmuch as it enables us to approach the subject of resistance from a different perspective. For example, if a patient rejects our interpretation, in addition to the familiar motives for such a rejection—that the interpretation is inaccurate, that the patient is prematurely confronted with unacceptable warded-off ideas, and so forth—our interpretation may be rejected simply for the reason that it is *our* interpretation. The capacity to incorporate divergent realities is another way of considering the capacity to learn from others; our understanding of this process may provide a rationale for and the possibility of codifying some aspects of our technique. For example, we have learned by trial and error of the untoward consequences of premature intrusions of our own constructions as a substitute for the patient's construction. Psychotherapists of many different persuasions agree on this point, and it has become the basis of certain techniques. Recall the technique of Carl Rogers (1942) of simply repeating the patient's utterances. This has become the subject of ridicule and caricature, but it may be based on a recognition that the therapist should be careful not to go beyond what the patient communicates. Balint (1968), in his book *The Basic Fault*, included a chapter entitled "The Non-Intrusive Analyst." And Winnicott (1971, p. 57) learned that correct interpretations could prove to be traumatic if they are experienced as evidence of the analyst's cleverness. The use of empathy as a therapeutic technique, which has been so much emphasized recently, is not unlike the Rogerian technique, in that an empathic comment does not go

beyond what the patient is already aware of. I do not wish to be misunderstood as suggesting that we foreswear the use of interpretations. But Freud, as well as subsequent generations of psychoanalysts, knew that interpretations should be only a short step beyond what the patient was already aware of. We also know how complex and variegated the act of interpretation is. There are interpretations that reverberate with the patient's experience, and there are others that are more the product of the therapist's mind and are therefore experienced as something imposed, as it were, from the outside.[1]

Those patients whom we refer to as schizoid are attached to their inner world defensively and in many instances the retreat to this inner world has proven to be a life-preserving alternative to the constructed world of their caretakers. For them, there is a danger in learning from others. I have described (Modell, 1984) schizoid patients as encased in a cocoon which nothing leaves and into which nothing enters. It can be a veritable fortress. This life-sustaining inner core of constructed reality may be felt to be at risk if such patients accept the therapist's ideas; any ideas that the patients have not already considered themselves may be viewed as an alien reality. I recall an extreme instance of this problem in the analysis of a patient whose parents were, in fact, both psychotic; for obvious reasons, the patient literally could not accept anything that I said. Even if I paraphrased what she had just told me and in the process introduced something of myself by using my own language, this would provoke a violent rejection.

But how is it possible to avoid intruding one's own construction of reality? The patient is, after all, paying you because of the assumption that you are the one who knows. Of course, the analyst betrays his or her own construction of the world in every possible way, in addition to the act of interpretation. The patient learns from the analyst not only as result of the analyst's interpretations; the analysand is also exposed to what has been

[1] I have discussed this subject in greater detail elsewhere (Modell, 1990).

described as the *analytic attitude* (Schafer, 1983)—an attitude toward life and living that can be described as an analytic *Weltanschauung*. The psychoanalytic *Weltanschauung* includes certain tacit assumptions regarding the virtues of an examined life. More specifically, it includes a search for unconscious meaning behind all thoughts and actions. In this search there is also an ethical position that states that only behaviors and not thoughts have ethical consequences and that empathic examination of all experience can be carried out while maintaining moral neutrality or objectivity.

The divergent constructions of reality of child and caretaker which reflect a divergence of need are repeated in the psychoanalytic situation when there is a divergence between the therapist's agenda for the patient and what the patient desires for him/herself. We all know that we try not to impose our moral values on our patients, but nevertheless we retain certain convictions regarding the aims of treatment which exist as an explicit or implicit agenda. I am not saying that it is wrong to have such agendas, as we all have some ideas of what we wish to accomplish in our treatment of patients. But we must be very clear in recognizing that these are our ideas and tacit assumptions and are not necessarily our patient's assumptions. Such beliefs, whatever they may be, are incorporated into the goals and aims that we have for our patients. Such goals may include the belief that treatment will enable the patient to establish a more "mature" object relationship;[2] that treatment will lead to a greater emotional spontaneity and authenticity; that treatment will lead to greater self-knowledge, and so forth. We all have such implicit agendas for our patients which are necessary and not unreasonable. The ideal treatment situation may be one in which we do not ask the question: "Whose reality is it?" Accordingly, from this point of view, one aim of psychoanalytic treatment might be described as enabling the patient, through the

[2] Kohut (1984) has emphasized the untoward effects of analysts' imposition of *their* definition of mental health.

play of merging and separateness, to share in other constructed realities.

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401 Woodward St.
Waban, MA 02168

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Steven H. Goldberg

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PATIENTS' THEORIES OF PATHOGENESIS

BY STEVEN H. GOLDBERG, M.D.

Certain patients embark upon analytic treatment with well thought out theories regarding the origins of their difficulties. Although there is always some validity to such theories, they turn out to be incomplete and serve to screen painful recollections and pathogenic unconscious wishes and the defenses against them. Two cases are presented to illustrate how analysands use these theories in the service of resistance. Painstaking analytic work is required to elucidate their defensive nature. The narcissistic importance of such theories in maintaining a coherent narrative about one's life in the face of uncertainty is discussed, and technical and countertransference considerations are explored.

INTRODUCTION

Many patients come to psychoanalysis with ideas regarding the origins and causes of their difficulties. In some patients, these ideas seem tentative, inchoate, and loosely organized. For other patients, however, such ideas are much better thought out and are associated with a considerable degree of conviction about their correctness. In the latter case, the ideas could be described as patients' theories of pathogenesis, although this would be neither the patient's term nor a term of clinical discourse. In contrast to patients' theories of pathogenesis that regularly emerge or are constructed as successful analysis proceeds, the

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theories of pathogenesis upon which I will focus are already formed at the outset of treatment, although analytic work may be required to demonstrate to the patient their existence, extent, and full implications. A central issue to be explored in this paper concerns the potential resistance function of patients' theories of pathogenesis. They conceal, though to a certain extent they also express, important unconscious wishes and defenses against them, as well as important aspects of the patient's life history. In this lies their clinical significance.

While considerable attention has been paid in the literature to theories of pathogenesis that are current in the field of psychoanalysis, as well as to some of the rational and irrational factors that maintain them, less attention has been paid to patients' theories of pathogenesis and to the motivations underlying them. My own interest in this topic was stimulated by observations concerning several patients who, during an early phase of their analyses, presented coherent theories to account for the origins of their problems. These patients held quite tenaciously to their theories, as well as to the autobiographical memories that purportedly provided supporting evidence for them. Although there was a significant degree of validity to these theories and associated memories, and though they served important communicative functions, they turned out to be substantially incomplete. They also tended to be overly simplistic and reductionistic; the theories usually identified a single causative factor, rather than reflecting the multiple, complex, and often uncertain determinants of psychopathology.

The theories of pathogenesis developed by my patients centered upon their parents, whom they viewed as having disappointed them by acts both of omission and of commission. Most patients' theories of pathogenesis take this particular form, identifying one or both parents—or less commonly, other important people or features of the environment—as pathogenic agents. Accordingly, patients' theories of pathogenesis usually involve externalizations which serve the defensive purpose of keeping the patient unaware of an inner world of forbidden

and conflictual wishes. Theories of pathogenesis that do not prominently involve externalizations are also encountered—for example, in depressed patients who may attribute their difficulties to something rotten and destructive within. Such theories of pathogenesis turn out, upon further analysis, to serve similar defensive functions.

Before discussing the relevant literature, I would like to distinguish patients' theories of pathogenesis from several closely related entities, bearing in mind that the differences are more clear-cut in exposition than they are in actual clinical practice. The theory of pathogenesis stands in close relation to autobiography. The patient's theory of pathogenesis, however, is at a higher level of abstraction than autobiographical memories, and represents a gloss on such memories. It reflects the patient's efforts at interpretation and synthesis. The theory is based on a certain autobiographical narrative, but is also used as a basis for selecting, editing, interpreting, and, most of all, distorting that narrative. In its defensive deployment to conceal certain aspects of the autobiography, the theory of pathogenesis serves a screen function.

The concept of the personal myth (Kris, 1956) is closely related to the theories of pathogenesis I am describing; it will be discussed in more detail below. At this point I wish to emphasize that both concepts are closely tied to the autobiography and, more important, both serve screening functions in relation to unconscious memories and fantasies. Both are subject to enactment in the transference. The concepts differ in that the personal myth is an aspect of the autobiography, a story within the larger story of the patient's life. The patient's theory of pathogenesis, on the other hand, is based upon the patient's personal myth, though it is also employed in constructing that myth. It is at one remove from the personal history, and represents an attempt to interpret and explain that history.

The patient's unconscious fantasy of cure (Abend, 1979), also to be discussed in more detail below, has the character of both theory and unconscious wish. Like the patient's theory of patho-

genesis and the personal myth, it typically affects the patient's behavior via the transference. It is also closely related to the theory of pathogenesis, in that there is a complementary relationship between notions of causation and notions of cure of illness, each one implying the other.

The final closely related entity to be mentioned at this point is transference. While the patient's theory of pathogenesis is a cognitive construction, transference is an enactment. It is most importantly in the transference that the theory of pathogenesis is enacted, so that in the clinical situation the two are highly imbricated. Shifts in the theory of pathogenesis and in the transference go hand in hand as successful psychoanalytic work proceeds.

Following the literature discussion, I will present illustrative material from two cases, one in which analysis of the patient's theory of pathogenesis was unsuccessful, and another in which such analysis proved successful. There will be an inevitable artifact of presentation, in that I will be attempting to isolate one strand from the complexly interwoven fabric of these analyses. My emphasis is primarily directed at illustrating and explaining the tenacious and formidable resistances posed by certain patients' theories of pathogenesis, and at documenting the painstaking analytic work that is required to elucidate the defensive nature of such theories. In light of the case material, I will then consider the resistance functions of patients' theories of pathogenesis from a number of points of view, before proceeding to discuss certain technical issues and countertransference considerations in working with patients who hold rigidly to a theory of pathogenesis and who seem determined to prove the correctness of their particular theory.

REVIEW OF THE LITERATURE

My literature review encompasses two areas of psychoanalytic inquiry. The first area is that of theories of pathogenesis and

closely associated theories of cure. The second area is that of autobiography, especially the screening functions of autobiographical memories. Within each area, I confine my attention to those contributions that are of direct relevance to my topic.

Though not explicitly a study of theories of pathogenesis, Freud's "Family Romances" (1909) provides a number of cogent ideas on the topic. Dissatisfied with their parents, small children notice that other parents seem preferable. From these ideas the family romance is constructed, in which the child imagines her/himself to be the child of other, preferable parents. What these other parents offer is precisely what the actual parents are felt to lack. These ideas serve as "the fulfilment of wishes and as a correction of actual life" (p. 238). Freud referred to these fantasies created by the child as "fictions"; and as "a correction of actual life," they provide indications of both the child's theory of what went wrong and the patient's wishful fantasy of cure.

Abend's 1979 paper, "Unconscious Fantasy and Theories of Cure," demonstrated that certain patients, and perhaps to some extent all patients, approach analytic work with a particular fantasy, usually unconscious, of how they will be cured, and that this fantasy may be an important determinant of their behavior in the analytic situation. Such fantasies "are derivatives of unconscious wishes for the fulfillment of childhood libidinal desires" (p. 589) and "correspond to the typical sexual theories and fantasies originally constructed by children in connection with these same libidinal wishes" (p. 589). It seems only a slight extrapolation from Abend's main argument to emphasize that fantasies of cure imply theories of pathogenesis, and vice versa. The two are intimately and inextricably interrelated, with each one implying, even requiring, the other.

Touching on theories of pathogenesis as well as on fantasies of cure, Abend made the crucial point that "even where the patient's perception of the parents' problems is an accurate and meaningful one, *this retrospective fantasy always serves to both communicate and disguise the patient's desires for other gratifications of a*

totally unrealistic nature" (p. 592, italics added). Even when the parents are accused of frustrating legitimate instinctual satisfactions, "concealed behind this lies the reproach that they have frustrated the patient's infantile wishes in other ways as well . . ." (p. 592).

Abend went on to argue that the influence of similar unconscious fantasies may be detected in theories of cure subscribed to by analysts, and that the roots of these theories in infantile fantasies may be one factor in their degree of appeal to certain practitioners and to the field as a whole. In developing a related point, Rothstein (1980) explored the role of the narcissistic investment of psychoanalytic paradigms in helping the analyst deal with the uncertainties of the clinical situation. Clearly, unconscious fantasies and narcissistic investments have considerable impact upon analysts and their patients in their respective attempts to develop explanatory theories of illness and cure.

Arlow (1979, 1986) has written about the close interrelationship of theories of pathogenesis and theories of technique. He argued that Freud's later views on the pathogenesis of neurosis were complex and comprehensive and that they encompassed biological, environmental, and psychological etiological factors. Arlow is critical of subsequent efforts to oversimplify pathogenesis, both by seeking an external "villain" and by seeking a unitary cause. Such efforts are also criticized both for ignoring the role of intrapsychic conflict and defensive transformations of unconscious fantasies, and for focusing too exclusively on one or another phase of development. Arlow elaborated on theories of pathogenesis which hold that someone external is to blame for the neurosis, most often the mother because of her inadequate caretaking. In his critique of such theories, Arlow stated that the "injustices that they feel have been perpetrated against them are related to the nature of their unconscious conflicts and to derivative expressions of these conflicts as articulated in unconscious fantasies" (p. 504). He appealed to analysts to acknowledge the complexity and multidetermination of psychopathology, as well as the likelihood that there are factors in pathogenesis that we as yet understand incompletely, if at all.

Very much in agreement with Arlow's discussion is Anna Freud (1983). She, too, decried the trend toward placing "single, pathogenic determinants at ever earlier phases of life" (p. 383). Like Arlow, she emphasized the complexity and many-faceted nature of pathogenesis. Shapiro (1981) also questioned the validity of theories which place the origins of neurosis at ever earlier periods of development. Like Arlow, he emphasized the transformational and restructuring processes which intervene between earliest experience and subsequent expression in symptoms and in other derivatives of psychic conflict.

Consideration of the tendentious nature of autobiographical memories began with Freud's 1899 paper, "Screen Memories." In that paper, Freud developed the idea that screen memories serve both to repress and to express in disguised form important childhood recollections. The process of screen memory formation involves conflict, repression, and substitution of a related but less emotionally charged memory. The repressed memory is associatively connected with the indifferent memory which becomes the screen; in the process, both the screen memory and the screened memory may be altered. Falsifications of memory are tendentious in that they serve repression and replacement of unacceptable memories.

Glover (1929) pointed out that memories of traumatic events in childhood are particularly well suited to the purpose of keeping other memories in repression and should not be accepted at face value. Although they differ from the type of screen memories discussed by Freud, in that there is no difficulty in accounting for their intrinsic significance and persistence, they nevertheless serve a screening function. This use of traumatic memories in the service of repression of other mental contents was particularly prominent in the cases I will be describing.

Fenichel (1927), Greenacre (1949), Reider (1953), and Greenson (1958) all suggested a distinction between screen memories, which conform closely to Freud's original description, and screen experiences, which are constituted by a range of phenomena that function as screens with respect to re-

pressed but associatively connected material. Reider (1953), in particular, elaborated on this point. He stated that many varieties of behavior may serve screen functions, and he proposed that there exists a hierarchy of screening functions, with screen memories as the most simple. Such phenomena as "affects, symptoms, déjà vu experiences, hysterical acting out, pseudologia phantastica, and even character structure" (p. 404) represent more complex variants. Greenson (1958) emphasized that screen experiences simultaneously serve libidinal, narcissistic, and defensive motives. He further noted that identifications and self-image can be conceptualized as screen formations.

Central to any consideration of autobiographical distortion and theories of pathogenesis is Kris's 1956 study, "The Personal Myth." Kris developed the idea that certain patients use aspects of their autobiographies as "a protective screen," in which "the firm outline and the richness of detail is meant to cover significant omissions and distortions" (p. 653). For these patients, "[*t*]*heir personal history is not only, as one might expect, an essential part of their self-representation, but has become a treasured possession to which the patient is attached with a peculiar devotion*. This attachment reflects the fact that *the autobiographical self-image has become heir to important early fantasies*, which it preserves. . . . Some aspects of the patients' conduct of life could best be viewed as a *re-enactment* of part of the repressed fantasies, which had found their abode in their autobiographical constructions" (p. 654, italics added). These patients were convinced that their memories were "both complete and reliable." It was precisely those aspects of the life history that were most emphasized that turned out to serve important defensive functions. Successful analytic work could be accomplished only after the "distortive biographical screening" had been "pierced," and its dynamic functions understood.

The close relationship of, as well as certain differences between, the personal myth and the patient's theory of pathogenesis has already been mentioned. Patients use both in the service of expressing and concealing important warded-off memories

and fantasies. Both may be enacted through the vehicle of the transference. An important difference in emphasis is that, while Kris highlighted the "mythic," in the sense of the fictional aspect of the autobiographical construction, I emphasize the incompleteness—the true but selective and tendentious aspect of the patient's theory of pathogenesis.

Spence (1982) and Schafer (1983) have argued that there is no life history that can lay claim to absolute historical truth. Instead, there are various narrative versions of a life history that vary according to the questions being asked and the setting in which they are being constructed. Thus autobiographical narratives are constantly shifting, particularly during the course of a successful psychoanalytic process. Certain narratives serve a defensive purpose vis-à-vis other narratives. By implication, because of their role in determining and being determined by autobiographical memories, the same would be true of theories of pathogenesis.

CLINICAL ILLUSTRATIONS

Case 1: Ms. A

A twenty-five-year-old single graduate student sought analysis because of problematic relationships with men and difficulty in committing herself to long-term relationships. The decision to enter treatment came several months after an esteemed older and married professor unexpectedly expressed sexual interest in her. Initially, she felt enraged and victimized by this event, but she subsequently wondered whether she might have had a part in precipitating it.

Ms. A described her father as autocratic, intolerant, and sexually provocative. An example of the latter was his persistently asking detailed questions about her sexual experiences and preferences. Mother was portrayed as a good caretaker, but as somewhat passive, helpless, and unable to protect her from her father. The marriage had been an unhappy one. Ms. A felt that

her parents were far too preoccupied with their own activities to be helpful and available to her, and believed that her father, in particular, had been sorely disappointed that she had not been a boy.

Ms. A had been an excellent student, though a rather unhappy one. She had been involved in several long-term relationships with men, but eventually broke them off, feeling bitter, disappointed, and convinced that she had subordinated her interests entirely to their needs and wishes. She continued to date despite these experiences, although her discouragement led her to find little pleasure in this activity. She felt that men did not understand her and that they exploited her. Yet, she also had some awareness that she had consistently chosen men who had little time for her.

In the initial consultation sessions, Ms. A spoke at length of her experiences of being mistreated by men—her father, teachers, boyfriends, and colleagues. She manifested a strong tendency to blame others and to externalize the sources of her difficulties. In particular, she believed that victimization by men was central to the development of her problems. This, as I saw it, represented her initial conscious theory of pathogenesis. Over the next several months, this theory was further developed and elaborated.

Ms. A quickly brought these issues into the transference by focusing on how I had the power to decide whether or not she could be in analysis with me, her own wishes being relegated to secondary importance. She mentioned dreams involving victimization by men and did not hesitate to connect these with her worst expectations about how the treatment relationship might evolve. She voiced her criticisms of psychoanalysis as a sexist and authoritarian mode of treatment. At the same time, she seemed bright, honest, in considerable pain, and highly motivated to work toward the amelioration of her difficulties.

Ms. A took to analysis eagerly, and there was an engaging quality to her initial enthusiasm and devotion to the analytic

work. Almost immediately she spoke of increased awareness of sexual feelings and of longing to be in a romantic relationship, which led to intense fears of losing control, of becoming vulnerable and overly dependent, and of being taken advantage of. Several dreams early in her analysis made obvious reference to erotic feelings about me and to fantasies about my erotic attraction to her. She found these dreams disturbing and uncomfortable, but she also acknowledged exciting and alluring aspects to them. Her associations referred to fear of surrender and to "vague fears of something sexual happening here."

During the next few sessions Ms. A manifested an intense defensive reaction to these wishes and fears. She began to express disappointment in me and doubtfulness about the analytic process. She reported feeling furious at a jeweler who had sold her a defective item. He claimed that he could repair it so that the defect could not be seen, but she insisted this was impossible. This sequence of hours, beginning with the early dreams, appeared to represent a version of what Ms. A was fearing and expecting in the analysis—*that something sexual would happen between us, that she would somehow be defrauded and damaged by me, that she would feel ripped off by me, and that she would have to counterattack in self-defense*. This sequence also appeared to further elaborate Ms. A's theory of the pathogenesis of her problems—only partly conscious at this point—*that she was cheated and mistreated, that there was resulting damage or defect that could not be repaired, that she was left hurt, ashamed, angry, and forced to demand reparation from those who had inflicted damage on her*.

Among its various defensive functions, this theory of pathogenesis diverted attention away from the sexual and incestuous wishes and fears with which Ms. A had previously been struggling. It externalized responsibility for any feelings of hostility, envy, and greed. In addition, it may have expressed in disguised form—and thus may also have served to repress—memories of *actual experiences* of sexual overstimulation and possibly of seduction. Although this was never confirmed in the analysis,

there was ample material to suggest at least the possibility that she had had such experiences.

In the ensuing months, Ms. A evinced tremendous concern that I would usurp her autonomy and impose my narrow Freudian views on her. There was increasing evidence of her fear of pursuing her free associations and of delving any further. She dreamed of losing control of a car that lacked brakes. She associated this to her fears of loss of control, of vulnerability, and of dependency. She showed some recognition that her attacks on me served partly to defend against these dreaded feelings, and that her projection of hostile attitudes onto me served to rationalize her defensive reactions.

Eventually, I made an error on Ms. A's bill, overcharging her for her sessions. While she understandably experienced the episode as evidence of my negative feelings about her, I believe that my parapraxis was far more complex, and involved both positive and negative countertransference reactions, as well as a component of unconsciously accepting a role that Ms. A was constantly assigning to me, that of a man who mistreated her. In any case, Ms. A was convinced that I had acted on my negative feelings about her, that I saw her as too boring, or too demanding, or too critical. She went on to say that she used this as evidence to confirm the belief system she already held—that I didn't like her and didn't want to work with her. She acknowledged that she seized upon such evidence for her beliefs, even though there had been times when I had acted quite differently. Although she was aware of the existence of her projections, her insight was quite intellectualized at this point and was of very limited use to her.

A central question following this episode was why Ms. A had to see me as having such a hostile and disparaging view of her. Clearly, there were important wish-fulfilling and defensive components to these ways of experiencing our relationship. In making herself important to me, though with a negative valence, she was giving expression to highly conflicted and dan-

gerous wishes for a loving relationship with me. In adopting a position of moral masochism, she was seeking a distorted version of love, but possibly the version she knew best. Feeling victimized by her father, her mother, and her analyst enabled her to evade consideration of her own hostile wishes, fantasies, projections, and distortions of early experience. It may also have been more reassuring for Ms. A to view me as hostile and distant than to view me as seductive and/or seduced by her.

Ms. A did arrive at some increased awareness that she was getting something out of holding so tenaciously to a tendentious view of her history. She began to speak of childhood memories of her father's being rather warm and playful. She went on to say that she had been finding it useful to put together a certain view of her father, as well as of other family members, and now she was beginning to see that her view was, at best, incomplete. The screening function of some of her memories was becoming more clear. All of this also had important transference implications, since Ms. A was simultaneously working to disentangle her experience of me from her projections and her transference distortions. The major concerns of the analytic work at this time consisted of efforts to clarify and to acknowledge Ms. A's experience of me in the transference and to begin to interpret her projections and defensive need to blame, to be angrily disappointed, and ultimately to withdraw. It was at least in some measure because of the defensive necessity of proving the correctness of her theory of pathogenesis at the expense of efforts to rework this theory in the light of alternative views of her history and of the transference relationship that the treatment ultimately foundered.

Increasing complaints about me and about the analysis characterized subsequent analytic work. I expressed some uncertainty about the date of an upcoming schedule change. Ms. A took this as further evidence of lack of interest on my part. Once again, however, she realized, at the same time, that this had something to do with her need to see me in a particular

way. "It may be that I expect to feel rejected by you, and then find evidence for it or set you up to find evidence for it." She went on to connect this to her underlying conviction that I found her difficult and did not like her, but this connection did little to mitigate her feelings of being hurt. Again, Ms. A was manifesting increasing awareness of an internal belief system which encompassed a theory of the pathogenesis of her problems.

Subsequently, Ms. A became increasingly silent and unwilling to continue her efforts to free associate. She seemed more and more unhappy both within and outside of the analytic situation. She emphasized feeling that her needs were not being met by me and that I was leaving her at sea with her painful feelings. I commented that she might be reacting to the intensity of various feelings about me, including not only her fear of being hurt and disappointed by me, but perhaps also a fear of wishing to feel closer to me. She acknowledged that her neediness and her wanting something from me had increased and that she was feeling more vulnerable. She would feel out of control and powerless and vulnerable if she were to let out and express these feelings. In seeking love, she would end up hurt, damaged, and devalued. She felt that she could not open herself up for such treatment again.

Discussion of discontinuing the analysis ensued. Ms. A said she knew she was repeating her pattern of becoming enraged, disappointed, and hopeless. I commented that she seemed compelled to prove that the analytic situation was no different from other painful relationships in her past. She agreed, in part, but also insisted that there was a considerable amount of reality to her perspective on the analysis. Although she had a certain intellectual understanding, she lacked any deep conviction about the wish-fulfilling and defensive aspects of her need to experience the analysis as a fruitless experience of masochistic submission; this recreated the very situation that she felt had led to her difficulties and thus confirmed the validity of her theory of pathogenesis. She could not use the analysis to free

herself sufficiently from the domination of early patterns of relationship to be able to experience something really new in her relationship with me.

As the analytic work drew to a close, Ms. A described a sense of sadness and regret that analysis had not worked out better for her, despite both of our best efforts. She seemed to understand that psychoanalysis involved repetition in the transference of painfully conflictual experiences and reconsideration of deeply held convictions about past and present experiences; but she felt that she was unable to tolerate the intense affects that were mobilized in that process. Although her theory of pathogenesis and the limited view of her life history upon which it was based were partly clarified, further analysis of them proved not to be possible at that time.

Case 2: Ms. B

Ms. B was a thirty-seven-year-old single, successful professional woman at the time of beginning analysis. One of her major goals in undertaking analysis was to improve her relationships with men. She spoke of a pattern of becoming involved with men whom she considered selfish, critical of her, and emotionally ungiving. Although at times she felt that she was a worthwhile person who deserved a man of quality who would adore and respect her, much of the time she felt unworthy of such a man. On the one hand, she saw herself as undeserving, devalued, defective, stupid, and an object of ridicule; on the other hand, she saw herself as mistreated, bright, accomplished, and worthy of respect and love.

Ms. B's father, a very successful trial attorney, was described as a highly volatile man. He would reportedly become infuriated for no clear reason and would punish the children severely without explanation. He could also be warm and at times seductive with Ms. B. He was said to have been extremely critical of Ms. B's academic and social accomplishments, and

would express his displeasure in cutting remarks. Her mother was described as warm and well intentioned, but something of a victim. Ms. B was highly derogatory of her father's behavior and had a tendency to idealize her mother's virtues.

During the early months of the analysis, Ms. B articulated certain ideas to account for what she viewed as her major difficulties. Her theory of pathogenesis was not presented as such, but a pattern became clear. Her considerable degree of investment in these ideas also became increasingly clear. Essentially, *Ms. B believed that she had been regarded as unworthy by her parents, especially her father.* She advanced the notion that she had been sold short by her parents, her boyfriends, and now possibly by me. She further claimed that these devaluing and critical views of her had fully determined her present negative view of herself. *She seemed to believe that her present difficulties could be completely explained by what she recalled of her past mistreatment.* Absent from this early account was any consideration of the possible role of fantasies, projections, and conflicts over her own inner wishes. It was as though there were no inner world of subjective experience through which early important relationships would exert their impact. She saw herself as an innocent victim whose potential had been undermined by an abusive father and a victimized mother. They had treated her as though she had no inner life, and she believed this to be the case about herself.

Ms. B took to analysis quite readily and worked extremely hard to make it work for her. She did everything possible to be a "good" patient, and in fact seemed to make significant progress in enlarging the scope of her understanding of her difficulties. She was quite interested in exploring her reactions to me and to the analytic process, including her motivation to be such an outstanding patient. She constantly feared that I would reject her because of her not being "good enough," and she consequently felt compelled always to be on her best behavior. In contrast to her own lack of mean, sadistic, or seductive motives, she was quite ready to attribute such motives to me. She expected me to get rid of her for the smallest mistake. And she spoke at length

of horror stories about other people's therapists who had sexually approached and seduced them. As yet, there was no awareness of any wishful motives in these ostensibly much feared scenarios, nor was there any thought that some of the attitudes she attributed to me might represent dreaded and disowned aspects of herself.

Subsequent analytic work both clarified Ms. B's theory of the origin of her problems and increasingly confronted her with the incompleteness of her theory. Her emphasis on her experience of having been mistreated and victimized was maintained, yet there was evidence that she was gradually changing her views and moving toward a deeper, less externalized, less reductionistic, and more comprehensive understanding of the genesis of her problems. As she continued to advance the theory that her low self-esteem was due to the way her parents treated her and that this mistreatment was sufficient explanation of her difficulties, I began to inquire why these beliefs persisted despite many experiences in which she had been treated appreciatively and respectfully. Her response was that it was self-evident why she'd feel bad about herself, yet I kept asking, and she didn't know what more to say. Nevertheless, in subsequent hours she began to wonder what she might get out of blaming her parents in this way. She went on to speak about the benefits she got from the victimized image she presented, and she connected this to her identifying with her mother, whom she also saw as a victim. This seemed to highlight a theme of moral masochism, in which Ms. B felt enobled by suffering and rendered herself immune to punitive retaliation by holding herself back. It was also a way of hiding and disowning responsibility for her own wishes. Someone else's needs and wishes became the focus, rather than anxieties and conflict about her own wishes.

Before long, Ms. B was reporting erotic dreams about me. Then, following a conversation with her mother in which she had become aware of feelings of surpassing her in various ways, she recounted, in richer detail than previously, experiences of warmth and closeness to her father when she was a little girl.

She had felt that she was his favorite child. Later, during her adolescence, the relationship became much more troubled, but even then, in between the frequent arguments, there were times when they could enjoy being together—for example, when father would proudly bring her with him to his office and to court. This was in contrast to the deteriorating relationship between her father and mother. Here Ms. B seemed for the first time to be alluding to conflicted sexual wishes, including oedipal wishes, which had been screened by memories of traumatic experiences with her father. "It's easier to say I have these horrible parents who treated me badly and that's why I have these problems." She recognized that acknowledging any responsibility for her difficulties would partially discredit her theory of how her parents' mistreatment had affected her. Here again is evidence of an evolving and more comprehensive perspective on her autobiography and on her beliefs regarding the genesis of her problems.

An important sequence of hours followed an experience in which Ms. B was critical of a man for his assertiveness in making sexual advances toward her. Gradually, she was able to acknowledge that she had not been entirely uninterested, and she suggested that her view of him might have been motivated in part by her discomfort with her own sexual feelings and needs. If she made men out to be mean, she could ignore her own discomfort about sex and her own capacity to be pushy and exploitative with men. She then spoke of having impossible expectations of men, just as she felt her father had had impossible expectations of her. Reviewing some of her expectations of her father, she decided that perhaps she had rejected what he could give, wanting only what he could not give. She noted similar trends in her relationship with her mother.

As a long-anticipated vacation trip for Ms. B approached, requiring several weeks away from analysis, she expressed the fear that I would feel angry at her for leaving and might retaliate by rejecting her. When I commented on the unfavorable light in which this would place me, she said that this was pre-

cisely how her father had frequently reacted. When I asked for more information about this, she was unable to think of an example, and she became somewhat irritated with me for accusing her of fabricating a story. She wondered how else her beliefs would have developed. I said that she seemed to maintain that her current beliefs were fully justified by the experiences she remembered with her parents. She agreed this was true, but wondered what was wrong with her maintaining this view. I commented that there was nothing wrong with it, but that it might turn out to be an incomplete account. She went on to express fear that I would minimize or ignore what she saw as the harmful things her parents did, and would put the spotlight on her. I suggested that she wanted to believe that the actions of her parents were the sole cause of her present difficulties but that this might not do justice to the actual complexity of things. In particular, it ignored the possibility of her having selected, interpreted, and distorted her early experiences. Subsequently, Ms. B said she thought I was right about her wanting to blame her parents so that she would not have to consider her own role. I commented that it was hard to get used to the idea that she might not be completely innocent, and she was quick to agree.

These interchanges illustrate the continuing struggle to interpret some of Ms. B's externalizations and projections. They clearly reveal *Ms. B's theory that her difficulties were a direct result of her parents' mistreatment of her, without the mediation of her own inner world*. Although she acknowledged, when confronted, that there was more to the story and that she could not continue to claim her own innocence in such self-justifying ways, it was clear that there would be continued struggle to work through this insight.

During the next several months, Ms. B substantially re-evaluated her relationships with her father, her mother, her former boyfriends, and her analyst. She became increasingly aware of the wish-fulfilling nature of her expectations that I would demand her complete devotion to me and to the analysis. She realized that this would indicate my strong personal investment in

her. What she remained unaware of until subsequent analytic work could be accomplished was that these wishful fantasies also reflected projections onto me of her own feelings of greed and entitlement.

Along similar lines, Ms. B felt she could expect me to be critical of successes in her life, since these might lead to her being less available to me. The wish for me to want her exclusively was clear, but also present was the convenience of her using my expected disapproval as a cover for her own conflicts over ambitious, competitive, and aggressive wishes. When I pointed out how she felt conflicted about such wishes, she said that in fact she was aware of competitive strivings, but that she could express them only in nonthreatening ways. "It hurts to realize all the things I could have done and had but didn't because of this fear and need to avoid being competitive and aggressive." Increasingly, her associations clustered around conflicted wishes to be the best, to excel, and to be victorious.

Ms. B began to realize that her projections and distortions had clouded her views of many of the important people in her life. She understood that this applied with particular poignancy to her father. She had only recently begun to allow herself to remember some of the more positive interactions with her father. She was also becoming aware of the pain that accompanied these shifts in perspective. "That opens up wounds—feelings I spare myself from by always being angry at him." A more complex, ambivalent, and realistic view of her father and of his impact on her seemed to be emerging.

Ms. B's theory of pathogenesis and her account of her life history were changing and would continue to change during the subsequent course of her analysis. In particular, there was an increased awareness of the important role played by her inner world of wishful and defensive motives. To be sure, certain externalizations and projections persisted, but they seemed progressively more amenable to analysis and eventually to self observation. Her conceptions of self and of objects shifted as productive analytic work continued.

DISCUSSION

Both patients, during the early months of treatment, presented evidence of coherent and well thought out explanations intended to account for the genesis of their difficulties. With Ms. A, the theory was presented somewhat indirectly, in dreams of victimization and in enactments, including, most saliently, enactments in the transference. It was incumbent upon me to demonstrate to Ms. A that these experiences suggested that she had a particular view of the genesis of her problems, and, in fact, this task was only partly accomplished before the analysis prematurely ended. With Ms. B, the theory was presented more directly, with little need for me to comment on the idea that she was articulating a theory of the origins of her difficulties. The case material illustrated an emerging shift in Ms. B's theory of pathogenesis in the direction of encompassing her own conflicted wishes and defenses. Such a shift occurred to a less substantial degree in the case of Ms. A.

Put somewhat schematically, Ms. A's theory of pathogenesis could be stated as follows: she was cheated and mistreated by her parents, sexual trauma may have occurred, there was resulting damage or defect that could not be repaired, and she was left hurt, ashamed, angry, and forced to demand reparation from those who inflicted damage on her. In her demands for reparation and her resolve never to allow herself to be abused again, she took on certain attitudes that she believed were noxious to others, especially to men, who would then be driven away. Ms. B's theory of pathogenesis could be summarized as follows: she had been regarded as unworthy by her parents, especially her father, and this treatment had caused her to believe herself unworthy. She saw her difficulties with men as repetitions of the highly problematic and abusive, though also intense and consuming relationship with her father. In both cases it was seen that these theories of pathogenesis served multiple dynamic functions. Both patients illustrated Abend's point, quoted earlier, that even when the criticisms of the parents' be-

havior are accurate and consequential, hidden by the patient's accusations are wishes of a highly conflicted nature.

Both of my patients initially maintained that there were direct, causal relationships between their present sufferings and their childhood memories of faulty and traumatic parenting, and they viewed the latter as sufficient to explain the former. Certainly, there were important connections between the considerable mistreatment they described and their presenting difficulties. What really happened, to the extent that this could be ascertained, really did matter. However, this view overlooked the role of psychic reality as "the 'real' recollection of a psychic event with its mixture of fact and fantasy" (Arlow, 1969, p. 43). It is this mixture of fact and fantasy which exerts its dynamic force upon subsequent fantasies and behavior, and which accounts for the manifold ways in which trauma may be experienced and may later contribute to symptom formation. Furthermore, this view ignored the various transformational processes in which memories, wishes, affects, and defensive reactions become organized into symptoms and other derivatives of psychic conflict. In light of these considerations, it does not seem clear that unusual degrees of trauma *necessarily* characterize the histories of all patients whose theories of pathogenesis resemble those of the patients I have described.

Patients' theories of pathogenesis involve more than specific defense mechanisms, such as projection and externalization. They involve a more encompassing view of one's history and one's relationships as well as of the development of one's problems, a view which is incorporated into the self-representation and into identity.

To return to the close interrelationships among the patient's theory of pathogenesis, the personal myth, and the unconscious fantasy of cure, I would maintain that both of my cases demonstrate all three of these phenomena and the fact that, in the clinical situation, they are highly imbricated. Either of the cases could have been used to illustrate these other entities had they been the focus of inquiry. While I believe that it would be re-

ductionistic to subsume all of these phenomena under the rubric of transference, they do have in common their capacity to be enacted as transference resistances. When observed in relation to transference, each becomes more or less visible at different clinical moments and from differing angles of view.

Theories of pathogenesis provide gratification of wishes, including powerful libidinal and aggressive wishes which subserve relatedness to important objects. This wishful aspect may be highly disguised, as was the case with both of my patients, though it became increasingly apparent as their theories of pathogenesis became more fully conscious during the course of treatment. For both Ms. A and Ms. B, this wishful aspect was expressed in the disguised and sadomasochistically tinged fulfillment of wishes for engagement with men and in the blaming of men contained in their theories of pathogenesis. Their theories also reflected the implied wish that things had been different, that their parents had behaved differently toward them, and that childhood desires had been more completely satisfied. In this complementary relationship to unconscious theories of cure, they indirectly expressed powerful unconscious wishful fantasies.

The defensive functions of patients' theories of pathogenesis are also central to understanding their tenacious appeal and formidable quality as resistances. Traumatic events and object relationships typically are emphasized, while an inner world of conflicted wishes and fantasies is denied, and responsibility for those wishes and fantasies is disavowed. In general, theories of pathogenesis employ a limited view of the patient's history and pathology, and ward off a more complete and comprehensive, though more disturbing and conflicted view. To borrow from Schafer (1983), patients' theories of pathogenesis highlight one narrative account of a personal history while failing to consider other, more comprehensive and psychoanalytically informed narratives, the latter to be mutually constructed in the course of analysis.

It is important to note that, as with any screen function, the

patient's theory of pathogenesis serves not only to repress, but also to express, in disguised form, conflicted memories, wishes, and other mental contents. The capacity of the patient's theory of pathogenesis to express—albeit in partial and often distorted form—certain aspects of past psychic reality is, I believe, an important factor in the tenacity and conviction associated with it. Psychic reality is based on both fact and fantasy (Arlow, 1969, 1985). Accordingly, the theory of pathogenesis could be said to contain that "fragment of historical truth" which Freud (1937) emphasized as being so crucial to the patient's sense of conviction in constructions, delusions, and hysterical symptoms, and which other authors have emphasized as being a central element in the motivation of the personal myth (Kris, 1956), of lies (Weinshel, 1979), of imposture (Greenacre, 1958), and of pseudologia phantastica (Fenichel, 1939).

This issue of historical truth, of the actuality and severity of the patient's traumatic experiences, may have bearing on the different outcomes of my two cases. A plausible hypothesis is that Ms. A was the more severely traumatized of the two patients and that the intensity and actuality of her experiences made it unusually difficult for her to consider any other perspective on these experiences. Her need for acknowledgment of her mistreatment may have precluded any interest in uncovering conflicted motives of her own, and any attempts on my part to explore such motives would have been experienced by her as re-enactment of her victimization. Her lack of trust in my helpful motives and her early loss of hopefulness about the analytic work would have compounded the difficulties for her of finding anything new in the analytic relationship. Ms. B, by contrast, seemed to feel considerably more trust in and hopefulness about the analytic relationship, and her positive transference enabled her gradually to become interested in her previously warded-off, unacceptable wishes. Thus an intriguing possibility is that the intractability of a patient's theory of pathogenesis may reflect the actual severity of the patient's traumatic experiences.

A larger issue would be why some patients' theories of pathogenesis can enter into the analytic process and be subject to investigation of their unconscious functions while other patients' theories cannot be engaged analytically and function as unanalyzable resistances. The issues of severity and actuality may figure prominently here. So, too, may the question of the degree of the theory's closeness to paranoid structures: the tenacity that often characterizes patients' theories of pathogenesis, along with the frequent use of externalizing and projective defenses, invites consideration of a relationship to paranoid structures. Theories of pathogenesis may involve actual paranoid delusions—e.g., the case of Schreber (Freud, 1911)—but this would represent one pole of a continuum, with theories that reflect intact reality testing and are amenable to psychoanalytic modification at the opposite pole. The latter indicates a greater degree of integration and flexibility of defenses than does the former. Ms. B would be placed near the latter pole. Ms. A was more complicated: although her reality testing appeared to be intact, her theory of pathogenesis seemed at the time not to be amenable to change through psychoanalytic understanding.

Another factor in the tenacity and the resistance function of patients' theories of pathogenesis is the narcissistic wish, and need, for a coherent narrative about one's life, in which discontinuities are bridged and one can achieve premature closure on inadequately understood aspects of the life history. This would be related to the human tendency toward myth-making and searching for coherent and plausible explanations for observed experience. Erikson (1968) discussed this phenomenon under the rubric of "identity resistance," in which the patient resists the analyst's potential intrusions into her/his highly invested sense of identity. Spence (1982, 1983) spoke of "narrative appeal," related to the ego's need to maintain a sense of identity and constancy of the self-representation. Both of my patients may have been alluding to such factors when they indicated that they could not bear the thought that their version of important

events had been incomplete. Another patient expressed something similar in saying, "I can't give that up—it would be like giving up my right arm." Rangell (1981) discussed this problem in terms of "tertiary gain" from symptoms, referring to the observation that there is "an identification of chronic symptoms with the 'self' " (p. 134). In the present context, the issue would involve the tertiary gain associated with a particular tendentious presentation of one's life story, including the genesis of one's difficulties.

Stein's (1989) discussion of secondary revision in dreams helps to explain the particular form that autobiographical memories and theories of pathogenesis take, as well as their considerable narrative appeal. He pointed out that the synthetic ego functions demand that there be a coherent and continuous story line, which the "editor" aspect of secondary revision supplies. He went on to discuss how editing may be employed "not only to remember better and to arouse interest in the listener, but also to create a 'cover story' to discourage deeper exploration of painful issues" (p. 73). Patients' life histories and corresponding theories of pathogenesis may be "edited" in similar ways. (Kris [1956], too, in discussing the personal myth, spoke of "revision and re-editing of the life history" [p. 671]). Under the heading of the "plagiarist" aspect of secondary revision, Stein (1989) showed how the latent dream content is molded to conform to pre-existing daydreams, fantasies, and cultural products (e.g., plays, films, myths). In just this way, my patients' theories of pathogenesis borrowed from widely held and currently influential psychological paradigms with which they were familiar.

Patients' use of their theories of pathogenesis in the service of resistance leads to certain technical implications. It is incumbent upon the analyst to recognize the implicit or explicit theory of pathogenesis that may be contained in patients' associations, as well as their use of it for purposes of resistance, and to communicate this, when necessary, to patients. Clearly, it may be extremely difficult, if not impossible, to convey to certain patients

that their theory of pathogenesis may be incomplete and may serve defensive ends. This is particularly likely to be the case with more disturbed and more severely traumatized patients, and may require considerable tact, patience, and persistence. With such patients, adequate acknowledgment of the patient's experiences of traumatization may be crucial.

It may well turn out that when alterations of the autobiography and the associated theory of pathogenesis are impossible, analytic work cannot proceed. This was the case with the three patients reported by Kris (1956). It was only after the autobiographical screen was "pierced" that successful analytic work could proceed. Conversely, it may be equally true that "piercing" the screen is a product of successful analytic work. It may not be possible to say which comes first, as each reinforces the other. With Ms. B, successful work with a variety of resistances made it possible for her to re-evaluate and ultimately to revise certain views about her history and the origins of her difficulties, which in turn enabled her to work with yet other resistances. With Ms. A, the difficulty in establishing a productive analytic situation was reflected in her inability to alter sufficiently her theory of pathogenesis and the related supporting autobiographical memories which, in turn, limited the scope of the analytic work. I have been suggesting throughout this discussion that behind the autobiographical screen and its associated theory of pathogenesis lie warded-off, pathogenic, conflicted wishes and defenses against them. These motives lead to the creation of symptoms, and so it is not surprising that failure to deal with these issues poses a major liability for the analytic work.

Blaming others for one's difficulties may lead to a dead-end for the patient, contributing to an attitude of hopelessness about therapeutic change. In drawing a patient's attention to the possible role of an inner world of unconscious meanings and wishes, the analyst may provide the patient with feelings of hopefulness and purpose concerning the analytic work. Ms. B stated this eloquently when she said that she used to feel that,

since others had caused her problems, she couldn't do much about them. Once she recognized that she had had some part in creating and maintaining those problems, she could also believe that she could do something about resolving them.

Although it has not been a focus of attention in this paper, it is important to note that patients' theories of pathogenesis may not be already formed at the beginning of treatment, but may emerge or be jointly constructed during the course of the analysis. Such theories of pathogenesis may also be employed in the service of resistance, and many of the above considerations would equally well apply to them. In the course of an analysis, a sequence of theories of pathogenesis may emerge, each one serving in part to ward off awareness of succeeding versions as a more comprehensive and psychoanalytically informed theory is developed.

I will conclude this discussion with some consideration of countertransference difficulties that may emerge in working with patients who cling tenaciously to the presenting version of their histories and theories of pathogenesis. Analysts, too, may approach their work with a particular theory of pathogenesis in mind. This may be a theory that is applied to all patients (e.g., drive theory, object relations theory, self psychology), or it may be a theory that is maintained for a given case. In either event, the analyst's holding to a particular narrow theory of pathogenesis would most likely interfere with optimal listening to the patient and with attempts to understand as fully as possible the intrapsychic factors that are involved in the patient's difficulties. As Arlow (1979), Abend (1979), and Rothstein (1980) have pointed out, such theories touch on the unconscious fantasies of analysts as well as on those of patients, and analysts as well as patients may, for that reason, be loath to give them up.

Similarly problematic would be the possibility of an analyst's relatively uncritical acceptance of a particular patient's view of pathogenesis. Both of the patients I described were quite compelling in their accounts of the mistreatment that they had received from their parents, and both reproduced aspects of those

relationships convincingly in the transference. At times I observed considerable temptation on my part to identify with these patients in blaming their parents and accepting the completeness of their traumatic theories of etiology.

For analyst, as for patient, there is the wish to have a coherent explanatory narrative, and there are tendencies toward intolerance of incomplete accounts, leading in some instances toward acceptance of premature closure on the life history and theory of pathogenesis being offered by the patient. Such factors would tend to undermine the analytic work and would lead to the reinforcement, rather than the analysis, of the patient's resistances. For these, among other reasons, it is of particular importance in the analysis of analysts and other therapists that the analysand become aware of his or her own fantasies of causation of illness and of how these may influence the analytic work.

SUMMARY

Certain patients approach analytic work with a particular and tenaciously held theory about the origins of their problems, with supporting autobiographical memories. Their rigid insistence on the correctness and completeness of their theories tends to limit the scope of the analytic work. Such theories of pathogenesis serve a screening function in relation to painful recollections and conflicted unconscious wishes and defenses against them. They also tend to be monolithic in their focus and to posit a direct causal connection between trauma and subsequent psychopathology. They fail to encompass the impact of inner wishes and fantasies and the complex transformational processes by which earliest experiences are structured into symptoms and other derivatives of psychic conflict.

Case material was presented to illustrate how patients' theories of pathogenesis serve wish-fulfilling, defensive, communicative, and narcissistic functions, and to demonstrate the importance of elucidating and successfully analyzing these theories.

Finally, certain technical and countertransference considerations related to analytic work with such patients were explored.

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2116 Sutter St.
San Francisco, CA 94115

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Karl A. Menninger 1893-1990

Jack L. Ross

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KARL A. MENNINGER

1893-1990

The death of Dr. Karl Menninger on July 18, 1990, four days short of his ninety-seventh birthday, brought to a close an era in American psychoanalysis and psychiatry. Psychoanalysis, the mental health professions in general, and all humankind lost one of their most beloved and esteemed, if also at times controversial, pioneers. He was often called the "Dean of American Psychiatry" and was a leader in the profession for seventy years. He helped bring the treatment of mental disorders out of the dark ages through his teaching, public lectures, well-known books, and countless articles which demonstrated in everyday language that the mentally ill could be helped.

"Dr. Karl," as he was often called, grew up in Topeka, Kansas, the city in which he died. He received his medical degree from Harvard University Medical School in 1917 and served an internship in surgery at Kansas City General Hospital. He was fascinated by patients with neurological illness, and he was encouraged by a friend to go to the Boston Psychopathic Hospital where his interest in neuropsychiatry blossomed under such stimulating and inspiring teachers as Elmer Ernest Southard and later the American psychoanalytic pioneer, Smith Ely Jelliffe. Returning to Topeka in 1919, he joined his father, Dr. C. F. Menninger, a homeopathic physician, in a family practice which increasingly focused on the mentally ill. A younger brother, Dr. William C. ("Dr. Will") Menninger, later joined his father and brother in the family practice. Impressed by the advantages of a group practice in what they had observed at the Mayo Clinic, the Menningers purchased an old farmhouse on the outskirts of Topeka, convinced local financiers to support their efforts, and established a psychiatric sanitarium

which became a model for the treatment of the mentally ill and a center for training mental health professionals in psychoanalytic principles. This was the beginning of the Menninger Clinic which later became known world wide.

In 1930, Dr. Karl published his first book, *The Human Mind*, in which he presented psychoanalytic and psychodynamic concepts to a vast audience of professional and lay people. In this book he cut through the jargon and complexities of formal textbooks on mental illness and human behavior to illuminate the human mind for the average reader. Through this work many came to see that mental disorders were not only treatable but often curable. Later, there were hundreds of scientific articles and thirteen more books addressing topics of interest to the psychiatric profession as well as to the general public. His clinical works, *The Vital Balance, Theory of Psychoanalytic Technique, The Manual for Psychiatric Case Study*, and *A Guide to Psychiatric Books* are still widely used by professionals. *Man Against Himself, Love Against Hate, Whatever Became of Sin*, and *Sparks* were books popular with both professionals and lay persons.

His interest in psychoanalysis having first been stimulated by Smith Ely Jelliffe in the early 1920's in Boston, Dr. Karl pursued this interest after returning to Topeka. He was one of the early physicians to acquire psychoanalytic training in the United States: he commuted from Topeka to Chicago for seminars and for an analysis with Franz Alexander at the Chicago Institute for Psychoanalysis. He was that institute's first graduate. He helped form a study group in Topeka which, in 1942, became the Topeka Institute for Psychoanalysis—the only psychoanalytic training institute between the Mississippi River and the West Coast at the time. During the late 1930's and World War II he was instrumental in bringing many well-known European analysts escaping Nazi oppression to the United States. Among them were Otto Fenichel, Edoardo Weiss, Martin Grotjahn, Bernard Kamm, Elisabeth Geleerd, Ernst Lewy, Ernst Simmel, Siegfried Bernfeld, Fritz Moellenhoff, and Frederick Hacker. Many of them remained in Topeka as part of the Topeka Insti-

tute, while others moved on to play key roles in other training institutes in the United States. Dr. Karl and the Topeka Institute were directly involved in the development of both the Los Angeles and the San Francisco Institutes in the early 1940's. He served as president of the American Psychoanalytic Association, 1942-1943. He was director and occupied other key positions in the Topeka Institute as a training and supervising analyst, and he continued as an esteemed teacher into the last years of his life.

Dr. Karl's contributions to the field of psychoanalysis were many, but to focus only on his psychoanalytic contributions would do him an injustice. His interests in the treatment of the mentally ill and in psychiatric education were apparent from the early days of his return to Topeka. During World War II he led government tours to the European theater as a consultant to assess the need for psychiatric care for military personnel. At the end of the war, seeing a great need for psychiatric training, he agreed to help establish Winter General Army Hospital in Topeka as a psychiatric training center and as a pilot psychiatric teaching hospital for the Veterans Administration. This led to the establishment of the Menninger School of Psychiatry (now known as the Karl Menninger School of Psychiatry), in cooperation with the Topeka State Hospital and the Menninger Clinic. Over the years training programs were broadened to include other disciplines, and the school has now trained some two thousand psychiatrists, psychiatric social workers, and other mental health professionals, with alumni in all fifty states and in twenty-six countries.

Dr. Karl's particular distinction as an educator—in addition to his breadth of knowledge from extensive reading—lay in his capacity to stimulate others' thinking by making them uncomfortable with what they "thought" they knew. He could always question, stimulate, or clarify in such a way that one could not be in his presence without having learned something new. His discourse in meetings with students (informal Saturday morning seminars called "Colloquia") might range from rele-

vant professional issues to new observations about earthworms. He emphasized the need to understand the total personality of the patient, and he eschewed the application of diagnostic labels such as "schizophrenic" or "borderline." In both writing and speaking he emphasized that the fewer words one might use to describe something with clarity, the better. If he realized that a resident or student had made a particularly valuable intervention with a patient, he would ask, "How did you do that?"—always willing to learn from his juniors. Some felt him to be abrupt and discourteous, and occasionally his students felt hurt by his remarks, but even these felt his support and interest as well and gained from having contact with him.

Dr. Karl's boundless energy was not confined to his professional interests. He was involved in advocacy for neglected and abused children, prisoners, wildlife, nuclear disarmament, and various aspects of social justice. Prison reform and ending capital punishment were issues about which he cared deeply, as attested to by his book, *The Crime of Punishment* (1968). Because he saw that many men and women in prisons had been neglected, abused, and deserted as children, Dr. Karl founded The Villages, Inc., in 1966, a nationwide, nonprofit organization providing homes for boys and girls in need of a reliable, loving place to live and grow. His interest in and devotion to this project in his later years reflected a growing conviction that efforts to prevent mental illness early in life held the key to many of our problems, one of which is our growing prison population. Other lifelong interests included horticulture, soil conservation, wildlife preservation, and American Indian life.

Truly a man for all seasons, Dr. Karl showed intense interest in all aspects of life, which was apparent in the way he lived his life and related to others. His humaneness lay in his capacity to establish contact with people at all levels, in his deep regard for the basic goodness of humanity, and in his tenacious championing of the disadvantaged and underprivileged throughout his life. This concern was based on a strong Christian ethic derived from his mother, a deeply religious woman who passed her

convictions on to others by originating and teaching a system of Bible studies still widely known and used as a guide today.

Dr. Karl continued a very active professional life into his nineties, even to the time of his death from abdominal cancer. Waning physical capacities in the last few years before his death only slowed and distressed him, but did not diminish his round of daily appointments, speaking, and writing. Although he was obliged in his seventies to give up such interests as horseback riding, he continued less physically demanding interests in the arts and in oil painting as he aged. He was a strong advocate for the aged and continued to teach a course on maturity and aging in the Topeka Institute for Psychoanalysis, often using himself and his failing capacities as an illustration of his points.

Dr. Karl is survived by his wife, Jeanne, a son, and three daughters, as well as by several grandchildren and great-grandchildren.

Dr. Karl will be remembered not only for his many accomplishments and honors, but for the hope he instilled for the betterment of humanity and the human condition.

JACK L. ROSS

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Anna Freud. A Biography. By Elisabeth Young-Bruehl. New York: Summit Books, 1988. 527 pp.

Katharine E. Rees

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BOOK REVIEWS

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ANNA FREUD. A BIOGRAPHY. By Elisabeth Young-Bruehl. New York: Summit Books, 1988. 527 pp.

For psychoanalysts, this is a daring and fascinating biography. As one who knew and worked with Anna Freud, I felt enormous admiration and respect for her. But she was a very reserved, private, sometimes haughty person to whom it was hard to feel close. This biography helped me to get to know her in a new way, to understand the emotional center of her life, the pain, the vulnerability, and the strengths that lay behind her public persona.

Elisabeth Young-Bruehl, philosopher, psychoanalytic candidate, and acclaimed biographer of Hannah Arendt, was chosen to write this life and given special access to thousands of letters carefully filed each year by Anna Freud. She decided to write not a more traditional, external, linear view of Anna Freud's life and accomplishments but rather to focus on recreating for us the inner journey which made these accomplishments possible. This seems entirely appropriate for the biography of a psychoanalyst. Young-Bruehl was able to take this approach only because Anna Freud herself, while unwilling to write an autobiography, left behind many accounts of her self-reflections and dreams, as well as all the letters.

Young-Bruehl believes the psychobiographer's charge is to present the evidence, but not to try to draw from it the "essence" of a human life. A biography is not a case history. As she has written elsewhere, for a biographer, unlike for an analyst, "there is no next session." The structure of the book is, however, akin to the psychoanalytic process, in that deeper and deeper layers of the personality are slowly revealed. We are first given an external account of Anna's childhood and early family life: her feelings of being left out, her jealousy of her sister, Sophie, her having been given over to the care of a baby nurse, Josephine. Yet we also hear from her father's letters that he admired the impish remarks of his little "Black Devil."

In adolescence, she seemed sad and troubled. The ambiguity of having an analyst-father is heralded by her letters to him full of longing and containing barely disguised confessions of masturba-

tion. A successful young teacher, she gradually grew closer to her father.

In 1918, Freud embarked on what he felt would be an "elegant analysis" of her. His letters reveal some, but not much, conflict about this enterprise. To hear about this arrangement is, of course, very disturbing to us, and it is still hard to understand—although we have become aware, through many recent biographies, of how intertwined were the lives and analyses of the early analysts. They understood intellectually about transference, but they still had not grasped its full power and its implications for psychoanalytic technique.

We get the first deeper analytic view of Anna's inner life when we meet her at the age of twenty-three. Young-Bruehl has taken the initiative of convincingly piecing this together from Freud's 1919 paper, "A Child is Being Beaten," for which Anna is almost certainly one of the examples, and from Anna's own paper in 1922, "The Relation of Beating Phantasies to a Day Dream," which seems to be largely biographical. Thus we learn of her intense conflicts over and defenses against sadistic thoughts and the regressive solution to her oedipal conflicts via masochistic beating fantasies (these conflicts must have been intensified by Sophie's death in 1921).

Neither analyst nor patient saw how the analysis might have been cementing this masochistic solution, though later Anna could complain to Lou Andreas-Salomé that her daydreams were being "pulled apart, analyzed, published, and in every way mishandled and mistreated" (p. 121)—a beating fantasy epitomized.

The story continues with a poignant picture of Freud, now nearly seventy, struggling to free his daughter—and free himself—of his need for her. "If she really were to go away, I should feel myself as deprived . . . as I should do if I should have to give up smoking!" (p. 117). She anxiously pushed away suitors, and Freud easily agreed with her rationalizations. The first sign of his cancer, and then his first operation in 1923, sealed their fate. His neediness deepened, and, for Anna, it was a wonderfully compelling reason to stay with him forever.

She returned for a second period of analysis with her father in 1924-1925. Again there are no direct accounts, but Young-Bruehl

cautiously suggests that this analysis may well have contributed to Freud's major new formulation of female sexual development in his 1925 paper, "Some Psychical Consequences of the Anatomical Distinction between the Sexes." He now argued that the mother, not the father, is the girl's first love object and that she turns away from the mother because of penis envy.

This raises the question of Anna's relationship to her mother, which still remains obscure. Young-Bruehl is unwilling to speculate beyond the slight evidence she has. Anna evidently viewed her mother for a long time mainly negatively, complaining about her mother's tendency to control and criticize. It was not until her mother's death in 1951 that she could fully admit her positive feelings.

Yet in 1925, she had already begun to enact what she saw as her "stupid" yearning, her need for "something for herself" through her relationship with Dorothy Burlingham and her children, who were her first child patients. She kept these longings away from her father-analyst, while confiding them to Eitingon. One cannot but feel sympathetic toward her for these longings, though they were enacted in a way which brought both sustenance and tragedy. Freud saw, acquiesced, and approved, three years later becoming Dorothy's analyst too.

It is interesting to note that three years after this, in 1931, he wrote in his paper on female sexuality that "where the woman's attachment to her father was particularly intense, analysis showed that it had been preceded by a phase of exclusive attachment to her mother which had been equally intense and passionate."[1]

The biographer feels convinced, as do others who knew both well, that Anna's relationship to Dorothy was not a sexual one but fulfilled a host of other needs and defenses. Indeed, she establishes this relationship as the basis of Anna's chapter on altruistic surrender. Her inner life centered on this complex triangle, Anna set out on her life's work in the psychoanalytic care, study, and treatment of children.

Part two of the biography describes "Another Life," which began after Freud's death in 1939. Anna now inherited his mantle and

[1] Freud, S. (1931): Female sexuality. *S.E.*, 21:225.

became a political leader, defending the integrity of his psychoanalytic theory. There is the impressive story of her external achievements, both at the Hampstead Nurseries and in the foundation of the Hampstead Clinic, which provided the abundant and rich clinical material on which her many subsequent writings were based. New to me is the extensive account of her bitter fight with the International Psychoanalytical Association for recognition of the vital contribution of child psychoanalysis and recognition of her non-medical, child analytic training, which met with the political impasse that still exists today.

Meanwhile, she also continued an inner journey of self-analysis and exploration. We come to this deeper core of her personality in Young-Bruehl's own chapter seven of the biography. She brilliantly explicates a remarkable series of dreams Anna had after a serious illness in 1946-1947. These put Anna more fully in touch with her feelings about the loss of her father as well as her own feelings of "being lost," deriving from early childhood experiences. This led to a new understanding of herself and others as reflected in her papers on the fear of emotional surrender and passivity and in a trend of greater empathy for mothers and their babies. These marked the beginning of her own journey beyond her analysis with her father, and beyond his conceptual writing. It seems to have given her a new inner security in her work and greater intimacy in her relationships.

Young-Bruehl believes in trusting readers to draw their own conclusions; she gives us unusually rich and deep material on which to muse about this remarkable personality. For example, I found myself reflecting on how the early despair over being lost may have reinforced the masochistic oedipal solution of her beating fantasies, on a deeper level than analysis had yet understood. But there is the danger of falling into the very reductionism that Anna deplored. One can see in fascinating detail a multitude of conflicts and life situations leading to her complex compromise solution—the fantasy of partnership with Freud and the fantasy of family life with Dorothy Burlingham. Sadly, the recent Burlingham biography suggests there were costs to the Burlingham children.

In her work, the identification with Freud is clearly rock-solid, in

its positive as well as in its defensive aspects. Why did she choose the direction of child analysis, however? Young-Bruehl emphasizes identifications with multiple mothers, especially her nurse, Josephine. From my experience with her, I would add her strong identification with the child, whose point of view must be understood, whose conflicts must be taken seriously, and who is capable of hard analytic work. After all, her own analysis was perhaps one of the first extended adolescent analyses. These complementary identifications may have enabled her to make her great and unique contribution: the preserving of a completely psychoanalytic approach while adding a new developmental perspective to the diagnosis and treatment of childhood pathology.

As for her theoretical position, it was, as always with psychoanalytic theoreticians, tied to her personality, and it is exceedingly difficult to disentangle the personal from the "objective."

Her identification with Freud made it hard for her to accept contributions from others. She had to come to these discoveries in her own way, but then she was willing to absorb them, which led to a greater range and precision in diagnosis and technique. To the end, she remained true to her belief in the complexity of ongoing inner psychic conflict and refused to reduce the sources of pathology to any one period of life.

The uncompromising psychoanalytic approach has survived at the Hampstead Clinic against all odds. Perhaps in identification with the aggressor, she became the Knight of her early "stories," defending the fortress against snipers from all quarters. She has thus played an utterly necessary role in preserving child psychoanalysis.

We now have quite a collection of biographies of the early analysts—they have become our "Bloomsbury Group," and their interweaving lives have taken on a fascination of their own. This biography stands out as perhaps the most literate, with the clearest sense of history, of the aims and limitations of psychobiography. It was written with a deeply psychoanalytic restraint and sensibility.

It is too soon to make a final assessment of Anna Freud's work, but we have here the innermost life of a powerful, complex woman who has made extraordinary contributions to the world.

KATHARINE E. REES (NEW YORK)

THE MEMOIRS OF MARGARET S. MAHLER. Edited by Paul E. Stepansky. New York/London: The Free Press, 1988. 179 pp.

It was my privilege to know Margaret Mahler over a span of thirty-five years, from the time she began the training program in child analysis at the Philadelphia Psychoanalytic Institute in 1950 until her death, at age 88, in 1985. During these years she was my teacher, mentor, colleague, and friend. I greatly admired and gained a deep affection and respect for her as a good friend and as a uniquely dedicated and determined woman with strong ambition and high ideals. This review of her *Memoirs* reflects my wish to understand the wellsprings of her ambition and creativity and the development of her remarkably effective character.

Paul Stepansky has succeeded admirably with the task of Editor, as defined for him and by him. Drawing entirely from transcripts of interviews conducted by different interviewers, he has produced a unified, harmonious account adhering to the substance and preserving the tenor, tone, and first-person language of Mahler's own reminiscences and reflections. In his Introduction (pp. xiii-xl), he goes further, offering his own insightful views of the origins, bases, and distinctly psychoanalytic mode of her observational research on early psychic development. Among these, he makes the significant observation that her pediatric and psychoanalytic concerns for the health and development of children were subtended by certain facts of her own childhood (p. xxx). Most intriguingly he introduces the idea that Mahler's own life exemplifies her theory of development, being something of a lifelong enactment of the separation-individuation process.

Indeed, to study Margaret Mahler's life, as presented in these *Memoirs*, is to conceive that her research was paralleled by self-exploration and self-discovery, and that her theory of symbiosis and separation-individuation was created in part out of her own experience of the first years of life. In this, she emulated Freud and affirmed the concept that psychoanalytic discoveries and contributions to theory characteristically involve self-exploration, sometimes deliberately, as in self-analysis, and always unconsciously, as in creative process.

In attempting to fathom the developmental impact of Mahler's early childhood experience, one sees, first of all, that her endow-

ment was a very important factor. She was gifted with talent, a high intellectual potential, and with other propensities that also served survival and success. Such is attested to, for example, by her self-motivated reading of Einstein and Freud in her sixteenth and seventeenth years, by repeated recognition of her excellent capabilities and promise by her teachers and mentors, and by her tenacity and persistence in the face of the reported prejudice against her as an unwanted child, a Jew, a female, and an "outsider."

Mahler felt that she was very much unwanted by her mother, whom she described as a beautiful, narcissistic, pampered mere girl of nineteen. She notes that it was her father and her nurse who arose and attended her at night during her first year of life, when she was quite sickly and had sleep disturbances. Observing that her symbiotic stage was difficult, she makes the interesting dichotomous statement: "I must have been full of frustrated rage at the rejecting mother whom I greatly loved nonetheless" (p. 4). As important as were her nurturant father and nurse, this statement suggests that her mother was a "good enough" mother during the early months of her life. In Mahler's own theoretical terms, she obviously did not fail to enter into or emerge from the symbiotic relationship, and she was imbued with a yearning for the unconsciously experienced and internalized, earliest mother-infant relationship that constitutes the fundament of the human relationship.

I would speculate that the rage she postulates was in reaction to the loss of sufficient emotional availability of her mother during the differentiation and subsequent subphases of separation-individuation. She, therefore, did not experience the sound internalization and structuring of object- and self-representations as they accrue from the graduated developmental steps and relinquishments of the optimal separation-individuation process. In my view, her countering, adaptive response was the precocious development and use of her very good ego capacities. Here, I take note of her observations on the remarkable adaptive capacity of the human infant.[1] Also, in her own theoretical terms, her adaptive response enhanced rather than impaired her ego development, while devel-

[1] Mahler, M. S., Pine, F. & Bergman, A. (1975): *The Psychological Birth of the Human Infant. Symbiosis and Individuation.* New York: Basic Books, p. 5.

opment in other areas of the separation-individuation process was temporarily arrested (pp. 147-149).

Loss of maternal availability can influence the embryonic personality in several ways. It can create the *yearning* which leads to a search for the lost relationship in new relationships. This kind of outcome, under a different developmental circumstance, is suggested in Mahler's research observation that toddlers whose early walking is ahead of their psychological readiness for separation would suddenly appear perplexed and stop their motoric exploration of the environment, as if to say, "Where is my symbiotic part?" (p. 141). It is suggested also by her intense transference involvements with her mentors and analysts (pp. 59-74), which I believe were driven by preoedipal as well as oedipal yearnings.

Similarly, such loss would tend to heighten the felt sense and awareness of the crucial importance of the mother for the child's well-being and development. That Margaret Mahler had such a view was clearly evident in her pediatric experience. At von Pirquet's clinic, she was "appalled by the sterile way in which they undertook to treat very sick children" (p. 46), a way that did not include the mother (p. 48); in contrast, at Leopold Moll's Institute for Mother and Child Care, she was in total accord with the "credo, then progressive to the point of being avant-garde, that a baby not only 'belonged' to its mother but that the presence of the mother (or mothering person) was essential if a sick baby was to get well" (p. 47).

On a more theoretical level, early loss in usual proportions enters into the formation of the ego ideal as it is conceived to serve the restitution of such loss.[2] In my view, the greater the loss, the greater the valence of the ego ideal, and thus the greater the gap between what one is and what one strives to become.[3] This concept could explain Mahler's high ambition and the life-long tenacity with which she pursued her work.

Given the postulated early loss of relationship with the mother,

[2] Freud, S. (1914): On narcissism: an introduction. *S.E.*, 14:69-102, see especially p. 94; Jacobson, E. (1964): *The Self and the Object World.* New York: Int. Univ. Press, p. 96.

[3] Settlage, C. F. (1972): Cultural values and the superego in late adolescence. *Psychoanal. Study Child,* 27:74-92, see especially p. 81.

how can we account for Mahler's strong and staunchly defended sense of self? My clinical experience suggests that such loss can evoke an integrity-serving, self-protective response that motivates a sustained desire to prove and gain recognition of one's lovableness and worth. I see this as reflected in a refined form in Mahler's observation, late in her life, that "to create, after all, is to believe that what one says will count" (p. 122). A clearly evident factor was the father-daughter relationship: her turning to her father (p. 5), and his being consistently available, caring, and supportive. This relationship began during her infancy and continued throughout her adolescent and adult life until they were separated, in her fortieth year, by the Nazi occupation of Austria. It contributed importantly to the further structuring of both her sense of self and her object constancy.

It is my impression that Mahler's life-long separation-individuation process was enabled by her ability to find and interact developmentally with numbers of helpful parent figures, some of whom were her mentors and personal analysts.[4] This ability was demonstrated at the time of her adolescent move away from her family in Sopron to undertake her *Gymnasium* (high school) education in Budapest. There, while staying with her mother's sister, who did not like her, she found and thrived in the surrogate family represented by the Kovács and their friends, among whom were Ferenczi, Balint, Róheim, Bak, and Benedek. Ferenczi in particular was an available and suitable developmental object. This was also true of Willi Hoffer and August Aichhorn, whom she met in Vienna, where she moved upon completion of her medical education. She credits Aichhorn with being the most powerful influence of her formative years (p. 54). Because of his closeness to the Kovács circle in Budapest, he and Mahler were favorably disposed toward each other; and, before and after she turned to him for analysis, he was a source of inspiration and help, and a model for identification in her professional development.

As another evidence of her striving for personal and professional growth, Mahler undertook successive analyses with four analysts over a span of ten or more years. Her first brief attempt at

[4] Settlage, C. F., et al. (1988): Conceptualizing adult development. *J. Amer. Psychoanal. Assn.*, 36:347-369.

analysis, with Helene Deutsch, appears to have been a re-enactment of, rather than an analysis of, the negative aspects of her experience with her mother. Her second analysis, with Aichhorn, was characterized by an intense positive transference, which led to their being "in love with one another, making impossible the classical relationship between analyst and analysand" (p. 68). She assessed both her third analysis, with Willi Hoffer, and her fourth, with Edith Jacobson, as having effected important changes in her personality. In keeping with the postulate that both therapeutic process and developmental process can take in the psychoanalytic relationship,[5] it is my sense that she related to Aichhorn, Hoffer, and Jacobson not only as therapists but also as developmental objects.

I believe it is true, as she says, that her creativity was mobilized by her move to America—by the "new beginning" that brought "new vistas, new curiosity, new opportunities, and vital new sources of collegial support" (p. 121). But I see this as an event that fortuitously helped bring about what was in any case ready to take place. As I have attempted to convey, I am impressed that Margaret Mahler's remarkable creativity had its experiential roots in the vicissitudes of her earliest development and that its flowering was the result of her life-long, resolute striving to grow and develop and prove her worth to herself and to the world.

CALVIN F. SETTLAGE (SAUSALITO, CA)

THE CLINICAL DIARY OF SÁNDOR FERENCZI. Edited by Judith Dupont. Translated by Michael Balint and Nicola Zarday Jackson. Cambridge, MA/London: Harvard University Press, 1988. 227 pp.

Sándor Ferenczi died of pernicious anemia on May 22, 1933, shortly before his sixtieth birthday. During the last ten months of his life, he kept a clinical diary. In 1969, Michael Balint transcribed it, provided footnotes, translated the diary into English, and censored several paragraphs, including Ferenczi's opinion about

[5] Settlage, C. F. (1989): The interplay of therapeutic and developmental process in the treatment of children: an application of contemporary object relations theory. *Psychoanal. Inquiry*, 9:375-396.

Freud. Believing publication of the diary, as well as of the Freud-Ferenczi correspondence to be "imminent," he drafted an Introduction and a Preface. These are included at the end of this English edition of the diary, which was finally published, uncensored, in 1988. It was edited by Judith Dupont, who provided her own enlightening Introduction and footnotes. The correspondence is in publication and may be available by the time this book review appears.

The diary chronicles Ferenczi's daily work and contains personal history as well as comments on technique, psychoanalytic theory, and the conflicted relationship with Freud. On some days, Ferenczi made two or three passionate entries. Upon occasion, several days of silence elapsed, or the entries were fragmentary and disorganized. One can imagine times of illness and low energy alternating with times of feverish activity. The uneven quality and discontinuity of some of the entries, as well as the "brainstorming" nature of many, make parts of this diary difficult to follow. The footnotes help clarify the more cryptic entries, add a historical perspective, and tie the ideas presented in the diary to Ferenczi's last, most controversial papers. Perhaps, had he lived, Ferenczi would have organized his manuscript into a more coherent expression of his ideas. Nevertheless, the diary is of great interest not only to those who value insights into the relationships, personalities, and struggles of both Ferenczi and Freud, but also as a commentary on the controversial issues both of their time and of ours.

In the first entry, on January 7, 1932, Ferenczi expresses concern that the rule to free associate will cause his patient to feel abandoned. This sets the tone of the diary, for Ferenczi undertook to be a healer and rescuer. To this end, he advocated "natural and sincere behavior" on the part of the analyst. In prior experiments with techniques, he had first tried an "active" stance, which urged abstinence from all pleasures, which he abandoned after a patient fasted to the point of starvation. Next, he tried a "relaxation technique," but his more disturbed patients fell into trances or experienced chaotic regressions. Other patients reacted to his "passivity" by taking "liberties." For example, one whom he coded as "Dm.," kissed him and then revealed it at a social gathering: "I am allowed to kiss Papa Ferenczi, as often as I like." This episode was the basis for Freud's sarcastic letter of December 13, 1931, about Ferenczi's

"kissing technique." Ferenczi's reply, included as a footnote to the first entry in the diary, expresses a longing for reconciliation with Freud.

Under the rubric of being himself and at the suggestion of a patient (coded RN), Ferenczi now tried an experiment he called "mutual analysis." Two of these attempts, with RN and with Dm. (who, according to Dupont, was Clara Thompson) were sustained over several months, and they are described. In her tactful Introduction, Dupont states that, as "usual," he "push(ed) the experiment to its limit," running into numerous problems and embarrassments before, upon stopping the mutual analysis with RN, he termed the technique "a last resort." The mutual analyses involved either alternating or consecutive sessions. One difficulty was that, when Ferenczi became the analysand, he associated to painful memories and confessed to embarrassing or confidence-breaking feelings and fantasies. A description of clinical sessions, using the technique of mutual analysis, replete with self-confessions and doubts, forms the text of several entries.

Many of the patients Ferenczi treated had been repetitively traumatized in childhood, sexually and otherwise. The perpetrators were usually close relatives. Some of his descriptions are so terrible that one does not want to believe them. For example, we are told that RN had been given drugs by her father, sexually violated, and "tortured almost to the point of death" (p. 150). OS had had an insane mother who abused and starved her for days when she was only one and a half years old (p. 100). One description simply seems too bizarre to have happened. A patient, SI, "was forced to swallow the severed genitals of a repugnant black man, who had just been killed" (p. 140). Was this part of SI's psychotic delusion, taken as reality by a credulous Ferenczi? It is timely, in today's climate, to ponder how much was psychic reality and how much was real physical abuse. Ferenczi was preoccupied with the ways in which a child who has sustained overwhelming traumata manages to survive, as well as with understanding what kind of adult that child becomes. He also wished to help such patients integrate the pain sufficiently for them to lead a bearable life. One way to view Ferenczi's extremes of technique may be to see them as a physician's desperate attempts to cure his severely damaged patients.

Ferenczi was bitter toward Freud because of the latter's growing

pessimism and cynicism about the efficacy of psychoanalysis as a therapeutic tool. He quotes Freud (p. 118) as calling patients "rabble . . . for making money." His anger toward his former analyst was also personal, as he had been repetitively frustrated in his demand for increased intimacy with Freud. Toward the end of the diary, the anger erupts in a sarcastic description of the aloof analyst sitting behind the couch, smoking his cigar (p. 178). Ferenczi yearned for Freud's love and approval, in contrast with several other of Freud's followers, who were competitive with the master. If Ferenczi was jealous of any of Freud's relationships, it was of that with Fliess, who had once been the center of Freud's world. (And indeed, at one juncture it appeared as though Freud had chosen Ferenczi to replace Fliess. In 1894, Freud had told Fliess that he was the indispensable "only other"; in 1915 Ferenczi was "the only one to remain working at my side"[1]).

Ferenczi eagerly accepted Freud's invitations to travel with him, but he never achieved the intimacy for which he longed. For example, Ferenczi reports that on a trip to Sicily, he confronted Freud with his distant attitude, and Freud countered by calling him infantile (p. 186).[2] Ferenczi wanted Freud to be both his analyst and a participant in his life, a contradictory combination of roles. However, since the small community of early analysts repeatedly attempted to overcome this identical dilemma with one another, it is not surprising that Ferenczi should be confused and that his analysis would be interminable. One hypothesis is that his unresolved transference to Freud was in large part maternal and negative oedipal. He hinted at homosexual desires and chronic problems with impotence. His complaints included Freud's lack of support for expressions of hostile dependency, his impatience with regression, and unwillingness to disclose his countertransference.

Jones spoke of Ferenczi's "mental disturbance," called him delusional about Freud's hostility, and said he had "violent paranoic and even homicidal outbursts" prior to his death.[3] Many other

[1] Grubrich-Simitis, I. (1988): Trauma or drive—drive and trauma. *Psychoanal. Study Child*, 43:7.

[2] See also Freud's letter of September 24, 1910, to Carl G. Jung. In McGuire, W., Editor (1974): *The Freud/Jung Letters*. Princeton: Princeton Univ. Press, p. 353.

[3] Jones, E. (1957): *The Life and Work of Sigmund Freud, Vol. 3. The Last Phase, 1919-1939*. New York: Basic Books, p. 178.

writers doubt Jones's diagnosis, and this reviewer sees no evidence to support it in the diary. Ferenczi describes his pain and anger about his frustrating relationship with Freud. He resists accepting the mortal severity of his current illness. He speaks of his troubled childhood with an emotionally abusive and overstimulating mother. He alludes to sexual problems. He frequently overidentifies with his tortured patients. He questions the bedrock assumptions of the universality of the oedipal conflict and perhaps (depending on how one reads his comments) the existence of infantile sexuality. However, he does not seem psychotic. He even has enough perspective to remind himself of his teacher Freud's admonition that he was "too much under the influence of my patients." Although some of Ferenczi's actions may have been unwise or even unethical, his sincerity and capacity for self-reflection pervade the diary. Also, his insights into such issues as trauma and countertransference foreshadow current concerns and advancements in technique. Unfortunately, we will never know where Ferenczi's thinking would have led had his life not ended so abruptly.

SYBIL A. GINSBURG (SYRACUSE, NY)

TREATMENT OF PATIENTS IN THE BORDERLINE SPECTRUM. By W. W. Meissner, S. J., M.D. Northvale, NJ/London: Jason Aronson, 1988. 625 pp.

The trend in contemporary psychiatry toward nosographic overkill must be met with skepticism by psychoanalytic clinicians. It is often said that as an analysis proceeds, the diagnosis of the patient becomes less and less clear. Seemingly pure diagnostic entities often evaporate when they are placed under the lens of psychoanalytic scrutiny. It is the exceptional patient who does not present a complex array of features stemming from various developmental crises and reflecting a myriad of defensive operations.

Nowhere is the wisdom of this axiom more apparent than in the psychoanalytic treatment of borderline patients. Obsessional, hysterical, and phobic symptoms may coexist with paranoid episodes in which reality testing is clearly lost. Diagnostic diversity of such proportions led Hoch and Polatin in 1949[1] to view such patients as

[1] Hoch, P. H. & Polatin, P. (1949): Pseudoneurotic forms of schizophrenia. *Psychiat. Q.*, 23:248-276.

suffering from pseudoneurotic schizophrenia. Much of the current controversy regarding the optimal treatment of borderline patients stems from confusion and disagreement about which patients are truly borderline.

In the midst of this controversy, Meissner's thoughtful and comprehensive new volume is most welcome. The author takes the eminently sensible position that borderline patients cannot be adequately characterized by a discrete diagnostic entity defined by eight or nine common phenomenological features. Rather, borderline pathology is more accurately captured by conceptualizing it as a spectrum of varying degrees of pathological organization. Within this spectrum, there are two broad groupings that can be discriminated: the hysterical continuum, characterized by more overt object seeking and more dramatic regression; and a schizoid continuum, in which rigid defensive isolation and withdrawal from object relationships are more typical. Within each of these continua, Meissner identifies groups of patients with varying degrees of ego strength that require differing treatment approaches.

One of the most impressive features of the book is Meissner's persuasive demonstration that analysis is the treatment of choice for a subgroup of borderline patients. His section on criteria for analyzability of borderline patients is the best discussion of that subject I have seen anywhere. He recognizes that classical technique without the significant use of parameters is rarely applicable to any patient in the borderline spectrum. Hence, the criteria for analyzability must be modified for this group of patients. He particularly stresses the capacity to form a meaningful therapeutic alliance as an essential ingredient for psychoanalytic work. He rightly emphasizes the importance of establishing and maintaining the alliance in the treatment of any borderline patient and devotes an excellent chapter to that subject.

Meissner is not overzealous in his prescription of psychoanalysis or highly expressive psychotherapy for patients in the borderline spectrum. He acknowledges the value and necessity of shifting flexibly between supportive and expressive interventions, depending on the needs of the patient at the moment:

> My own view is that, while the theoretical discrimination between supportive and expressive modalities has a certain utility from the point of view of articulating and describing aspects of the psychotherapeutic process, attempts to hold rigidly to a dichotomous view that prescribes a given form of therapeutic mo-

> dality to specific diagnostic entities is neither theoretically sustainable nor clinically practical. . . . the therapist needs to maintain a position of flexibility and adaptability, allowing the selection of available techniques from the range of psychotherapeutic interventions to deal with the problems presented (p. 121).

Meissner is less successful when he attempts to classify subgroups of patients within the hysterical and schizoid continua. Within the former, he delineates the following categories: pseudoschizophrenia, primitive affective personality disorder, dysphoric personality, and the primitive (oral) hysteric. Within the schizoid continuum, he identifies the schizoid personality, the false-self personality, the "as-if" personality, and the syndrome of identity stasis. In the last section of the book, he provides detailed clinical examples of the treatment of patients in each of these categories.

Meissner's taxonomy presents two major difficulties. First, the distinctions are perhaps more fine grained than is realistic, given the kaleidoscopic changes seen in the treatment of most borderline patients. In the clinical examples provided, one observes considerable overlap among the different categories. In fairness to Meissner, he acknowledges that the boundaries separating the subgroups are not hard and fast and that his classification is primarily of heuristic value.

The second problem is that his nomenclature is confusing at times because it is at odds with other systems of classification. For example, Meissner states that pseudoschizophrenic patients, who occupy the lowest level of the hysterical continuum, are basically similar to those with schizotypal personality disorders. However, the clinical descriptions of these patients present a picture of a far greater degree of object relatedness and much more destructive acting out than is typical of the schizoid adjustment found in the usual schizotypal patient. Meissner's discussion of the primitive affective personality disorder acknowledges the depressive elements within this group without dealing with the well-known comorbidity of characterological depression and major affective disorder.[2]

Yet another example of this nosologic confusion is his category of the primitive oral hysteric, which is presented as the highest

[2] See Gunderson, J. G. & Elliott, G. R. (1985): The interface between borderline personality disorder and affective disorder. *Amer. J. Psychiat.*, 142:277-288.

level of the hysterical continuum; a modified form of analysis is advocated as the treatment of choice for most of these patients. This subgroup is likely to confuse the reader who is familiar with the extensive literature on the "good" or "phallic" hysteric versus the "so-called good" or "oral" hysteric.[3] The conventional understanding of this distinction is that the latter, more primitive group of hysterics is *not* analyzable, while the former, higher-level group is. Meissner appears to be describing a group of "hysterical borderlines" with greater ego strength than is generally attributed to the more primitive oral group.

Meissner's chapters on treatment are comprehensive and thoughtful. In addition to detailed discussions of transference, countertransference, interpretation, and confrontation in psychoanalysis and individual psychotherapy, he includes several chapters on adjunctive treatments such as pharmacotherapy, family therapy, group therapy, and hospitalization. Each reader will find areas of agreement and disagreement in these sections. Some will find Meissner's distinction between transference and therapeutic alliance a bit arbitrary. Others will find his conceptualization of projective identification somewhat narrow. Still others will disagree with his suggestion that one clinician can serve as both individual psychotherapist and family therapist. For the most part, however, Meissner's discussions of treatment reflect sound clinical wisdom.

Despite my reservations, this fine new volume is one of a handful of books on borderline patients that should be on the shelf of every clinician who attempts to treat such patients. Analysts in particular will find the author's discussions of analytic technique with borderline patients highly illuminating. The encyclopedic scope of Meissner's scholarship makes the book a marvelous reference tool as well. The author's scholarly critique of the vast literature on the subject is superb. The detailed clinical cases presented in the final section are most instructive and serve as useful illustrations of the theoretical points made earlier in the book. To

[3] See, Easser, B. R. & Lesser, S. R. (1965): Hysterical personality: a re-evaluation. *Psychoanal. Q.*, 34:390-405; Lazare, A. (1971): The hysterical character in psychoanalytic theory: evolution and confusion. *Arch. Gen. Psychiat.*, 25:131-137; Sugarman, A. (1979): The infantile personality: orality in the hysteric revisited. *Int. J. Psychoanal.*, 60:501-513; Zetzel, E. R. (1968): The so called good hysteric. *Int. J. Psychoanal.*, 49:256-260.

Meissner's credit, he presents cases of therapeutic failure alongside his successes, and he readily admits the limitations of our craft with the most challenging patients in the spectrum. With this group of patients, we would all do well to remember Freud's dictum that we learn as much from our failures as we do from our successes.

GLEN O. GABBARD (TOPEKA)

TREATING THE SELF. ELEMENTS OF CLINICAL SELF PSYCHOLOGY. By Ernest S. Wolf, M.D. New York/London: The Guilford Press, 1988. 194 pp.

If I were asked to recommend one book among the burgeoning offerings on self psychology, it would be this monograph by Ernest Wolf. In a direct, clear style, Wolf has provided a succinct but comprehensive description of psychoanalysis from the perspective of self psychology.

The book is organized into two sections, of roughly equal length, on theory and its clinical application. Wolf begins by tracing the evolution of the concept of "self" from Freud, who did not distinguish it clearly from "ego," through Hartmann, Fairbairn, Guntrip, and Winnicott. He attributes the resistance to interest in the narcissistic and borderline disorders to ongoing focus on the classical neuroses and to a moral aversion to problems that derive from a "miscarried love of self." Wolf notes that "our Judeo-Christian civilization . . . can sometimes forgive and try to redeem the man who is victim of his passions, whether they be sexual or aggressive, but . . . finds it very difficult to give a fair hearing to the man who presents himself as smugly superior or arrogantly self-righteous. . . . Yet, it seems, the time to face our own narcissism has come" (p. 8).

Wolf describes the theory as follows. There is a central psychological structure, the *self*, and "[s]elf psychology is the study of this structure, its subjective manifestations, and its vicissitudes" (p. 11). The *selfobject* is defined as the experience of the presence of others that evokes the emergence of the self and the maintenance of its *cohesion*. Faulty selfobject experiences lead to *fragmentation* of the self, variously experienced as a loss of self-esteem or as a feeling of emptiness, depression, worthlessness, or anxiety. Selfobject experiences are necessary throughout life. In early life, they must be pro-

vided by the actual presence of the caregiving object; in maturity, selfobject functions that "maintain the structural integrity of . . . [the] self . . . [are] generated in symbolic representations of the original self-evoking experiences" (p. 11).

Wolf defines the self as "that psychological structure which makes its presence evident by providing one with a healthy sense of self, of self-esteem and well-being" (p. 27). "[S]elf-sustaining responses are performed for the self by objects, and we call these needed responses *selfobject responses*, or, more precisely, *selfobject experiences* of the object" (p. 26). Of particular interest to this reviewer is his statement: "[T]o the extent that the environment provides selfobject experiences, one may speak of a selfobject ambience consisting of a net of selfobject *relationships*" (p. 15, italics added). Wolf later observes that "there has been a subtle but discernible shift in our major focus toward the selfobject rather than the self as our center of conceptual gravity" (p. 63). In my opinion, Wolf's rendition of *self* psychology also constitutes a significant bridge between self psychology and theories of *object relations*.[1]

There is a brief but rich account of the triple functions of empathy in psychoanalysis: its *defining* function, defining psychoanalysis in terms of empathy as its method of data collection; its *processing* function, emphasizing the role of empathy in gathering the kind of data that is characteristically psychoanalytic; and its *self-sustaining* function, in which attuning to the analysand's inner experience and participating in that experience strengthens the analysand's self-cohesion and increases his or her self-esteem. Many patients experience the analyst's accurate empathic attunement as the analyst's *centrally* useful function.

Five types of selfobject needs—mirroring, idealizing, alter ego, adversarial, and merger—are differentiated, defined, and placed in a developmental context. In addition, Wolf discusses *efficacy* need which, while not a selfobject need per se, is a "need to experience that one has an impact on the selfobject and is able to evoke needed selfobject experiences" (p. 55). Elaborating on his earlier

[1] In another context—see Bacal, H. A. (1990): Does an object relations theory exist in self psychology? *Psychoanal. Inquiry*, 10:197-220—I have quoted Wolf as asserting this even more forcibly: "The trouble with our theory (Self Psychology) is that we look at the self or personality to find what it's like. We need to look at the *relationship*. That will tell us. Everything occurs in the context of a *relationship*."

description of the developmental line of selfobject relations,[2] he traces the vicissitudes of normal selfobject relationships from the oedipal phase through the rest of life. Recognizing that limitations in our present knowledge permit only the most general assumptions correlating early faulty selfobject relations and self pathology, he describes selfobject relations disorders and classifies them, according to the nature of the damage to the self, into psychoses, borderline states, narcissistic personality disorders, narcissistic behavior disorders, and psychoneuroses. He classifies the self pathology in these disorders into four categories: the understimulated self, the fragmented self, the overstimulated self, and the overburdened self. He identifies characteristic behavioral patterns, variously present in the disorders of the self, but on a continuum from normal to severely pathological, as mirror hungry, ideal hungry, alter ego hungry, merger hungry, and contact shunning personalities.

A chapter is devoted to the subject of narcissistic rage, in which Wolf clarifies the distinction between competitive aggressiveness, a healthy reaction that is directed at objects which impede access to precious goals, and narcissistic rage that is aimed at selfobjects who threaten or damage the self. He distinguishes non-pathological competitive aggressiveness that derives from the oedipal situation, which can have constructive effects in human relations, from narcissistic rage that can arise in the same situation "when the oedipal selfobjects react to the oedipal child's sensual-competitive strivings with horror, or outrage, or derision, or rejection and humiliation [injuring] the child's self [to] its very core" (p. 79). He understands the dynamics of narcissistic rage as a reaction to helplessness, in effect, a state where no healthy self assertiveness is possible: "The offending selfobject or the totally ashamed self must be made to disappear" (p. 79). He concludes this chapter with an interesting discussion of the narcissistic rage of opposed religious and national groups, suggesting that real peace—the peace of mutual empathic understanding—will come not from weakening the enemy's self, but from strengthening it (pp. 82-84).

The seven chapters on treatment address the psychoanalytic set-

[2] Wolf, E. (1980): On the developmental line of selfobject relations. In *Advances in Self Psychology*, ed. A. Goldberg. New York: Int. Univ. Press, pp. 117-135.

ting, self psychological principles of psychoanalytic treatment, the therapeutic process, selfobject transferences, selfobject countertransferences, the determinants of cure, and termination. Wolf emphasizes Kohut's observation that when he adjusted his listening stance from a "classical" approach in which he was in an implicitly adversarial position to one that was empathically attuned to certain aspects of his patients' experience, this produced new therapeutic effects. Kohut concluded that the cohesiveness of his patients' self experience was of central importance and that their experience of him as a selfobject was the most potent factor in the therapeutic process.

Wolf particularly stresses the importance of recognizing when the analysand's subjective experience is at variance with that of the analyst and of addressing these differences in a therapeutic way. A major task is to accept and understand the patient's frustrations and difficulties about these differences, particularly when they are fueled by failures in understanding and responsiveness by significant figures in the patient's childhood. Wolf identifies these phenomena as a form of *transference*, that is, "the fears, the defenses, and the distortions imposed by early traumatic threats to the self [at a time] when they are no longer appropriate," but are triggered by current experiences which are perceived as repeating or threatening to repeat them (p. 44).

Wolf's discussion of "selfobject transferences" would, in my view, be enhanced by utilizing Basch's distinction between "transference of need" and "transference of solution."[3] Interestingly, he does contrast *countertransferences proper*, "mainly based on the analyst's residual selfobject needs," to *reactive countertransferences*, "[which are] evoked by the patient's demands for selfobject experiences" (although, surprisingly, he does not indicate that there may be mixtures of the two). For Wolf, the concepts of transference and countertransference are means of denoting the subjectivities of both participants in the analytic situation, and the interaction between these subjectivities is the *dialectic of subjectivities*, a term that Wolf proffers as essentially the same as, but more clearly reflecting

[3] Bacal, H. A. (1985): Optimal responsiveness and the therapeutic process. In *Progress in Self Psychology, Vol. 1*, ed. A. Goldberg. New York: The Guilford Press, pp. 202-226. See, especially, p. 223.

the analytic process than Atwood and Stolorow's term *intersubjectivity*.

Wolf's discussion of selfobject transference also demonstrates that self psychology has yet to clarify the important distinction between *selfobject transference of need* (displacement of the need for a responsive selfobject matrix that arises from derivatives of remobilized archaic as well as current age-and phase-appropriate selfobject needs), *and the experience of fulfillment of that need*. These are quite different self states, but the term, "selfobject transference," is used for both.

Initially (p. 23), Wolf, like Kohut, asserts that the therapeutic effect of interpretation comes from the patient's experience of the analyst's attitude of interest and concern rather than from the content of the interpretations; that is, from provision of a selfobject matrix in which the patent "[feels] respected, accepted, and at least a little understood" (p. 100). His further discussion, however, creates doubt about the extent to which he feels each plays a part. While there is much in Wolf's book to indicate that his ultimate criterion for therapeutic effect is selfobject experience, he appears to be diffident in asserting it unequivocally. He also is equivocal about the extent to which he concurs with Alexander that psychoanalysis can be a corrective emotional experience.

Wolf identifies two pathways that can lead to increased strength of the self: the *ambience* and the *disruption-restoration process* that provides an opportunity for working through experiences of self-injury that have left the patient psychologically crippled. Often against considerable transference resistance emanating from fear that experiences with the analyst will repeat early trauma to the self, the patient regresses to awareness of selfobject needs which the analyst inevitably fails to meet. Since the empathic "in-tuneness" and responses to the patient can never be perfect, selfobject transference disruptions inevitably occur. These disruptions lead temporarily to more archaic forms of relatedness, characterized by defensively distorted and exaggerated demands or by defensive distancing and withdrawal and at times by acting out. The selfobject relationship is restored by the therapist's exploration and interpretation of what has taken place "on the basis of an empathically informed understanding" (p. 115) that re-establishes the pa-

tient's equilibrium via what is, in effect, a *selfobject experience* that leads to "a rearranged or reorganized self structure" (p. 116).

An analysis informed by self psychology recognizes the value of increased knowledge about oneself, but this is not what is primarily aimed at. What is sought is an increased sense of well-being, an improved overall functioning, and more creative and happier relationships with others, any of which may or may not be accompanied by insight.

Termination is indicated when strengthening processes have enabled the patient to become "[less reliant] on defensive maneuvers designed to protect the cohesion, boundaries, and vigor of the self. . . . [A]ware of its increased resiliency and lessened vulnerability, the self has become more expressive of itself and more daring in its actions" (p. 169). In addition to these improvements, the development in the analysand of self-analytic skills also signals the approach of termination. For Wolf, however, no imputation of analytic failure should be attached to the patient's need for occasional post-termination contact with the analyst. Many patients feel the need for this; indeed Wolf recommends that analysts encourage their patients to stay in touch "because it is in the spirit of an *appropriately responsive relationship*" (p. 170, italics added).

This book is a bench mark in the literature of self psychology. It is a concise—perhaps too concise—but remarkably complete handbook that requires more clinical illustration to convey how the author as practitioner understands and struggles with the complex theoretical and clinical principles he describes. Yet, even in its present compressed form, it is an invaluable resource for practitioners, students, and teachers of self psychology.

HOWARD A. BACAL (TORONTO)

FREUD WITHOUT HINDSIGHT. REVIEWS OF HIS WORK (1893-1939). By Norman Kiell. Madison, CT: International Universities Press, Inc., 1988. 758 pp.

For those in the psychoanalytic community who may have accepted the idea of some revisionists that the early reviews of Freud's works were positive rather than negative or non-understanding or neglectful, this volume serves a useful purpose. It places those ideas

in a more objective light by providing a verbatim account of the reviews of Freud's early work. The reader comes to appreciate that blind trust in secondary sources is the graveyard of any serious historical enterprise. It is upon reliance on secondary sources and inferior translations that much revisionist thinking rests.

Freud without Hindsight shows that the early Freud was the recipient of numerous inept reviews, was generally neglected by the medical authorities of his time, and was misunderstood by lay reviewers. Late reviews show Freud to be the victim of yet another generation of reviewers. Thus, the revisionist notion that holds that Freud complained too loudly about neglect withers when we are faced with the reviews in this volume. Freud, it seems, had some reasonable complaints, and this superb collection of the original reviews of his works may set some of the record straight.

Norman Kiell, Professor Emeritus, Psychological Services, Brooklyn College, has produced an extraordinary work of scholarship and bibliographic research. Anyone seriously interested in the history of psychoanalysis is in his debt. Not only are 172 reviews of 39 works of Freud reproduced in whole or in part in this volume, expertly translated into English, but a rich reference list and appendix are provided. The appendix, arranged according to both title and reviewer, lists a total of 800 reviews that extend from Freud's early short writings to *Moses and Monotheism.* Culled from journals and newspapers in libraries throughout Western Europe and the United States, the list comes fairly close to exhausting all the book reviews of the time. Many of the citations in the appendix, however, are to recent reviews of newer translations of older texts. These are not reproduced, since they are readily available in psychoanalytic journals.

Each book under review is introduced by careful notes that place the book in a proper historical and cultural context and provide biographical data on the reviewer. These notes enormously enrich the text and offer a running commentary on the history of the evolution of Freud's reception and that of psychoanalysis. The complete file of reviews has been placed in the Sigmund Freud Archive in the Library of Congress and in the A. A. Brill Library of the New York Psychoanalytic Institute for those who wish to read further.

It is in the obvious challenge to the debunking revisionists who

were critical of Freud's view of himself as slighted by his peers and colleagues, especially in the neglect of *The Interpretation of Dreams*, that this work distinguishes itself. These revisionist ideas achieved the status of seeming "truth" as the result of the work of Bry and Rifkin and Decker; and they were repeated without search of primary documents by Sulloway, Ellenberger, Fine, and others.

The Interpretation of Dreams was well received in the non-scientific journals, but it was from the medical-scientific audience that Freud most wanted recognition. Reading these reviews provides a balance between the demythifiers' revisionism and Freud's view of himself as the neglected hero whose "book-child" went unrecognized. Most authors are overly sensitive to bad reviews and will dwell on negative comment contained in an otherwise laudatory review, but this was not really the case with Freud.

While Freud could hardly complain about the praise offered by the poet Alfred Freiheer von Berger in his review of *Studies on Hysteria* published in a Vienna newspaper in 1896, the *Morgenpresse* was *not* a medical journal. Von Berger found the book "permeated with unconscious and unintended beauty" and saw "much wisdom in the book, much goodness, depth of feeling, and psychological acumen which must have deep roots in the sensitivity of an all-knowing heart." He exclaimed that "it is almost miraculous when you see how the two physicians search the soul of a stranger and finally come upon the affective stimuli which the psyche could not become aware of by its own efforts" (p. 70). Another review, of *The Interpretation of Dreams*, described the book as "epoch-making," but again this was in a literary journal. Freud, however, can be faulted in part for its poor reception, since he was not a good publicist and would not allow Fliess to advertise the book.

The *Three Essays* also were generally not reviewed in the German language psychological journals of the day. It is ironic that a fairly favorable review was published in *Die Fackel*, edited by a notorious Jewish anti-Semite, Otto Soyka (p. 299). And even when psychiatrists wrote reviews, they were often brief and unevaluative. William Alanson White, writing in 1911, found the *Three Essays* "vastly competent" (p. 318), but his review was a perfunctory summary, as was the one written by Adolf Meyer (p. 311).

Almost a quarter of *Freud without Hindsight* is taken up with reviews of *The Interpretation of Dreams*, and Freud's early work is given

primary coverage. As Freud's reputation grew, the number of reviews increased and they, of course, began to appear in serious scientific journals, and to be written critically and objectively.

Freud's work found many reviewers. Such intellectuals as T. S. Eliot, John Crowe Ransom, and Horace Kallen were reviewers as well as more expected reviewers such as William James, Wilhelm Stekel, Carl Jung, Theodor Reik, Sándor Ferenczi, Paul Moebius, Havelock Ellis, Otto Fenichel, Eugen Bleuler, Willi Hoffer, James and Edward Glover, Karl Abraham, and Robert Waelder. Their reviews make for fascinating reading.

At first, the intellectuals were not kind. Writing in the *Criterion* in 1928, T. S. Eliot found *The Future of an Illusion* a "strange" book, and he wrote a harshly critical review of it. The review reminds us that when Freud wrote about other than clinical psychoanalysis, he was frequently vulnerable to attack. Eliot wrote: "We can hardly qualify it by anything but negatives; it has little to do with the past or present of religion, and nothing, so far as I can see, with its future. It is shrewd and yet stupid; the stupidity appears not so much in historical ignorance or lack of sympathy with the religious attitude, as in verbal vagueness and inability to reason. The book testifies to the fact that the genius of experimental science is not necessarily joined with the genius of logic or the generalizing power" (p. 575).

And in 1925, Clive Bell, writing about the *Leonardo* book, exclaimed that "Dr. Freud has made himself slightly ridiculous by talking about things of which he knows nothing, but imagining that the books and pictures he likes are works of art. . . . Dr. Freud may be an excellent psychoanalyst, but I am sure he had better leave art alone" (p. 369). Most reviews of this work were not favorable, until 1947, when it was reprinted; then *The New Yorker*, no lover of psychoanalysis, found it "an interesting and perfect clinical demonstration of the Freudian method" (p. 369).

In this space, it is only possible to note a few fragments from a packed book. The book, regrettably, is filled with too many typographical errors. These have no place in any book, and certainly not in a bibliographic work such as this. Readers should rise up against this continuous outrage from the publishers of psychoanalytic texts.

Let there be no ambiguity for future historians, or for Professor Kiell. This is a rave review!

JOSEPH REPPEN (NEW YORK)

FREUD IN EXILE. PSYCHOANALYSIS AND ITS VICISSITUDES. Edited by Edward Timms and Naomi Segal. New Haven/London: Yale University Press, 1988. 310 pp.

This volume is an exception to the rule that symposium papers make bad books. A group of scholars met in London in October 1986 to discuss the dissemination (and transformation) of Freud's ideas in the course of the migration of psychoanalysis from Vienna to London. Appropriately, this volume, derived from that discussion, appeared near the 50th anniversary of Freud's arrival in London after his escape from the Nazis: hence, the title, *Freud in Exile*.

The scholars represented in this volume are mainly social scientists, philosophers, historians, and political scientists, all interested in psychoanalysis, many of them trained as analysts. The collection of essays reflects deep scholarly and interdisciplinary interests, all to the enrichment of psychoanalytic theory. Beautifully written, the essays provide intellectual stimulation over a wide range of issues of historic interest to psychoanalysis and social science. These include lay analysis, the scientific status of psychoanalysis, the role of Ernest Jones in the development of psychoanalysis in English-speaking countries, the fate of analysts as refugees, possible misinterpretations in translating Freud into a "Standard Edition," psychoanalysis and feminism, and the relation of psychoanalysis to psychotherapy.

While a book of this sort should not be judged in terms of critical arguments around a central theme, what emerges from this lively volume of essays is a sense that psychoanalysis has been affected by the cultures in which it found itself, both in its natural migration as a science and in its forced migration under the onslaught of Hitler and World War II.

There is much to ponder—for example, the problems arising in translating Freud from German into English. In the judgment of

several authors, casting Freud in a language of science at the expense of freely used metaphors in the original German constricted the understanding of psychoanalysis. The authors suggest that psychoanalysis is in evolution and is naturally susceptible to various cultural influences. According to this view, the work of James Strachey's *Standard Edition* attempted to create a more formalistic structure not inherent in the original German. This transformation of "Freud in exile" was not accidental, but rather an effort to make psychoanalysis perhaps even more scientific than its founder intended. From this criticism of the English version of psychoanalysis one can range into the effects on psychoanalysis of its institutional character both in England and in the United States.

While it would be easy to come away from the essays on the translation of Freud with the view that psychoanalysis endured an unnecessary constriction in the journey from middle Europe to England and the United States, consider this problem: is psychoanalysis subject to a peculiar kind of entrepreneurism in which one may feel free to invent language, exclude hypotheses, alter the practice according to personal observation as well as conviction, and otherwise invent a new psychoanalysis to suit one's taste (as well as "the market"?) in a free-for-all competition? Science and scholarship are free, but they involve certain disciplines which can be seen at work in the many controversies in the physical and biological sciences. There is no simple solution to settling controversy in psychoanalysis, witness the enduring debate between British Kleinians and Freudians which could be contained only in a political solution that established three groups in The British Psycho-Analytical Society.

The net effect of devoting some time to the essays in *Freud in Exile* is the renewed sense that psychoanalysis thrives on debate. Each generation of intellectual leaders in the various nations in which psychoanalysts practice and reflect will engage the debate in terms meaningful to both the universal and the local issues that define attempts to understand the human condition. The editors and authors are to be congratulated for producing an exciting volume.

ABRAHAM ZALEZNIK (PALM BEACH, FL)

BY SILENCE BETRAYED. SEXUAL ABUSE OF CHILDREN IN AMERICA. By John Crewdson. Boston/Toronto: Little, Brown & Co., 1988. 267 pp.

John Crewdson is a journalist who has brought his investigative skills to bear in the area of childhood sexual abuse. He presents facts and figures on the prevalence of this particular type of mistreatment of children that startle even the psychoanalyst. His case histories of both the victims and the abusers are interesting to read but are, of course, the case histories of a journalist and lack the sophistication of a psychiatric or psychoanalytic report. He tends to focus in great detail on the "acts" themselves, which is itself a type of exploitative journalism.

In trying to explain the motivation of the abuser, he has adopted the now popular diagnosis of narcissistic personality as a label to apply to this very large and heterogeneous group of individuals. Once having applied the term "narcissist," he generalizes about "narcissists," what they need and how they should be treated. This is quite misleading. The numbers of victims and of abusers involved are staggering. According to Crewdson, about twenty percent of the adult population has been sexually abused by an adult before the age of eighteen, the ratio of male to female victims is about one to two.

Of course, this number includes victims in many different situations. Some involve incest, and others involve more distant family relations, or strangers. It can be the act of an individual or the premeditated action of a group functioning over a long period of time. The latter may masquerade as a social institution, such as a day care center or a school. These statistics probably do not surprise psychoanalysts, who hear about such incidents from our adult and child patients. However, since we deal with small numbers and with a selective patient population, it is hard for us to generalize from our small sample about the extent of the problem.

The chapter derived from interviews with victims suffers from allowing the victims themselves to decide what the sequelae of their traumata were. This amounts to a wholesale blaming of whatever misfortunes or personality problems the victims have upon their experiences with sexual abuse. Crewdson fails to evaluate the alterations of the ego structure of the affected individuals. He also fails

to take into account the role of fantasy elaboration, distortion, and revision that can be expected to take place in any individual under such circumstances, particularly in the case of young children. Nor is the issue of secondary gain adequately taken into consideration.

There is also a lack of psychological sophistication in the way trauma is defined. It is generally used in the lay sense of something shocking to the observer rather than in terms of what the particular experience means to a person intrapsychically, in accordance with the person's own past history and psychic structure.

I found the chapters on families of more value. The author describes in detail the lack of support, the parental failure, or the disintegration of family structure of the child who becomes sexually vulnerable to a stranger or relative because of the wish for closeness and acceptance at any price. On the other hand, institutionalized sexual abuse of the type that has made headlines lately should remind us that under certain circumstances all children can be vulnerable.

The chapters on the law and on legal solutions clearly illustrate the shortcomings of the legal approach to issues either within a family or in institutions. Crewdson highlights the problems associated with focusing on gathering legal proof. He describes the stress placed upon child victims who are forced to testify in court and undergo cross examination by defense lawyers. A strong point of the book is its description of the sad state of affairs that exists not only with regard to the prevalence of childhood sexual abuse, but also to the insufficient and poorly crafted tools the law has devised to protect the victims. The real trauma may come as much from the legal process and the way it uses and what it requires from the child victim witness, as it does from the original crime. The failure of the law and therefore of society to acknowledge the special needs and vulnerabilities of children is reflected in the bungling of the legal machine.

In his historical review of the status of children in society, Crewdson portrays the sad plight of children over the centuries, especially their position as the property of their parents. It is only recently that in Western civilization a child has begun to be recognized as a person with rights and as someone deserving of protection under the law.

It is clear that until society truly recognizes the psychological

needs of children, the legal machinery will continue to forget about the baby as it preoccupies itself with the bathwater, so to speak. The even larger issue of the influence of our contemporary society, with its emphasis on overt sexuality, instant gratification, and acceptance of sexual perversion as simply a variant in life style, unfortunately is not addressed in this book.

LAWRENCE SHADEROWFSKY (NEW YORK)

FUGITIVES OF INCEST. A PERSPECTIVE FROM PSYCHOANALYSIS AND GROUPS. By Ramon C. Ganzarain, M.D. and Bonnie J. Buchele, Ph.D. Madison, CT: International Universities Press, 1988. 123 pp.

This book contains a report on the combined individual and group treatments of twenty-five patients and observations on an additional fifty patients who were seen only in consultation. The twenty-five patients were expected to remain in treatment for a year. Only patients who had clear memories of incest were accepted. The follow-up also included patients who, in addition to individual and group treatment, had hypnosis or psychotropic medication, were hospitalized, and participated in marital and sexual treatment. The treatment conducted by the authors themselves was guided by psychoanalytic theory and was therefore considered to have been depth-psychological in nature. The patients were expected "to work through the trauma, to overcome the resultant conflicts and to achieve a better integration of their personalities" (p. xi). These are obviously ambitious goals, and the authors acknowledge that because of the nature of the trauma, "improvement must be necessarily relative and limited" (p. xiii).

The chapter headings and the organization of the book indicate that the authors' major aim in reporting the combined individual and group treatments of these patients was to arrive at certain generalizations regarding the transference, the countertransference, the psychopathology, and the acting out potentials, as well as the survival of the self of patients who were incest victims. The small size of the sample permitted them to indicate only "trends and tendencies," which, however, they felt were "clearly observable" and which they hope will be substantiated when "greater numbers become available."

Transference in these cases was found to be intense and intractable. The nature of the transference varied, in keeping with the setting and the therapist's gender. Since there was no effort made to explicate the meaning of the incest trauma for each individual patient, generalizations relative to the nature of the transference were derived from the history of incest. In this sense, the book is about "psychotherapy for incest" and not about the psychoanalytically informed exploration of how the trauma of incest affected a particular individual patient. The group psychotherapy, which was to "provide a surrogate peer group in which members can deal with emotional difficulties derived from the incest . . ." (p. 6), may well have interfered with the spontaneous evolution of transference that would have been specific for the individual patient.

The outstanding feature of the therapists' countertransference feelings was that, in their view, the magnitude of the trauma had eclipsed all other aspects of the patients' personalities. Since their attention was focused exclusively on the trauma itself, no other dimensions of the patients' psychological lives were explored and reported.

Both transference and countertransference considerations appear to have been affected by some difficulty in deciding whether the therapists were dealing with distortions in the transference or the patients were reliving events that had actually occurred in their lives. Though the authors state that what is "traumatic for one individual . . . is contingent upon this person's preexistent internal conflicts" (p. 105), this theoretical orientation to the impact of a traumatic experience is not reflected in the actual reporting of the clinical material.

Acting out during group psychotherapy for incest victims is another topic covered. Sex, power, sadism, and self-destructiveness are discussed as areas that are particularly likely to be acted out. Although the authors acknowledge that "working through is the solution to acting out" (p. 46), this important aspect of the treatment process is discussed only in theoretical terms. It would have been particularly helpful to have at least one case reported in some detail for the reader to learn how the working through in these major areas of psychopathology was accomplished.

The chapter on survival of the self in incest victims contains a brief and not very adequate review of the literature related to the

concept of self. Clinical examples are cited to indicate that disturbances in the structure of the self find expression mainly in the patients' inability to parent. It is noted specifically that they have "difficulty letting their children individuate and separate" (p. 68).

Psychopathology induced by defenses after incest is another focus in the book. In essence, the psychopathology of incest is viewed here as a post-traumatic stress disorder. The various defenses that this psychopathology makes use of are illustrated via two clinical vignettes.

While this book is clearly written and attempts to be comprehensive, the generalizations appear to have been arrived at mainly from the history of incest and mainly on theoretical grounds. The book fails to be convincing as to the value of combining group with individual treatment in cases where patients have suffered the trauma of incest, as neither form of therapy is explicated with sufficient care.

ANNA ORNSTEIN (CINCINNATI)

WHAT WE KNOW ABOUT SUICIDAL BEHAVIOR AND HOW TO TREAT IT. Edited by Stanley Lesse, M.D. Northvale, NJ/London: Jason Aronson, 1988. 466 pp.

In our careers as mental health professionals, we occasionally face suicidal patients, either in an evaluation or in the midst of treatment. This can occur in an outpatient or inpatient setting. The patient may be of any age, i.e., child, adolescent, or adult. Because suicidal patients may be intentionally or unintentionally successful in their suicidal efforts, they require the most cautious and considered management. The rising tide of suicide among our youth, in addition to suicide as a common cause of death in our adult population, attests to the pressing need for enhanced clinical skills to help the suicidal patient. Lesse believes most suicides are avoidable with adequate assessment, prediction, and intervention. He openly states that many professionals do not have the range of clinical skills or access to clinical facilities to appropriately handle these patients. There is an assertion that some therapists are not emotionally suitable for treating suicidal patients. Such therapists may contribute to the patient's death because of the therapists' unconscious attitudes. As an example, the therapist may deny the seri-

ousness of a patient's mental state and not intervene in a timely fashion, or the therapist may unconsciously support the patient's suicidal attempt. This book was written to help build the reader's "diagnostic sensitivities, therapeutic acumen, and overall management skills . . ." (p. x).

The book is a composite of twenty-six well-selected chapters. Although the material of these chapters was written or presented between 1969 and 1986, the diversity of subjects and the comprehensiveness of each chapter is impressive. The material is well-balanced between theory and clinical vignettes. There are three basic sections entitled, "Understanding Suicide," "Treatment," and "Children and Adolescents."

Part I looks at biological and emotional causes of suicide by examining genetic factors in suicide and depression, learned suicide behaviors, the prediction of suicide, the current controversial social issue of rational suicide, suicide in the hospital setting, suicide in manic-depressive disorder, double suicides, and even eroticized repetitive hangings. This latter chapter is quite provocative. The author integrates issues of the psychological and the neurocirculatory mechanisms, and stresses the repetitive nature of this particular masturbatory conduct. Tragically, there are some deaths each year from repetitive hangings, even though the individuals may not have consciously intended to die.

Part II addresses psychopharmacology; electroconvulsive therapy; various psychotherapies, including an excellent chapter on cognitive therapy; and suicide precipitated by psychotherapy. The authors of a chapter called "Guidelines for 'Suicide-Proofing' a Psychiatric Unit" interestingly turned to hospitalized suicidal patients to help them ensure the safety of the unit. The patients were quite happy to answer the doctors' questions about what techniques they would employ to prevent suicide in the hospital. The patients' answers helped the patients and staff to suicide-proof the psychiatric unit. The inquiries did not aggravate suicidal ideation.

Part III looks at children and adolescent suicides, student suicide, the family systems of suicidal children, and various modalities to treat suicidal children and adolescents. An especially interesting chapter on depressed, hospitalized preschoolers presents material on severely depressed preschool children with active suicidal attempts. These children had parents who were diagnosed as suf-

fering from problems falling in the depressive spectrum and at times involving substance abuse. The children had been exposed to a depriving, rejecting, abusive, punitive environment. In the four clinical vignettes the authors present, all four children required removal from their parents' home.

Lesse does meet his goal of presenting an organized, well-written collection of papers on the multifaceted problems of evaluation, prediction, and treatment of suicidal patients. I can strongly recommend *What We Know about Suicidal Behavior and How To Treat It* as an important source of information for mental health professionals, regardless of the style or setting of the professional's practice.

EDWARD H. TOBE (CHERRY HILL, NJ)

PSYCHOANALYSIS AND THE NUCLEAR THREAT. CLINICAL AND THEORETICAL STUDIES. Edited by Howard B. Levine, Daniel Jacobs, and Lowell J. Rubin. Hillsdale, NJ/London: The Analytic Press, 1988. 290 pp.

After the second world war, psychoanalysts generally narrowed their focus almost exclusively to personal psychological distress and its treatment.[1] With the exception of child care, at least in the English speaking world, psychoanalysts rarely asked for or received hearings on the great social and political issues. The threat of nuclear holocaust has aroused a group of analysts to attempt a more active contribution to society, to try to apply psychoanalytic insights to literally save the world. The nobility of the task should not blind us to the limitations of their methods and results, nor should the enormity of their undertaking and the unlikelihood of success obscure its importance.

In well-written essays, the authors explore the nuclear threat from many viewpoints. The first set of essays examines theoretical issues. Does the deployment of a way to destroy life support the idea of a primary destructive impulse in man? Is that impulse so strong that nuclear war is inevitable? Sanford Gifford discusses the place of the death instinct in Freud's thought. Hanna Segal provides a clear and compelling description of the manifestation of a

[1] Jacobi, R. (1983): *The Repression of Psychoanalysis*. New York: Basic Books.

death instinct that is close to clinical experience. How does apocalyptic thinking operate and contribute to the danger of nuclear war? Janine Chasseguet-Smirgel and Mortimer Ostow show how the ancient idea of purification through destruction re-emerges in the statements of contemporary political leaders, most notably Ronald Reagan, and they demonstrate how nuclear annihilation can make psychological sense in an apocalyptic context. What defensive operation can be at work to lead people to contemplate and arrange the end of humanity? W. W. Meissner and Vamik Volkan examine the role of paranoid processes that lead to a world view that includes implacably dangerous enemies to whom the only reasonable response is nuclear war. Each author, but especially Segal, discusses the centrality of denial. What is the role of gender? Malkah Notman observes that war is men's business, and she explores the role of gender in thinking about and attitudes toward nuclear war.

The first group of essays offers useful psychoanalytic speculations. Many of them, incidentally, provide excellent brief summaries of important theoretical positions developed by their authors in other contexts. In all these views the processes that support the continued nuclear threat are seen as primitive and archaic. Judging from these papers, those who support nuclear armament—from presidents to technologists to the beer-guzzling masses—are clearly insane. Comprehending the nature and motives of the insanity may provide a step toward salvation. Hubris pervades these chapters.

In their horror at the consequences of such thinking, the authors treat those in power as though they were entirely irrational and thoughtless. The papers are sparse in data and certain that the reasoning of those favoring nuclear armaments is mere rationalization. This is unfortunate, since data is available about the modes of thinking of nuclear strategists.[2] The very power of some of the explanations limits them—it disrespects the complexity of the situation.

Blema Steinberg, a political scientist, is the only author in this volume to use a satisfactory and comprehensive appreciation of the issues. Attentive to the interaction of multiple forces, internal and

[2] Nolan, J. (1989): *Guardians of the Arsenal*. New York: Basic Books.

external, that are operative in shaping nuclear policy, Steinberg warns analytic colleagues that their insights will only contribute to peace when they address the full spectrum of motives and psychological operations at work in the nuclear situation.

A second, more modest, section of the book addresses clinical issues. A repeated, easily confirmed finding, emphasized by Henri Parens, is that patients rarely make reference to nuclear war. When nuclear war does come up, it is usually as a metaphor for internal catastrophe. Why is this? Are the anxieties, defenses, and countertransference responses to the nuclear threat so great as to pervasively impede the emergence of these issues in analyses, as Martin Wangh suggests? In particular, as Lowell Rubin argues, is a failure of the capacity to mourn central to a failure to address the probable destruction of the world? Have analysts and the community who use us become so focused on personal "mental health" that we implicitly support a narcissistic indifference to the larger community? Daniel Jacobs asserts that "in our daily clinical practices, we have not paid sufficient attention to the way in which our patients, by pursuing through love and work their own happiness, have failed to identify themselves with the larger human community . . ." (p. 177). Does the common psychoanalytic focus on independence impede the appreciation of necessary interdependence? John Mack addresses the analyst's mode of listening and interpreting material about nuclear war and activism. There are many clinical puzzles. When is external reality best understood as a defense against internal reality? When does a too exclusive focus on inner life reflect an avoidance of the external world or pathological self-preoccupation? How do the analyst's views on matters like nuclear war and activism affect the analytic process and what is the optimal technical management of these effects? Yasuhiko Taketomo describes the decompensation of a woman who lost her family in Hiroshima. It confirms the finding that massive psychic trauma leads to denial rather than working through, with dangerous consequences not only for the individual but for humanity's capacity to learn from the most horrible events.

These clinically based essays, though more modest than the theoretical ones, come closer to what the analyst can contribute to understanding the nuclear situation. When we are confronted with real people and our own dilemmas in dealing with them, the mi-

croscopic exploration of the psychology of action and inaction provides us with unique data about how people respond to or avoid external realities and how historical situations interact with personal experience. The complexity of the clinical encounter that mirrors and provides us with insight into the complexity of living and forces on us an appreciation of how people doing their very best can come to destructive and maladaptive conclusions might help enable us to make some contribution to understanding and controlling the nuclear threat.

ROBERT M. GALATZER-LEVY (CHICAGO)

"CATCHING THE DRIFT." AUTHORITY, GENDER, AND NARRATIVE STRATEGY IN FICTION. By Laura Tracy. New Brunswick, NJ/ London: Rutgers University Press, 1988. 229 pp.

Patients talk, analysts listen; writers write, readers read. Within this grid of human activity a new literary criticism can be plotted, according to Laura Tracy in "*Catching the Drift*." Tracy examines the novels of Jean Rhys, Ford Maddox Ford, Nathaniel Hawthorne, and Jane Austen, with briefer forays into the short stories of the contemporary writers Grace Paley and Alice Munro. She employs an often bewildering combination of psychoanalytic, feminist, and reader response theories to fashion her argument:

> Transference guides the relationship between the analysand and analyst, as the former perceives the latter through a screen of unconscious conflicts and desires originally experienced with important figures in early childhood. In brief, transference means unconsciously fictionalizing the present according to a narrative created in the past. . . . Similarly, writers imagine, consciously and unconsciously, readers for their work (p. 188).

This review focuses on Tracy's arguments about Jane Austen; however, the problems she runs into with Austen are inherent in her general theoretical approach, and so resurface with all the writers she deals with: "to understand the transferred attitudes Austen brought to her imagined reader, then, one must first examine the ruptures in her canon, through which ideas excluded from her conscious awareness are visible" (p. 138). While noting a number of "anomalies" in Austen's work, she focuses on the omniscient narrator, who frequently paraphrases crucial dialogue or inner reflections of the heroine, or offers general reflections on

courtship and marriage, the central themes in all the novels. Tracy argues that readers' intense emotional reactions to this narrator—they either love or hate her—reveal Austen's unconscious reasons for creating her, just as an analyst's countertransference may shed light on the patient's transference. The reader recognizes in the narrator a strong assertive voice that embodies female autonomy and authority. At the same time, the reader also feels overwhelmed and overcontrolled by this too-good mother/narrator, and perhaps a bit rebellious as well. Direct access to the main protagonist is denied the reader, because the protagonist is denied direct speech of her own, and is instead filtered through the narrator. Moreover, while the narrator embodies the assertive woman, she also brings about overly neat happy endings that reinforce the oppression of women in early nineteenth century rural England. The result is a reader who may be delighted but who also feels manipulated and oppressed.

Why does Austen create such a double-dealing narrator? To begin with, she was liberated, but not quite liberated enough, at least by modern standards, although she comes close in her final novel, *Persuasion*. Austen was a professional writer, and so challenged a usual view of a woman's "proper" role as daughter, wife, and mother. At the same time, she was ambivalent about her autonomy and artistic creativity. We readers know this because we discern her ambivalence through the "ruptures" in her work, such as the oppressed narrator and her happy endings, or the banishment of evil heroines from Austen's restored rural societies. Austen was also apparently unaware of the late twentieth century notion, prevalent in the higher reaches of the academy, that all readers are—or should be—co-authors of the texts they read.

Having found Austen culpable on both these counts, Tracy then turns to genetic reconstructions, and we are off and running in that highly entertaining sport known as wild analysis. Drawing on Melanie Klein's notion of the repressed "bad mother," she tells us that Austen "projects onto her protagonists and imagined reader her own unconscious feelings in regard to female authority, placing the protagonist in the position she herself inhabited as a child" (p. 149). Drawing on Winnicott, Tracy describes Austen as similar to her evil heroines. In rejecting and silencing them, "Austen also was silenced and made to comply with the value

structure of the community in which she lives." She developed a "false self" because of an alleged failure "in the early childhood nurturing relationship" (p. 142).

Add to this Rube Goldberg concoction of psychoanalytic speculations a few biographical fragments, like the fact that Austen was sent to a wet nurse and so was "overmothered," or the theory that she had Addison's disease caused by the stress of having to "admit her power in the world," and the psychohistorical sourcebook of narrative parapraxis is presumably complete.

Or is it? Perhaps Elizabeth Bennett of *Pride and Prejudice* can guide us in assessing Tracy's work when she says: "I hope I never ridicule what is wise or good. Follies and nonsense, whims and inconsistencies do divert me I own, and I laugh at them whenever I can." To start with what is wise and good in this book, there is much here that resonates with clinical experience. In trying to understand our patients, we do use the same skills we use in a close reading of fiction. We attend to patterns in the analysand's associations, such as repetition of themes, tone of voice, shifts in mood, choice of diction, and the discrepancies between what is said and how it is said. Silences and disruptions do signal the advent of interpretable transference. But despite these attractive coherences, is there such a fundamental unity between reading a novel and analyzing a patient as Tracy asserts? If there are serious fissures in that alleged unity, then the legitimacy of applying psychoanalytic concepts to literature is in doubt.

One must begin with what is obvious, since the obvious is often overlooked when the boundaries between disciplines are blurred. Real living people can be psychoanalyzed; long-dead historical figures, like Jane Austen or Nathaniel Hawthorne, cannot be. The most difficult and the most exhilarating lessons of clinical work are one and the same: the analyst cannot know the unconscious meanings of surface phenomena in a patient's life until the patient provides more or less free associations concerning them. We are at our best as analysts when we resist the facile leap from consciously known data to unconscious significance, and instead travel carefully on that bridge which is the center of psychoanalysis, free association. We are wary about assigning unconscious meaning to *any* known fact, be it historical event, career choice, or dress style, or to a penchant for writing novels with an all-knowing narrator, until

the patient provides associations. Jane Austen is not a patient, and has not done so. Consequently, the attempt to see unconscious conflict in her narrative preferences is little more than a simple projection of the favorite ideologies of the critic.

Tracy states that as Austen "progressed" over the course of her career, she permitted her reader to be a more active participant in the creation of the heroine and text. In *Persuasion*, the happy ending is more ambiguous and more open to elaboration by the reader; Anne Elliott is a more autonomous, complex, and modern heroine, and thus a more therapeutic role model for the modern reader. The dialogue that liberates heroine/sister liberates reader/sister. Tracy attributes this shift to Austen's growing, though incomplete realization that daughters—fictional or real, in novels or reading them—must be freed from the benign narrator who reinforces the solutions and certainties of patriarchal society. This move away from narrative fracture into literary and psychological egalitarianism is Tracy's main evidence for her thesis. Obviously, this is "evidence" only if one shares Tracy's feminist view that any culture that values clear gender differentiation, or that upholds the roles of wife and mother for women, is oppressive to women, *by definition*. For the reader who might not share these presuppositions, the argument is not persuasive.

Also, while Tracy emphasizes a change in Austen's work toward a more independent heroine, it is important to remember that *all* of Austen's novels are social satire, and so are inherently questioning of the status quo. For example, both Elizabeth Bennett and Charlotte Lucas in *Price and Prejudice*, Austen's second novel, are fully aware that Charlotte's marriage to the pretentious clergyman, Mr. Collins, is for the sole purpose of gaining an "establishment," so crucial in a society that offered women no alternatives to marriage. The narrator says: "She [Elizabeth] had always felt that Charlotte's opinion of marriage was not exactly like her own, but she could not have supposed it possible that when called into action, she would have sacrificed every better feeling to worldly advantage. Charlotte the wife of Mr. Collins, was a most humiliating picture!" This is as questioning and feisty a narrator as one could ask for.

Tracy gives short shrift to alternate explanations for Austen's move to a more open narrative. Such a change may have been

equally due to general developments in narrative technique as a whole during the time Austen was writing. However, as is common in much psychoanalytic literary criticism, such historical trends are barely mentioned and "deeper" intrapsychic explanations are given automatic priority.

Tracy's arguments are also problematic from a more strictly literary point of view. With regard to the heroine of *Persuasion*, she states: "Anne . . . becomes a collaborator of the novel and, as surrogate for Austen's imagined reader, offers the reader the invitation to . . . become a cocreator" (p. 174). This implies that Anne Elliott is real, an agent of her own fate. It grants a reality to a fictional character which she simply does not have. Whether Austen uses the ubiquitous narrator or dialogue, her characters are still wholly her creations. They exist only because she has authored them, and have no life outside the printed page. This is true even if Austen did base her fictional characters on friends or relatives in her own life, as most writers probably do. To miss this crucial difference is to confuse life and art, to the detriment of both. Similarly, while a sensitive reader may bring new understandings to any great text, that does not make her a "cocreator" of the text. Willing recognition of the authority of genius, and submission to it, is not necessarily self-oppression.

This leads to another important disjuncture between reading a novel and listening to a patient. When we read a fictional text, we hold a book in our hands that has a title and that was written by a particular person at a particular time; it is *that* text and no other. Deconstructionists would protest, given their view of language, that every text also contains what it excludes. Too, analysts have long been interested in the antithetical meaning of words, going back to Freud's paper on the topic. Nonetheless, *Pride and Prejudice* still opens in 1991 with: "It is a truth universally acknowledged, that a single man in possession of a good fortune, must be in want of a wife," just as it did in 1813 and just as it will in 2091. Of course, bibliographical research may, on occasion, correct the received text. More importantly, every new era brings new readers and new understandings of any text that enrich its significance as a work of art. However, the text is fixed; it contains certain words and not others, within a structure that is not all structures. The joy

of close reading is returning to the same text again and again, each time noticing new elements that lead to new interpretations. Yet, paradoxically, all those elements were there on first reading, as were all the interpretations, at least potentially. It is the very sameness of the text through time that *permits* different interpretations to be made.

Contrast this with the analytic situation. While it may, at times, be a helpful technical stance to view the analysand's associations as a story, there is still no text in a psychoanalysis, in the ordinary meaning of the word *text*. Rather, there is an interactive verbal and oral process, moving through time and altering itself as it goes. Even if we record and then transcribe every word in an analysis, there is still no text, because no analysis is just words, though they are at its core. Also, the analysand's words will vary, in subtle and not so subtle ways depending on who the analyst is. The words on the pages of *The Blithedale Romance* or *Emma* do not change for each new reader. Too, we instruct patients to say whatever comes to mind, and not to withhold any thought for any reason. Writers do not work that way. Also, the analyst has certain ethical and professional obligations with regard to the analysand that no writer has toward a reader and no reader has toward a text. The social and legal context that legitimates psychoanalysis and the purpose for which it is undertaken are very different from those of writing or reading novels.

All this is to say that there is an immanence to actual clinical work that makes it real in a way that fiction cannot be real. Why else would we refer to fiction as art, and value it precisely because it is *art*? This does not mean that literature has nothing to say about reality, nor does it mean that Jane Austen's readers cannot profitably apply some of her lessons to their own personal lives at the same time they are delighted by her wit. Nor does it mean that psychoanalysis does not have "fictions" of its own. It *does* mean that however evocative the metaphor connecting psychoanalysis and literature may be, we need to guard against forgetting the differences, lest we confuse appearances with what is true. By the way, that's what Jane Austen's novels are all about too.

PATRICIA A. WESLEY (NEW HAVEN, CT)

WHO WILL BENEFIT FROM PSYCHOTHERAPY? PREDICTING THERAPEUTIC OUTCOMES. By Lester Luborsky, Ph.D., Paul Crits-Christoph, Ph.D., Jim Mintz, Ph.D., and Arthur Auerbach, M.D. New York: Basic Books, Inc., 1988. 416 pp.

The contributions of Luborsky and his associates in this book constitute a significant advance in systematic empirical research. The authors describe the development of their research methodology for the study of the therapeutic process and the achievements resulting from its utilization in the Penn Psychotherapy Project.

The Penn Project addressed the question of the predictability of therapeutic outcome through studies of pretreatment qualities of therapist and patient and the interaction of the participants in the therapeutic process. The 73 subjects were a varied group of nonpsychotic patients, chiefly outpatients in a clinic setting. The therapists differed widely in experience but shared a psychodynamic orientation. Of the 42 therapists, 12 were characterized as Freudian and 32 as eclectic. The treatment was generally described as of medium length, with 8 sessions a minimum for inclusion in the study and 32 sessions the median. Two-thirds of the patients were moderately to much improved by the measures of outcome. None of the patients were seriously worse after treatment.

With regard to methodology, three approaches among a wide array proved most useful. The health-sickness rating scale served as a measure of outcome. Helping alliance scales were used to determine and follow the nature of the therapeutic alliance. Luborsky introduced his most creative measure, the examination of the Core Conflictual Relationship Theme, to study the process itself. The CCRT method identifies recurring patterns in the patient's narrative as the unit of study. Each unit consists of an expression of the patient's wishes, the response of the other person, and the patient's response in turn. The method thereby explores relationships and conflict in the same narrative segments. Transference and countertransference phenomena are obviously included in the data but are not specified as such. The CCRT patterns are found to be consistently present throughout the process of treatment, with changes observable in relation to methods of coping and the pervasiveness of conflict.

With regard to the findings, while treatment outcomes could be

significantly predicted from pretreatment information, the correlations were small. Only 5-10% of outcome variance was predicted. More crucial predictive factors were demonstrable when the interaction between patient and therapist was the focus of study. The two major findings in the process of treatment were: (1) a positive relationship and involvement in the process predicted a good outcome, and (2) congruence between the CCRT and the content of interpretations correlated with changes in psychotherapy outcome.

The research literature comparing different types of psychotherapy does not point to significant differences in their outcomes. Most of the research efforts are nondynamic and tend to support the orientation of the researcher. In this context, the development of a technique to study and confirm specific dynamic factors positively correlated with outcome is a remarkable achievement. The authors offer as well a critique of their instruments and conclusions in preparation for further studies.

In developing the helping alliance scale, it was apparent that there was a problem in differentiating the positive transference from the alliance. In an attempt to address this problem, they divided the helping alliance scale into two types. In Type 1, the patient expects help in the form of support; in Type 2, the concept of help is defined as working together to understand and resolve conflicts, thereby providing tools for the patient to help him/herself. The authors present a sample of clinical outcome sketches (3 among the 10 most improved and 3 among the 10 least improved) to illustrate the various experiences in psychotherapy. They acknowledge that there was limited evidence of insight as a mechanism of change among the most improved cases, while insight was insignificant among the less improved patients. While Type 2 has more of the ring of an alliance, as differentiated from a positive transference, the limited significance of insight in the sample cases cited raises a question about the degree to which the collaboration in a Type 2 helping relationship was distinct from a positive transference.

Two additional positive findings with regard to the helping alliance are worthy of note. Therapist-selected cases had a better outcome than randomly assigned cases. Similarities in social class, interests, and values and compatibility in interpersonal relations constituted a match between therapist and patient and were positive

factors. The concept of the match is not limited to conditions that would presumably facilitate empathy and understanding. Discussion of the concept of the match is further elaborated in the following manner: what the patient wishes for and expects in a relationship and his or her perception of the therapist's characteristics and responses should match. For the patient who fears dependency, the therapist may function appropriately as a "brick wall"; the same therapist would not be a match for the patient with a fantastic fear of being brushed off and a need to be drawn out. The distinctions between Type 1 and Type 2 helping alliances are blurred in this discussion, since the emphasis seems to shift to essentially supportive measures in these "medium-length" treatments.

The effort to put into operation measures of insight and self-understanding remains a difficult task. In view of the limited function of insight in this study, it is remarkable that congruence between the CCRT and the content of interpretations proved significant. It is not surprising that there was no confirmation that a gain in self-understanding was related to a more favorable outcome. The studies on self-awareness were done in sessions 3 to 5 and would therefore be more a measure of the therapist's diagnostic understanding than of self-awareness in the patient.

The research perspective in this volume conforms to the purpose of the research—the rigorous testing of the assumptions of practice. The authors suggest correctives for problems encountered: more precise measures of improvement, treatment manuals, matches in studies for psychopathology, matches for therapist skills, and the match of the type of therapy to the patient's problems.

In addressing the issues of the helping alliance and repetitive patterns of conflict and relationship in the therapeutic process, the authors have created a common ground in the area of study for clinical research and experimental research. Furthermore, their conclusions bear a striking resemblance to the conclusions in our follow-up research,[1] in which cycles of conflict were seen to be repetitive in the analytic process. Repetitive themes correspond to

[1] Schlessinger, N. & Robbins, F. P. (1983): *A Developmental View of the Psychoanalytic Process. Follow-Up Studies and Their Consequences*. New York: Int. Univ. Press.

cycles of conflict. These large cycles of conflict persist throughout treatment; and the measure of change involves methods of coping with conflict. Predictions of outcome remain very difficult, and each therapeutic experience continues to have the quality of an adventure.

The work of Luborsky and his colleagues has unquestionably brought clinical and empirical research into closer conjunction, with prospects of improved communication and cooperation. Has it eliminated the divergences in goals and methods between clinical research and experimental research? Of course not. Efforts to prove or disprove specific assumptions in practice require a narrowing and sharpening of focus and the development of conditions for consensus among judges. Treatment manuals have proved to be increasingly necessary to achieve reliability and validity. In clinical practice, the study of outcome rests more on the usual functions of the analyst in single case studies, and the effort is more directed at discovery than at proof of assumptions. In analysis, new techniques and theoretical propositions and changing perceptions of diagnosis and process emerge from such clinical research. This attests to the vitality of the method and to its contribution to psychotherapy as a form of applied psychoanalysis. Divergences in goals and methods do not detract from the significance and usefulness of these separate endeavors in the pursuit of scientific progress.

NATHAN SCHLESSINGER (CHICAGO)

THE CREATIVE PROCESS OF PSYCHOTHERAPY. By Albert Rothenberg, M.D. New York/London: W. W. Norton & Co., 1988. 210 pp.

Albert Rothenberg views psychotherapy through the lens of the creative process. He looks at the complex acts of creativity in psychotherapy, the similarities between creative acts in the arts and psychotherapy, and the mechanisms of creativity. He believes that the therapist's special sense of engaging in a worthy activity derives from its creative aspects—specifically from the paradoxical mixture of consistent rigor and free rein intuitiveness. He has studied creative people in the arts and sciences, has reviewed manuscripts

of writers, has conducted a series of experimental studies, and has compared all this with the creative process in psychotherapy.

Rothenberg describes two special types of cognitive, motivational, and affective processes which he sees as operating at all phases of the creative act: (1) the homospatial process, which is an active conceiving of two or more discrete entities occupying the same space, leading to the articulation of new identities; and (2) the janusian process, which involves looking both forward and backward and which consists of actively conceiving two or more opposites simultaneously.

Rothenberg defines three functions of the homospatial process in art and psychotherapy: (1) the creation of effective metaphor in which the dissimilar or disparate elements in objects are equated in a dynamic interaction with one another, which heightens the appreciation of both and provides metaphor with its affective power; (2) the creative use of empathy and empathic understanding, which derive closely from the initial construction of "feeling into" another subject: the therapist conceives her or his self-representation together with that of the patient, in the same space, and the understanding of the patient's preconscious concerns that ensues allows the therapist to formulate a verbal interpretation; and (3) serving as a mirror to decode unconscious processes. This is a reversal of dreaming functions, such as condensation.

In the janusian process, the therapist conceives, in an actively formulated leap of understanding, simultaneously operating opposites or antitheses regarding the patient's mental functioning and behavior. The author traces janusian thinking in Freud's ideas about transference and countertransference. The janusian processes are also involved in the creative interventions of paradox and irony. A paradoxical intervention is a dramatic, enacted form of interpretation that serves to disrupt ingrained patterns. Irony also manifests an antithetical structure, and this makes it nonhostile as well as therapeutic.

Rothenberg uses the term "articulation" to refer to the patient's act of selecting and choosing new patterns of behavior. He sees it as similar to the way the artist chooses to produce new patterns of form and content. It is the patient's response to the therapist's focus on form and structure. Both janusian and homospatial processes involve articulation—the janusian of propositional ideas,

and the homospatial of mental imagery. Articulation of error is the use of the creative process to understand errors, rather than correcting them; it is not trial and error thinking. Artists seek their humanness or individuality in the errors they make, and a special orientation to error is intrinsic to the creative process. Errors may provide an additional route for unconscious material to appear in creative works. Transference is an error: feelings about one person are transferred to the presence of another. One aspect of working through and resolving the transference is recognition of errors and distortions about the therapeutic situation and about the therapist.

Rothenberg states that in psychotherapy the creative process emphasizes worth, innovation, and volition for both the therapist and the patient. The patient's major role in this endeavor resides in choosing new patterns of behavior. It is the therapist's creative activity that effectively instigates the mutual creative process, and a trial domain becomes available for the patient. Understanding is the core facilitator of creativity, and it results from the use of homospatial and janusian processes. Therapists' creative love for the human materials of their work is similar to that of the creator in any field.

This is a problematic book. Its strength and its weakness is that it attempts to view psychotherapy solely from the viewpoint of creativity. The author raises a number of new and interesting ideas: the homospatial and janusian processes; articulation; articulation of error; and the creative parallels between psychotherapy and artistic productions. However, his view of psychotherapy seems to be one dimensional—not the creative process in psychotherapy, but creativity as a theory of psychotherapy.

Creativity ends up as a theory of technique. Rothenberg recommends that therapists study psychological approaches to creativity, with the implication that this will improve their abilities as therapists. The multidimensional concepts of resistance, conflict, transference, character traits, ego strength, instincts, etc., are reduced to the act of creativity. With this approach, creativity winds up being sterile.

Rothenberg wants to separate the janusian and homospatial processes from the primary process, regression in the service of the ego, compromise formation, and conflict. He sees these functions as *intentionally and consciously performed acts.* In discussing an ex-

ample of janusian patterns and themes in psychotherapy, Rothenberg believes that the therapist's insight was not an unconscious welling up, or a theoretically derived construction, but a conscious connection of opposites. He does not deny the role of unconscious material, but he strongly argues that the attainment of insight in this case resulted directly from the operation of the creative janusian process. Rothenberg's case would be stronger if he argued that he was trying to describe the ego mechanisms that operate in creativity, but instead these mechanisms become almost the totality of conscious and unconscious processes. This makes them flat and separate from other mental processes.

The author argues against what he refers to as "traditional psychoanalytic thinking." He does not define what he means by this, but he seems to need a straw man he can knock down. It is not a sophisticated argument with specific examples or points of disagreement, but rather a sweeping generalization that seems to include the topographical and structural models, as well as all of ego psychology. Resistance, conflict, and hostility play a limited role in his thinking. Instead, there is an upbeat, positive emphasis on creativity as expressed in mutual articulation by therapist and patient.

The writing is also problematic. When the author is describing specific psychotherapies and the experience of different artists in creation, the material is clear and convincing. When he is describing the theory behind his thinking about creativity, the writing can be dense, turgid, and on occasion, incomprehensible. There is a contradiction between the creative acts the author is talking about and the jargon-filled theoretical writing.

This book presents many interesting ideas about creativity and about creativity in psychotherapy, and it contains good examples of creative acts in the arts and in psychotherapy. However, as a theory of the technique of psychotherapy, the author's case is not convincing.

ROY GINSBURG (STANFORD, CA)

INTRODUCTION TO PSYCHODYNAMICS. A NEW SYNTHESIS. By Mardi J. Horowitz. New York: Basic Books, Inc., 1988. 252 pp.

This book is the result of much scholarly effort, clinical experience, and research, especially involving post-traumatic stress disorder. It

grows out of the author's long-standing dissatisfaction with classical psychoanalytic theory. Mardi Horowitz aims to synthesize a wide range of psychodynamic theories, but especially ego psychology and object relations theory. He wishes to integrate the concepts of the cognitive sciences and, ultimately, to introduce an advance in theory, expressed by a new language.

In a chapter entitled "States of Mind," Horowitz defines psychodynamics as focusing "on why maladaptive states occur" and why one cannot "enter or sustain a desired state of mind" (p. 13). One assumes that the noun form, "psychodynamics," as used in the title of the book, is the name of a new theory and that its use is different from the usual use of the word as an adjective describing one metapsychological point of view of psychoanalysis. Its use seems to have the purpose of replacing psychoanalysis as a term and as a theory.

In using the term "state of mind," Horowitz expands on Eric Berne's term "ego states," which Berne used interchangeably with states of mind. Berne credited Paul Federn with the term and with the concept, which referred specifically to the notion that psychosis does not represent the total functioning of the ego but only a particular ego state. Berne based his transactional analysis on this concept, and by eliminating the id, he schematized the mind into "child," "adult," and "parent," as representing ego states which compete with or intrude on each other. Horowitz tells us that he was once pressed to choose between his personal psychoanalysis and therapy with Berne, which were ongoing simultaneously. It does seem that an attempt to reconcile the two positions finds expression in his formulations.

One finds here a conflict model of the mind in which symptoms are compromises between impulse and defense. This sounds like standard psychoanalytic theory to this point. But the impulse here is not toward an object; it is toward a desired state of mind. What is feared is not a danger situation, such as loss of love or castration, but a dreaded state of mind. Thus, in an example, a young man wishes for exhibitionistic excitement in his work but fears the shameful mortification of failure. The compromise is a state of ruminative rehearsal, that, according to Horowitz, does not include expressions of drive derivatives. A practical problem for the analyst with this formulation is that a patient's complaint may be the fear

of a dreaded state, such as panic or despair, that serves to avoid object-directed wishes. By taking the complaint at face value, the analyst supports a resistance.

Horowitz does caution against discarding the drives. This seems to be for theoretical reasons only. In examples, he does not include drives as motives. He intends to discard the structural model as unwieldy. He states correctly that "the id is not the same as the repressed because the ego functions of representation and memory are involved in ideational form of urges. Superego values are also involved in the repressed conflictual thematic conflict" (p. 34). As explanation, however, this hardly seems to justify discarding the structural model. It was for good reasons that Freud evolved this model, with its openness between structures and freedom from the false schematization inherent in the earlier topographic model.

Horowitz seeks to replace the structural model with a schema model; the reason given is that the words, "id, ego and superego," are "global." Instead, he introduces the terms motivational schema, self-schema, and value schema. Motivational schemas are defined early on but do not appear in the examples. Self-schemas are defined as self-representations, particularly those that are not available to consciousness. The ego as executor is replaced by the person as a whole. Value schemas do not have the power of the classical unconscious superego, with its expression of the id. Sometimes his language is not consistent, as when a strong self-schema represses a weak one, in which case the decision to repress and to maintain the repression must reside in the schemas themselves.

On the basis of the introductory description of primary and secondary processes, the use of the concept "schema" seems justifiable as filling a theoretical gap. However, the description falls short of the wide spectrum from primary process to full secondary process thinking. There is a whole range of immature secondary process distorting cause and effect, the explanation of sexual differences, etc., underlying the wishes and fears generating unconscious fantasy.

In the section that develops object relations theory, there are echoes of Berne and his language, for example, in the use of the words, "transaction," "ploy," and "script." The schema for object relations is called "role-relationship model." The theory allows for

many levels of schemas, from primitive to high-level role-relationships, within the same individual. Transference is conceptualized as one form of role-relationship model. Here also considerations involving role-relationship models and transference are devoid of attention to wishes toward original objects. They emphasize instead the learned aspects of relationships with them. This leads to a learning and unlearning view of the treatment process. Some of this must and should occur in every psychoanalysis, though it tends to be much more the characteristic mode of action of superficial psychotherapy; and it often leads to the therapeutic effects characteristic of the inexact interpretation. Horowitz states that by practicing a new working model, one is gradually desensitized to fear and other painful emotions associated with stressful new experiences and that outmoded ways of doing things gradually become dormant.

This conception of the mode of action of treatment is evidenced clearly in one of the last examples. A sexually inhibited woman provides a history of having grown up with a seductive father. In the therapy, she learns to differentiate the therapist's intentions from her father's. When she was a girl, her father would enter into long discussions with her while he was nude. There is no indication that the patient has ever had wishes to see the therapist nude, or to possess his penis, or to castrate him. There is no indication that insight into these kinds of impulses serves to relieve her inhibitions. Instead, in her treatment, the author formulates that she learns to exclude her defective body schema at times of difficulty in her current relationships. This sounds like a technique employed by cognitive therapists; and it can be understood as suggestion.

Because so much that is essential to psychoanalysis is missing in this theory, and because the utility of the new language created by Horowitz is highly questionable, it is unlikely that this book will be helpful either to the beginning or the experienced psychoanalyst.

ERIC LAGER (PHILADELPHIA)

THE PSYCHOANALYST IN PSYCHIATRY. By Thomas Freeman. New Haven: Yale University Press, 1988. 198 pp.

This reviewer had a very mixed reaction to Freeman's book, which reports on a senior psychoanalyst's work with seriously ill, hospital-

ized psychotic patients. The first half dozen chapters provide detailed descriptive material on the symptoms, primarily delusions and fantasies, of psychotics, together with some low-level clinical explanations of them. The remainder is a relatively brief miscellany of specialized chapters on organic mental states, developmental considerations, and the theory of neurotics, borderlines, and psychotics. They are less integrated than the first six chapters and seem almost deliberately minimal in their exploration of essential issues. But the writing is clear, well focused, free of jargon, and easy to read.

Freeman thinks reductionistically about psychopathology, although his ideas are internally consistent. His therapeutic approach tends to be parsimonious and low key, but somewhat categorical and abstract with respect to the content of interpretations. He uses a classical approach of facilitating regression to encourage a transference neurosis that can be examined and resolved. His ultimate aim is more than symptom relief; he attempts to reinstitute derailed libidinal development.

Freeman traces psychotic symptoms to vicissitudes in the development of the libidinal instinct, especially the oedipal experience. Thus, fantasies (and "actual" events) involving incest, castration anxiety, penis envy, primal scene phenomena, and other universals become the ultimate basis for explaining the steps that lead to a psychotic breakdown. The immediate precipitants of the breakdown are described, with but passing reference to vulnerable character flaws or unfavorable life circumstances. But the "final common pathway" for psychopathology remains unfavorable developments involving the oedipus complex.

Freeman states, in the Introduction: "Other benefits are to be gained by moving from the neurotic patient to the psychotic patient and vice versa. For this concurrent work confirms the oft reported observation that the wishes and fears of the psychotic and the non-psychotic patient are basically identical" (p. 1). Of course! But how is this pertinent? One wonders how many psychoanalytic researchers at institutions such as Chestnut Lodge or Menninger's would be satisfied with this statement. Are there not psychotics for whom the vicissitudes of earlier development have resulted in profound early distortions and deficits, particularly with respect to the management of affects and the processing and making sense of the

data of experience? For them, vicissitudes of the oedipus complex are insufficient to explain either their extremely flawed personality structures or the events that lead to their psychotic breakdown.

Freeman implies that a single array of motives and a single developmental path explains psychosis as well as neurosis and forms an adequate conceptual basis for a treatment model applicable to both. He does not consider the possibility that clinging to oedipal dynamics might serve a restitutive function aimed at making some kind of sense out of the disaster of a psychotic experience. Nor does Freeman consider the possibility of transference compliance by the patient with his (oedipal) thesis.

In the chapter on the organic brain syndrome, Freeman utilizes the "releasor" theory of Hughlings Jackson: as higher cortical and immediately sub-cortical centers are compromised by an organic dementing process, motives and mechanisms belonging to lower centers are "released" in the form of primitive, uncontrolled sexual and aggressive wishes and fantasies. Freeman ignores current "systems theory" neurological thinking about the very complex manner in which perceptual data are processed and assigned meanings. He also does not consider the possibility of the ego defense of expressing primitive excitement to prove that one is still alive and able to function "somehow."

Freeman's basic therapeutic approach, relatively the same for all three major categories, seems to me to depend for its success on an unacknowledged effort at establishing a quiet, reassuring, transference context that allows the patient free expression and exploration of his/her basic wishes and feelings. This provides a glimpse of the patient's inner life and facilitates a selective, manageable regression that permits a transference neurosis-like state to arise in connection with the analyst. Parsimonious interpretation of the transference can then lead to some reconstruction of the past that can help to free the individual from the psychotically distorted identifications and object relations derived from the failed (and atypical?) oedipus complex. By implication, Freeman suggests that his patients arrived at the oedipal phase possessing integrated, coherent personalities capable of engaging in an adequate oedipal experience. The possibility of major personality disorder as the consequence of *primary failures in preoedipal development* is barely considered.

Freeman decries the fact that in the hospital treatment of the seriously ill, patients tend to be pulled out of treatment prematurely because of family pressures, institutional practice, and funding pressure. They return home to their families without adequate exploration of the unconscious dynamics of their psychotic processes and with insufficient opportunity to rebuild or rearrange their inner psychological structure.

Freeman ignores the developmental ideas of Lichtenberg, Kohut, Gedo, Kernberg, and George Klein, as well as the work of Sander and Stern on early development. He also ignores the work of Will, Searles, Ping-Nie Pao, as well as Wallerstein and the Menninger group, on the inpatient treatment of psychotics, save for inclusion in the bibliography. One wonders whether Freeman utilizes constructs such as attempting to build bridges to the patients' healthy islands of reliable observing ego; whether he attempts to strengthen their capacity to deal with their terrible affects or with the desperately masochistic and self-destructive aspects of some of their psychotic identifications or with their bizarre cognitive failures. One wonders what kind of holding environment, positive transference, or self-object support plays a part in Freeman's clinical work. Surely, he could not be effective without providing such assistance. Yet, nowhere does he mention these issues.

Also missing are references to recent neuropsychological studies of schizophrenic defects in processing data, of the effect of utero viral disease on brain development in certain classes of schizophrenics, on genetic aspects of schizophrenia, etc.

Of the more than 140 references in the book, about 40 are from 1970 on, and 15 of these are to Freeman's own works. In other words, 70% of the references are to early works with psychotic and severely disturbed patients published between 30 and 70 years ago.

In conclusion, would I think of recommending this book to those who might enter full-time institutional work with severely ill patients? I would do so, not to provide instruction as to how such people are currently understood or treated, but to show how one thoughtful, talented clinician, using the best tools available at the time, was able to use classical, psychoanalytic drive-defense constructs in a sensitive, and, apparently, reasonably effective way. But I suspect that it was not Freeman's conceptual approach but rather

the high order of his personal qualities that made the difference with his patients.

MEYER S. GUNTHER (CHICAGO)

THE PSYCHOPATHIC MIND. ORIGIN, DYNAMICS, AND TREATMENT. By J. Reid Meloy, Ph.D. Northvale, NJ/London: Jason Aronson, Inc., 1988. 474 pp.

Since the early nineteenth century, countless treatises have been written about the mental disorder once referred to by Prichard as "moral insanity"[1] and later known as psychopathic, sociopathic, or antisocial personality. Benjamin Karpman deplored the plethora of writings on this subject because, in his view, they contributed nothing to an understanding of the condition "but merely cluttered up an already over-cluttered wastebasket."[2] He admitted, however, that the disorder itself—characterized by the absence of moral feelings—is a distinct diagnostic entity (which he termed "anethopathy" or "ideopathic psychopathy"), although it afflicts only a small number of people and is based not on psychogenesis but on constitutional factors. Hervey M. Cleckley conceived of the psychopath as an ingenious robot, devoid of human emotions and unable to relate to people on a personal level.[3] Cleckley's concept of psychopathy is similar to Prichard's "moral insanity" and Karpman's "anethopathy" or "ideopathic psychopathy." Thus, all these terms refer to antisocial conduct in non-psychotic individuals whose actions are not guided by moral feelings or a sense of guilt.

The diagnostic criteria for this disorder have undergone changes and refinements, as have the criteria for most other psychiatric conditions. The criteria currently in use and generally accepted (Diagnostic and Statistical Manual III-R) constitute a behavioral description rather than a general personality assessment. The DSM lists specific (antisocial) behaviors manifested by individuals with

[1] Prichard, J. A. (1835): *A Treatise on Insanity*. Philadelphia: Hoswell.

[2] Karpman, B. (1948): The myth of the psychopathic personality. *Amer. J. Psychiat.*, 104:524.

[3] Cleckley, H. M. (1941): *The Mask of Sanity: An Attempt to Reinterpret the So-Called Psychopathic Personality*. St. Louis: Mosby.

this disorder, whereas earlier diagnostic criteria had emphasized these individuals' characteristics—their lack of ethics, empathy, or ability to feel guilt or remorse.

Unfortunately, Karpman's complaint about earlier publications on the psychopathic personality is applicable to J. Reid Meloy's recent book, *The Psychopathic Mind*. Meloy has not materially increased our understanding of the antisocial or the psychopathic personality, mainly because his own definition of psychopathy is exceptionally broad: "an aggressive sub-category of narcissistic personality disorder" where there are "low levels or an absence of empathy as well as sadomasochistic behavior and the need for power as opposed to interpersonal attachment" (p. xvii); "a deviant developmental disturbance characterized by an inordinate amount of instinctual aggression and the absence of an object-relational capacity to bond. . . . Psychopathy represents both a category or class of disorders for diagnostic purposes, and a continuous psychological disturbance that may vary in terms of treatment from one individual to another in kind and degree" (p. 5).

In essence, Meloy's psychopathic personality seems to be simply an individual who has a great deal of aggression: "Predatory aggression is the hallmark of the psychopathic individual, whether it is a primitive act of violence against the stranger or a technically sophisticated act of revenge against the business associate" (p. 25). In this sense, *The Psychopathic Mind* is really a book about aggression and not about psychopathy, either in the historical sense of the concept or its current usage.

In his explanation of the origin of psychopathy, Meloy posits the theory that, because of an underlying biological and neuropsychological predisposition, psychopathic individuals are hyporeactive and therefore have difficulty in learning from experience, gaining insight, and developing the anticipatory anxiety that should result from negative experiences. Meloy's "dual-track orientation" (which takes into account both biological and experiential factors) is not a new concept but is basically a restatement of ideas conceived a century ago.

Meloy's discussion of structure and dynamics (approximately 115 pages are devoted to this topic) also does not contribute to our understanding because much of it is unclear. Inevitably, given the breadth of his definition, Meloy's idea of psychopathy includes such a widely diverse group of individuals—from serial murderers

to paranoid psychotics to depressed and suicidal cases—that one must question the concept's usefulness as a psychodynamic formulation, since it can apply to just about anyone.

The chapter on psychotherapy is a high spot in the book. Meloy makes the point that psychopaths can be treated, at least those who are not "so psychopathically disturbed" (p. 322). His discussion of countertransference is illuminating, as are his comments on resistance. He clearly has had extensive experience in the psychotherapeutic treatment of aggressive individuals through his work in jails, hospitals, and outpatient settings. It is unfortunate that the bulk of the book is not devoted to the area of treatment. If it were, Meloy would truly have made a significant contribution.

In spite of Meloy's laudable effort, impressive erudition, and wealth of experience, *The Psychopathic Mind*, as a whole, is disappointing. It does not tell us a great deal that is new about various manifestations of aggression and various forms of antisocial acting out, although most of the cases make for interesting reading. I have argued elsewhere[4] that we really know very little about true criminality, as described, for instance, by Thomas Mann in *Confessions of Felix Krull, Confidence Man*,[5] since the Felix Krull type of criminal is rarely caught or examined and often does not seek treatment. In prisons and ambulatory settings, we see instead the "inadequate criminal," mostly from the lower social classes, with moderate to severe psychiatric symptoms and engaged in crude antisocial behaviors such as assaults and armed robberies. Further understanding of the Felix Krull type of psychopathy—the type of psychopathy of greatest interest to the psychoanalyst—will not be gained from *The Psychopathic Mind*.

LOUIS B. SCHLESINGER (MAPLEWOOD, NJ)

THE RADICAL RENEWAL. THE POLITICS OF IDEAS IN MODERN AMERICA. By Norman Birnbaum. New York: Pantheon Books, 1988. 275 pp.

A book dealing with the "politics of ideas" in modern America is not of a kind that is usually reviewed in a psychoanalytic journal,

[4] Schlesinger, L. B. (1980): Distinctions between psychopathic, sociopathic and antisocial personality disorders. *Psychological Reports*, 47:15-21.

[5] Mann, T. (1954): *Confessions of Felix Krull, Confidence Man*. New York: Knopf, 1955.

and its topic is not generally in the focus of analytic readers. This reviewer makes the assumption that the majority of the readers of this *Quarterly* will be as unfamiliar with the author and his works as I was and will therefore welcome an introduction. Norman Birnbaum is a sociologist who is currently University Professor at Georgetown University Law Center, after having taught at Amherst College, the New School for Social Research, the London School of Economics and Political Science, Oxford University, and the University of Strassburg. In addition to his academic activities he was a founding editor of *New Left Review* and was on the board of *Partisan Review*. He is currently on the boards of *The Nation* and *Praxis* and has been actively involved in the presidential campaigns of Edward Kennedy and Jesse Jackson, as well as having advised political parties, unions, and the peace movement in Western Europe. In his own words he has "always worked in the Marxist tradition and been active in radical politics" (p. xi). These are the vantage points from which he writes.

What Birnbaum is concerned about in this volume is the search for new ideas to confront and deal with America's current changed historical situation and problems of "the control of aggression, sexism, racism and alienation." He decries what he considers to be the "focus on the transient, the superficial and the immediate," not only by the media, elected officials, and appointed political administrators but by those from whom one might presumably expect more, such as religious leaders, historians, economists, political scientists, and intellectuals of all kinds in and out of academia. In describing this loss of focus and depth he attempts to present the reader with a history of the currents and crosscurrents of thought in America as they are brought to bear on these problems. This involves him in a review of religion, sociology, feminism, history, economics, law, political science, and, yes, psychoanalysis.

To say that this is a daunting task is to put it mildly. Unfortunately it is too daunting, particularly in a relatively short book of 275 pages in which the last 50 pages consist of bibliography and index. The presentation of the names of figures in the various fields, particularly when the reader (even a reader of average expectable education and sophistication) is not as knowledgeable as the author, at times gave this reviewer the feeling he was reading a telephone book. Take, for example, the following sentence (a type

of sentence unfortunately all too common in the book): "I have not found in the discussion of Rawls the aphorism from Durkheim's criticism of Spencer's view of contracts as the basis of industrial societies: everything in the contract is not contractual" (p. 22). One must be intimately familiar with the work of Rawls, Durkheim, and Spencer to know what the author is talking about. This reviewer is not familiar with their work and questions how many of his analytic colleagues might be.

The question has arisen in my mind as to why I was asked to review this book for an analytic journal. One reason might be that since psychoanalysts are interested in human thought in general and psychoanalysis can only exist within the context of a society that permits and encourages freedom of thought and expression, it behooves the analytic community to be familiar with currents of political thought of all kinds. Another reason probably is that Birnbaum is familiar with and respects analytic thinking and integrates it into his search for new ideas.

Birmbaum is a member of the Wellfleet Psychohistory Conference, which is led by Robert J. Lifton. Interspersed throughout the book are references to psychoanalytic thought and thinkers, in particular Kohut, Wilhelm Reich, and Erikson, as well as Freud. It is particularly in speaking of the problems of alienation in society, the education of the young, the formation of character, and aggression and the atomic bomb that he turns to these and other analytic thinkers. While it is always gratifying to have analytic insights taken seriously by people in other disciplines, I wondered as I read these sections whether others less familiar with these names and ideas than is an analytically sophisticated reader might not have the same difficulty I had in dealing with the highly condensed presentation of names and ideas from sociology, political science, and economics. In short, I believe that the audience that could read this book with profit is a small one confined to an intellectual elite equally at home with the nuances of a wide variety of disciplines. I was not among them.

EUGENE HALPERT (GREAT NECK, NY)

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James R. Edgar

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ABSTRACTS

Psychoanalytic Inquiry. IX, 1989.

Abstracted by James R. Edgar.

Concepts of Therapeutic Effectiveness in Psychoanalysis: A Historical Review. Arnold M. Cooper. Pp. 4-25.

The author traces the development of the various schools of psychoanalysis and identifies the agent or agents each school feels is responsible for therapeutic effectiveness. He brings us to the present where therapeutic effect is seen as dependent upon multiple interacting processes, with none able to claim priority, and points to the need for clinical research to clarify the situation.

Structural and Interstructural Change in Psychoanalytic Treatment. Leo Rangell. Pp. 45-66.

Rangell says that "structural change" is often used as a symbol for the change brought about by analysis without a clear understanding of or agreement on what "structures" are. He proposes Rapaport and Gill's formulation that "structures are configurations of a slow rate of change." A concept of change based on this understanding of structure must include a structural theory of neurosogenesis, comprising the dynamic, genetic, economic, topographic, and adaptive points of view of psychoanalytic metapsychology. He then delineates in some detail what he considers to be structural changes that occur during psychoanalysis, adding that he feels this process is more unconscious than conscious. These alterations in the id, ego, and superego are familiar to most analysts. Rangell draws our attention to what he feels is the neglected area of superego analysis. He next turns to the how of change, giving us his "own succinct working credo distilled from over four decades of clinical immersion." He focuses on two elements: the interpretation of the material that emerges from the patient's unconscious filtered through the analyst's "analyzing instrument," and the unique human relationship fostered by the analyst's maintenance of the analytic attitude. Although he gives more weight to interpretation as the causal agent, he underlines the necessity of a flexible human analytic attitude. He now sees clear evidence of structural changes in patients seen in dynamic psychotherapy and not just those in psychoanalysis, and he gives some examples from his own practice.

The Psychoanalytic Setting as a Container of Multiple Levels of Reality: A Perspective on the Theory of Psychoanalytic Treatment. Arnold H. Modell. Pp. 67-87.

Modell proposes that it is not the resolution of the oedipus transference neurosis that brings about change, but the "fundamental psychoanalytic setting." His ideas come from experience in psychoanalysis but apply as well to long-term dynamic and psychoanalytically informed psychotherapy. He makes this sweeping statement in a footnote and does not follow it up with evidence. By "fundamental psychoanalytic

setting" Modell means what Stone called the "psychoanalytic situation," which includes what Freud referred to as the unobjectionable positive transference. Modell feels that the unobjectionable positive transference plays a much greater part in the process of change than has been acknowledged. It provides a setting or medium through which psychic time can be retranscribed. The ideas of retranscription and psychic time come from Freud and from St. Augustine. Modell feels that had Freud integrated the idea of retranscription with the concept of transference neurosis, he would have clarified the agent of change in psychoanalysis. The separation of the analytic relationship into "real" and "transference," he suggests, is not the most accurate or illuminating way to look at it. He proposes that "the psychoanalytic setting frames a level of reality separate from that of ordinary life, an area of illusion; within this area . . . there are further transformations (retranscriptions) of levels of reality." With this background Modell suggests that what we observe in psychoanalysis is not an active "regression" to earlier stages of life, but "symbolic actualization," a process that contains many elements of the earliest mother-child relationship. It is through this symbolic actualization that change is made in a retranscription of past time/present time/future time. This is possible because of the "frame," the "rules of the analytic game," created by the analytic setting which includes the physical regularity of the set-up and the emotional constraint of the analyst. The ability to appreciate and work with different realities of the analytic setting and symbolic actualization make change possible.

Therapeutic Change: Perspectives of Self Psychology. David M. Terman. Pp. 88-100.

Kohut's ideas about the process of change in psychoanalysis shifted in emphasis from 1971 to 1984. Kohut postulated that change in psychoanalysis is brought about by "transmuting internalizations," a process consisting of (1) a receptivity for introjects, (2) breaking up of the psychological function of the object via optimal frustration, and (3) the depersonalization of those aspects of the object and their transformation into an integral part of the patient's structure. His emphasis in Step 3 later shifted to the substitution of direct need fulfillment, with the establishment of a "bond of empathy" between self and selfobject. This change of emphasis from "the self-contained process of depersonalization of an introject" to "the establishment of a bond of empathy between the self and selfobject" is crucial and makes the process of being understood, the bond of empathy, an intrinsic part of the process of change. Self psychologists can be divided into two groups according to how they conceptualize the crucial aspect of change: those who emphasize the explanatory-interpretative framework, and those who emphasize the patient's experience of empathy. The explanatory-interpretative group feels that optimal empathy is not itself curative but is necessary for establishing the narcissistic transferences which are then dealt with by interpretation which brings about structural change. Those in the group stressing the experience of empathy emphasize the new experience in the "selfobject transference" and the possibility of a "new beginning." These "new beginnings" are implied to be quite different from those brought about by interpretation. Just how they differ is not clearly defined.

The Fear of Change and Its Consequences in Analysis and Psychotherapy. Pietro Castelnuovo-Tedesco. Pp. 101-118.

The author feels that the fear of change and its principal manifestation, the fear of treatment, have not been given enough attention, having often been grouped under the general heading of resistance. The development of a comprehensive theory of resistance may have deflected our attention from the clinical manifestations (fear) seen in individual patients. Castelnuovo-Tedesco points to the necessarily ambivalent attitude that everyone brings to analysis since it involves stirring up old drives more or less put to rest, and disturbing our narcissistically invested vision of ourselves. He then gives twenty-seven clinical examples of patients expressing fear of change. There are several common elements: treatment will result in a negative outcome or loss rather than a gain; treatment will be a passive/submissive experience; treatment will inevitably end in disappointment; the patient is too far gone to help or there is apprehension about what large changes the patient will experience passively. Castelnuovo-Tedesco feels that the phenomena of fear of change are present in all patients to some extent in all phases of analysis, and that the analyst should be attuned to them and help bring them to consciousness so that the possibility of change will be preserved.

The Idealization of Structural Change. David S. Werman. Pp. 119-139.

Werman focuses on the way some writers use changes in psychic structures as a shibboleth to distinguish psychoanalysis from psychotherapy with its more limited "modifications" of derivative aspects of deeper conflicts. He believes the literature regarding change in psychoanalysis can be divided into that which focuses on structural change and that which focuses on observable behavior. For Werman "the idea of structural change based on metapsychological concepts has outlived whatever usefulness it might ever have had." He traces the literature up to 1950, pointing out how frequently change in psychoanalysis was conceptualized in clinical (behavioral) terms, not structural ones. Beginning in 1950, the literature began to be more heavily weighted toward concepts of structural change, in an attempt to distinguish psychoanalysis from psychotherapy but at the price of neglecting the clinical picture. He points to the (inevitable?) awkwardness of structural metaphors and suggests that this very awkwardness interferes with a clear understanding of the clinical behavioral picture. The more recent literature suggests that (1) structural change in psychoanalysis is not as far-reaching or permanent as was once thought, and (2) structural change is possible through psychoanalytically oriented psychotherapy. Werman is very suspicious of any structural change not accompanied by behavioral change. After discarding the concept of structural change, he proposes that what separates psychoanalysis from dynamic psychotherapies is the practical arrangements of the psychoanalytic situation.

The Therapeutic Action of Psychoanalysis: Strachey Revisited. W. W. Meissner. Pp. 140-164.

Meissner reviews the historical context of Strachey's classic paper in which mutative interpretations were proposed as the central vehicle for change in psychoanalysis. He traces the development of crucial theoretical schools since Strachey's paper,

and identifies their major contributions to the current analytic scene. These are: ego psychology with its emphasis on defense mechanisms and the conflict-free sphere; object relations theory with its attention to the "reality" of the objects in the developing infant's world and interest in early preoedipal phases of development; self psychology and its concern for the vicissitudes of narcissism and "selfobject needs"; and developmental theory with its focus on ongoing developmental process throughout life, with special attention to the early separation-individuation process and its effects on later development. With the growth of these schools has come a much more complicated and comprehensive view of the process of change. In spite of this, Strachey's view is still correct. Meissner feels that Strachey anticipated the concepts of transference and therapeutic alliance, and he emphasizes his own view of the importance of the concept of therapeutic alliance in change. Strachey emphasized the process of internalization that must take place for mutative interpretations to be effective. Meissner distinguishes two processes that lead to internalizations. The first includes projection-introjection, which is more closely tied to drive derivative elements related to the transference relationship, and externalization-identifications, which are related to the therapeutic alliance. The second of these processes emphasizes more strongly the give-and-take of the therapeutic alliance, secondary process, and autonomous ego functions. It provides a more stable set of psychic structures. This work follows, builds on, and consolidates the earlier, more primary-process, projection-introjection. Whereas Strachey limited himself mostly to aggression and the superego, Meissner would add narcissism and self-system in conceptualizing change in today's theoretical climate. Returning to his earlier distinction between transference and therapeutic alliance, the author says that only those interpretations developed within the therapeutic alliance are truly mutative, and he gives a clinical example. He feels that alliance must be developed and carefully nurtured, cannot be contrived, and has much to do with the analyst's real self.

Bulletin of the Menninger Clinic. LIII, 1989.

Abstracted by Sheila Hafter Gray.

The Place of the Dream in Psychotherapy. Donald M. Kaplan. Pp. 1-17.

Sigmund Freud's early presentation of dreams as special proof of the existence of unconscious mental processes has led to a persistent notion that dreams have a special position in clinical psychoanalysis as well. A review of Freud's writings, however, tends to support the view of the Kris Study Group that in the clinical situation the dream is one of many equally valid modes of communication from patient to psychoanalyst. The public, however, believes that psychoanalysts are, or ought to be, exceptionally competent in the interpretation of dreams and that they will use that skill in their clinical work. Patients therefore expect that their dreams will be addressed, and the psychoanalyst's performance in this area impresses the patient as do few other interventions. While our theory holds correctly that early dreams should be approached with great restraint, clinical circumstances often mandate active interpretation even when this poses a threat to the narcissism of the analyst. The author presents a brief vignette from his personal psychoanalysis that illustrates the great value of interpreting the first dream.

Several of the papers abstracted below refer to *The Psychoanalytic Process: Theory, Clinical Observation and Empirical Research* by J. Weiss, H. Sampson, and the Mount Zion Psychotherapy Research Group (New York: Guilford Press, 1986).

The Role of Unconscious Guilt in Psychopathology and Psychotherapy. Marshall Bush. Pp. 97-107.

The author explicates Weiss's theory that individuals who suffer trauma in childhood imagine that they have in some way injured family members. As adults, they harbor a baseless sense of guilt derived from "grim unconscious beliefs" in their culpability. He agrees with Weiss that this experience is the matrix of most neurotic symptoms and personality disorders. Clinically, patients will manifest their unconscious guilt by actively testing the psychotherapist in the hope that their frightful beliefs will be invalidated. If their efforts prove futile, they may develop intractable resistances or a negative therapeutic reaction. Bush suggests that one may test this theory by studying a patient's response to therapeutic interventions. He offers a brief report of a patient who resisted completing an apparently successful psychoanalysis soon after having set a termination date. Interpretations that focused on id resistance did not alter her attitude. Comments that addressed the unconscious fear that she would wound the psychoanalyst by separating from him yielded a statistically validated shift in her attitude toward the termination.

Unconscious Guilt as a Cause of Sexualized Relationships. Suzanne G. Weatherford. Pp. 108-114.

A middle-aged man consulted the author when his psychotherapist of very long standing went on maternity leave. At about the same time, the patient had been fired from his job because of seemingly deliberate poor performance. Early in the course of intensive psychotherapy, therapist and patient established some consensus that he feared he would hurt his father if he were to succeed in his profession. Then the patient recovered memories of traumatic childhood experiences that were characterized by defective control of both aggressive and libidinous impulses by beloved relatives. Later, the patient staged crises that seemed aimed at testing the therapist. In one, he informed the therapist that he was performing sexual acts with his sleeping stepdaughter. The therapist confronted him calmly with the gravity of his situation, and counseled him firmly to cease that practice. This behavior was sufficiently different from that of his mother to allow the patient to discover a deep identification with a father whose own behavior was impulsive and immoral. Eventually, he was able to see that his professional inadequacy and his incestuous acts were both precipitated by a sense of guilt for having been more fortunate than his father both in work and in love.

Crisis Intervention through Early Interpretation of Unconscious Guilt. Nicholas H. Nichols. Pp. 115-122.

This model of crisis intervention is derived from Weiss and Sampson's theory that psychopathology is based primarily on unconscious guilt that originated in early traumatic experiences. The model assumes that (1) crisis confirms a person's grim unconscious beliefs and exacerbates unconscious guilt, (2) increasing unconscious

guilt leads to decreasing capacity to cope with crises, (3) patients' capacity to cope with crisis may be augmented by decreasing their unconscious guilt, and (4) a psychotherapist best effects this by fostering patients' insight into their unconscious pathogenic beliefs. The therapeutic work is accomplished in an open-ended interview during which one focuses on the origins and development of the patient's pathogenic beliefs and their relationship to current stressors. The therapist then exploits the transference manifestations of testing and turning passive into active by using special therapeutic techniques to expose, and to help the patient modify, unconscious guilt feelings. The patient tends to experience rapid initial symptom relief and to seek further insight. There are two illustrative case reports.

Critique of a New View of Unconscious Guilt. Leonard Horwitz. Pp. 123-128.

Horwitz notes that the views of Weiss, et al., diverge from the formulations of classical psychoanalytic theory in two important ways. They believe that unconscious guilt stems from and is proportional to an individual's perception of having harmed a family member. Classical theory holds that it is derived from a fear of punishment that is linked to oedipal wishes and that its magnitude varies with the strength of those wishes. The Weiss group tends to downplay the importance of a person's attitude about her own motives. It emphasizes the pathogenic significance of beliefs based on the patient's actual experience. The Mount Zion group has expanded our theory of unconscious guilt to deal with clinical phenomena that are unrelated to instinctual themes. We should not, however, use their postulates to explain all mental disorders. It seems best suited to clinical work with neurotic patients who have achieved a level of psychic structure in which guilt can play a central role in psychopathology. Primitive or borderline individuals lack the capacity to view themselves as responsible agents. People who suffer from a narcissistic disorder view themselves as tragic rather than as guilty.

Reply to "Critique of a New View of Unconscious Guilt." Marshall Bush. Pp. 129-134.

In response to Horwitz's critique (above) Bush asserts that the position of Weiss and his group is not that unconscious guilt is the primary cause of all psychopathology, but that irrational guilt and the defenses against it are important and frequently neglected determinants of psychopathology. Pathogenic grim unconscious beliefs not only create anxiety and unconscious guilt, they also form a context for perceived threats to the integrity of the self. Thus, they can motivate a broad range of defensive behavior. If one is careful to differentiate unconscious beliefs from unconscious fantasies, one sees that this new theory broadens and does not contradict the classical theory of neurosis or the more recent contributions of self psychology. It is essential in clinical practice to address the transference manifestations of a person's grim unconscious beliefs and their traumatic origins, to deal appropriately with the "tests" that represent the patient's unconscious efforts to mitigate these beliefs, and to understand and analyze the compelling psychic dangers against which patients defend themselves through their symptoms, inhibitions, and resistances. The author offers brief formulations of several common, difficult pathological conditions, and suggestions for therapeutic intervention in them.

Commentary on a New View of Unconscious Guilt. Lloyd H. Silverman. Pp. 135-142.

The author confirmed, in laboratory studies of subliminal psychodynamic activation, that unconscious guilt motivates behavior. He and his co-workers found that normal subjects who were exposed to subliminal stimuli designed to activate their unconscious guilt developed maladaptive behavior. They also discovered evidence of unconscious adaptation-enhancing beliefs. This and similar studies also proved that unconscious guilt is not the key pathogenic factor in all mental disorders. For example, the dynamics of loss rather than of guilt are dominant in patients who suffer from anaclitic depression. The core of the Mount Zion group's thesis is the connection between unconscious guilt and unconscious beliefs. Silverman cautions that this important new contribution ought not to replace our interest in unconscious wishes or classical oedipal views of neurotic behavior. He illustrates this point with a formulation of Weatherford's case (above) that blends the two theories. Finally, Silverman suggests ways one may use the concept of the therapist's passing a patient's "tests" to discover the curative element in a variety of psychotherapies.

Reply to "Commentary on a New View of Unconscious Guilt." Suzanne G. Weatherford. Pp. 143-148.

In her response to Silverman's critique, the author explicates the Mount Zion Group's theory of how trauma is transformed into an unconscious pathogenic belief. She concedes that unconscious guilt may not be a universal pathogenic element; but she notes that some unconscious pathogenic belief always figures in the etiology of a mental disorder. She feels that unconscious guilt is linked to most pathogenic beliefs, but she also maintains that there may not be a direct link between an unconscious wish and a symptom. She therefore seems to reject Silverman's reformulation of her case. The Mount Zion Group holds that patients exercise control over their own unconscious mental life and that they are motivated in treatment to master their problems. This leads to "testing" behavior in the psychotherapeutic situation. Weatherford describes how these theoretical notions are tested in their psychotherapy research. She shows how one may integrate Silverman's findings with this work. There is a detailed illustration of the application of the notion of unconscious adaptation-enhancing beliefs to explain how a therapist's appropriate response to "testing" may be curative.

Journal of the American Academy of Psychoanalysis. XVII, 1989.

Abstracted by Lee Grossman.

The Fate of the Father-Representation in Adolescent Sons. R. N. Atkins. Pp. 271-291.

Atkins revises the proposal of Blos that the resolution of the negative oedipal attachment to the father is the terminal event in the boy's adolescence. He suggests that the occurrence of physical maturation often subdues the omnipotent father representation that had been present from early childhood; thus the de-idealizing event initiates, rather than ends, the boy's adolescent process. In Atkin's view, the

work of adolescence concerns the restitution of the father. Case examples show how the father contributes to the de-idealization, and how the mother's view of the father affects the father representation.

Psychoanalytically Oriented Supportive Therapy: Literature Review and Techniques. L. H. Rockland. Pp. 451-462.

Rockland reviews the literature on psychoanalytically informed supportive therapy and lists techniques culled therefrom. These include building rapport, reassuring, "accepting abreaction without analyzing it," intervening in the patient's environment, speaking for reality, clarifying for the patient, confronting maladaptive behavior, educating, advising, encouraging, prohibiting, and using somatic treatment "liberally without analyzing unconscious meanings." He more fully describes supportive techniques that "absolutely require psychodynamic sophistication and skill." These include strengthening adaptive defenses; undermining maladaptive defenses; supplying partial and inexact interpretations to aid repression by distracting the patient from the true source of anxiety; undermining overly intense or negative transferences by confrontation with reality and/or facilitating displacement; tailoring interventions to fit the patient's character traits; and discouraging free association in favor of logical thinking.

Psychoanalysis and Contemporary Thought. XII, 1989.

Abstracted by Luke F. Grande.

The Idea of Progress in Psychoanalysis. Morris N. Eagle and David L. Wolitzky. Pp. 27-72.

The authors discuss progress made by psychoanalysis in conceptual clarification and systematic empirical inquiry. They examine such key concepts as transference, countertransference, working alliance, free association, meaning of dreams, and self psychology, and note the discrepancies not only in definition, but in how these phenomena are dealt with in practice. They note the recent move to call psychoanalysis a hermeneutic discipline, and they take issue with this attempt to eliminate the need to validate psychoanalytic concepts. They also consider whether psychoanalysis is able to define truths that are cross-cultural and transhistorical. They discuss change in the nature of psychopathology and the relationship between psychoanalytic concepts and social change. The authors believe it is essential for psychoanalytic concepts to be more systematically examined, clarified, and verified, and to get beyond the clinical vignette to establish a doctrine. They cite the work of several researchers who have begun to explore some issues in a meaningful and systematic manner, especially in the area of transference and the therapeutic relationship. They express their belief that psychoanalysis offers too valuable a contribution to the understanding of personality and human nature not to be researched seriously.

Reinspecting the Foundations of Psychoanalysis: A Rejoinder to Adolph Grünbaum. Allan D. Rosenblatt. Pp. 73-96.

Rosenblatt believes it important to counteract the effect of the second half of Grünbaum's book, *The Foundations of Psychoanalysis: A Philosophical Critique*. As Ro-

senblatt sees it, Grünbaum takes the position that psychoanalytic theory must not be based on clinical evidence, but must, rather, be validated by extraclinical observations and studies. Through a series of arguments, clinical examples, and citing of research, he attempts to refute Grünbaum and to demonstrate that data obtained through clinical work is vital to the development of psychoanalytic theory. At the same time, he acknowledges the service rendered by Grünbaum's argument for more varied, systematic, and careful psychoanalytic research.

Picasso: The Pictorial Structure of Cubism and the Body-Image Construct. Tom Ettinger. Pp. 147-263.

Ettinger believes that Cubism began with Picasso's painting of *Les Demoiselles d'Avignon*. He posits that Picasso used it to express his libidinal and aggressive drives at the oral incorporative and phallic levels of development, and to master his conflicts and anxieties related to fusion, separation, and castration. He traces Picasso's covert and repetitious use of transitional and fetishistic objects through the Cubist phase, and then his overt use of them in the Surrealist phase. He does so by referring to various plates of Picasso's paintings, drawings, and sculptures, and by biographical anecdotes.

Humanism, Hermeneutics, and Humanistic Psychoanalysis: Differing Conceptions of Subjectivity. Louis A. Sass. Pp. 433-504.

The author presents an exposition and, to some degree, an endorsement of ontological hermeneutics. He does so by sketching first the key concepts of humanism and then of hermeneutics, comparing and contrasting the two approaches. Thus, he outlines their psychological and philosophical underpinnings, focusing primarily on the writings of Allport, Rogers, Maslow, Dilthey, Sartre and, especially, Husserl, the humanist, and Heidegger, his protégé and the father of hermeneutics. He notes that humanism and hermeneutics both flow from Romanticism, which developed as a reaction against objectivism and scientism, but humanism espouses subjectivity and individuality and stresses the subject's self-awareness, whereas hermeneutics de-emphasizes those aspects of being and knowing, and focuses on the lack of self-transparency and the importance of the relationship between the subject and the external environment. He criticizes the humanistic trends in modern psychoanalysis, especially as exemplified by the writings of Schafer, Kohut, and Spence. He posits the value and relevance of hermeneutic principles for psychotherapy and for broader methodological issues.

The Tension Between Psychoanalysis and Neuroscience: A Perspective on Dream Theory in Psychiatry. Harold Kudler, M.D., Pp. 599-617.

Kudler takes issue with Hobson and McCarley and then with Crick and Murchison who claim that dreams have no psychical meaning but are simply the result of random, meaningless thoughts that have accumulated during the day. He likens their notions to those expressed by W. Robert in 1886, which Freud partly refuted and partly integrated into his own theory. He notes the tendency of some present-day neuroscientists to confuse the study of the brain with that of the mind and to attempt to disqualify Freud's theorizing because he, of course, was formulating

ideas in the context of nineteenth century knowledge. Kudler stresses the value of integrating the findings of psychoanalysis and neuroscience instead of seeing them as being opposed.

The Psychohistory Review. LVIII, 1990.

Abstracted by Thomas Acklin.

Authoritarian Attitudes and Personalities: A Psychohistorical Perspective. Thomas T. Lewis. Pp. 141-167.

Lewis discusses authoritarian attitudes and personalities, particularly in terms of the monumental work published in 1950 by Theodor Adorno, *The Authoritarian Personality*. Considering a number of criticisms of Adorno's work, Lewis concludes that, whatever its conceptual and methodological limitations, it has contributed a great deal to our understanding of authoritarianism and is relevant to the study of modern history. Lewis sees the major weakness of this work as its failure to take into account the cognitive, social learning aspect of authoritarianism. Moreover, it now seems clear that there are many kinds of personalities (rather than just one kind) which have authoritarian traits. Lewis feels that it is likely that such traits have their source in deep-seated unconscious needs emerging out of early life experiences, but that they can just as easily result from cognitive learning of ideals and values which are a part of the cultural environment. Therefore, authoritarianism is likely to be caused by a multiplicity of variables in complex interaction.

The Case for Clinical Training and Challenges to Psychohistory. Robert A. Pois. Pp. 169-187.

Considering a variety of points of view toward the question of the relationship between psychoanalysis and historical hypothesizing, Pois notes that there have been numerous and sustained challenges to both psychoanalysis and psychohistory over recent years. He agrees with Thomas Kohut that theoretical knowledge of the guiding tenets of psychoanalysis tends to subsist at the very center of most psychohistorical enterprises. For the psychoanalytic clinician, however, theory is only a tool to help the investigator comprehend the particular on its own terms, whereas the crucial task of psychohistory is to determine the relationship between the individual and general forces so as to expand the realm of historical consciousness. Even if psychohistory has to move beyond the boundaries of "traditional" psychoanalysis, it is plain to Pois that psychoanalysis and psychohistory "go together." Pois concludes that the clinically trained psychohistorian is best able to deal with the most vexing historical problem: "the relationship of historical individuals or collections of them to the vanished solidarities which influence them and upon which they in turn have exerted influences."

Torture and Related Behavior. Micheline Guiton; Rodolphe Bydlowski; Monique Milhaud-Bydlowski. Pp. 219-227.

This paper presents the results of studies of types of torturers. The Secret Service torturer in concentration camps in Germany during the Second World War typifies

the torturing behavior characterized by anal regression, and the second type of torturer, the phallic type, is typified by the French paratroopers who fought in Algeria during the Algerian War. Characteristics of anal regression in the torturer are exhibited in such behaviors as kicking, punching, and clubbing, meticulous accumulation of files, reaction formations such as exaggerated cleanliness in reaction to camp filth, and in defense mechanisms such as compartmentalization and euphemism. The phallic type is characterized by self-confident behavior in the face of anxiety, clinging to visible and particularly phallic signs of status, torture aimed especially at the male genitals indicating a primacy of the phallus, and fighting against passive and anal-regressive tendencies. The phallic torture would seem to be a strong attempt to deny castration anxiety, often through the identification of the self with the phallus and the need to indicate that "he is being damaged, not I." The authors point out that there are other types of torturers besides the anal and phallic, for instance, the exhibitionist tendencies of Japanese torture. Moreover, the anal and phallic bear the imprint of a collective context, showing, as Freud indicated, how perversions find a favorable ground in the group and how individual and group psychology have a profound interconnection.

Introducing the History of Emotion. Carol Z. Stearns and Peter N. Stearns. Pp. 263-291.

Carol and Peter Stearns propose that the historical study of emotion will elucidate a vital link of the psyche with a broader understanding of social change, a link which has been one of the important promises of psychohistory. The study of emotional change through models of emotionality focuses on group patterns more than on individual biography. Emotions such as love, anger, grief, fear, and parental and romantic love can be studied in themselves, and changes in emotion from one age to the next can be grasped in particular contexts and amid some particular continuities. The Stearns argue that emotional standards change more rapidly and completely than emotional experience does. Referring repeatedly to the book of essays they edited, *Emotions and Social Change*, they discuss the importance of studying the history of emotions by expanding the chronological range of the study, by considering a wider array of emotions, by examining a wider number of sources, by distinguishing more carefully among ideas, standards, and direct expression or experience of emotions and, above all, by holding the issue of changes in emotions at the forefront of their historical study. From the purview of this wider array of emotions, the priority Freud placed upon sexuality and aggression comes into question, and also whether the emotions connected with these two are biologically determined or social constructs. The study of the history of emotions deepens the task of historical study and calls for a major redefinition of the human subject. Historians of emotions are reported by the Stearns as having no single theoretical reference point, tending most often to go beyond a Freudian perspective and seeking more open-ended patterns such as those available through research in child development. They are not particularly interested in individual cases except insofar as these are representative of larger groups and generations, with general hypotheses flowing from these.

Some Comments on the History of Emotion. Fred Weinstein. Pp. 293-302.

Fred Weinstein, in his comments on the work of the Stearns, objects to their identifying psychohistory or psychosocial studies with Freudian psychoanalysis. He feels that the interpretative statements made by historians and social scientists about what people have done are inferential leaps not warranted by the evidence and are based on some implicit or explicit notion of unconscious mental activity and repression. He concurs with Robert Wallerstein that larger interpretative psychoanalytic points of view become ideology, and that psychoanalysts should confine themselves to clinical matters and avoid the shortcomings of cultural and historical studies based on a psychoanalytic point of view.

Cultural History, the Construction of Subjectivity and Freudian Theory: A Critique of Carol and Peter Stearns' Proposal for a New History of the Emotions. John E. Toews. Pp. 303-318.

Toews by no means feels that psychohistory will need to relegate Freud to "the historical dust bin" if the trends of the history of emotions become the new conventional wisdom. He feels that Freudian theory has contributed a great deal to understanding ways in which somatic energies or forces are transformed or constructed into subjective inner experience that yields personal identity in the very process of cultural formation. He does, however, see a conflict between Freudian theory and therapy, namely Freud's vision of a decentered, externally determined psyche invaded by forces from its own soma and the sociocultural order, and the goal of therapy to construct "an autonomous, centered and bounded subject in which the ego [is] the rational manager of its psychic household." The process of integrating the psychoanalytic perspective and a history of inner experience tends to make relative some of the particular constructions of inner experience which Freud viewed as universal. Toews appreciates that the individual history upon which Freud focused, is, in its unconscious dynamics, the moment of entry into the collective historical world replete with its cultural significations and social relations. In this sense he sees Freud's own case studies as consonant with the investigative method and descriptive endeavors of historical ethnography in the way in which they show how individual inner experience is formed within networks of social and cultural relations. Toews feels that Freudian theory is often more relevant to the work of cultural historians than are the Stearns's efforts at the history of the emotions.

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Meetings of the Psychoanalytic Institute of New England, East

Gary Goldsmith

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NOTES

MEETINGS OF THE PSYCHOANALYTIC INSTITUTE OF NEW ENGLAND, EAST

January 23, 1989. P.I.N.E. FACULTY FORUM: DISCUSSION OF THE MEANING OF THE HOLOCAUST FOR THOSE NOT DIRECTLY AFFECTED—A PSYCHOANALYTIC VIEW. Rafael Moses, M.D. and Rena Hrushovski-Moses, Ph.D.

Dr. Sheldon Roth opened the discussion by reciting an Old Testament parable told by a Hassidic rabbi who had escaped the concentration camps. It ended with the words: "There are events of such overbearing magnitude that one ought not to remember them all the time, but one must not forget them either. Such an event is the Holocaust." The movement between remembering and forgetting was echoed by Dr. Arthur Valenstein's question regarding closeness to and distance from such an overpowering event. In reply, Dr. Rafael Moses said that a major theme arising in a 1988 conference held at the Hebrew University of Jerusalem was just that: "How much closeness can we stand, and how much distance do we need?" He remarked that the initial denial by survivors was great, with the mourning process gradually beginning only later on, abetted by the problems and questions of their children and by the increasing number of writings published about the Holocaust.

Dr. Roth described the reception given the remarks of a German psychoanalyst at the Jerusalem conference. The German analyst described Auschwitz as a metaphor for the sense of depletion; he felt that references to Auschwitz were used by some analysands as a displacement of infantile omnipotent potential, so that the analysands could avoid their own potential. The survivors present at the conference resented this characterization of Auschwitz as a metaphor, given the enormity of the event and its tragic reality.

Dr. Valenstein expanded upon earlier remarks regarding how close to the event a non-participant could ever get, by suggesting that in some ways "it is an indignity to analyze such a horror (or any unbearable trauma our patients may have experienced) in a dispassionate manner. Such events need room to be 'lived out,' not abreacted, because the work of mourning is never finished. For those who were in it, talk has its limitations, and perhaps psychoanalysis does as well." Dr. Ana-Maria Rizzuto expanded upon the notion of the limitation of words to describe unbearable physical or emotional pain. She noted that one mechanism used is to "create a wedge between the you who had the pain and the you who remembers you are you," which thereby separates the narrator from the sufferer. Dr. Roth had found that although survivors felt a gulf between themselves and those who were not in the camps, they still had a wish not to be abandoned in their experience, and to have others bear witness to their stories of suffering. Dr. Moses added that the narrating and experiencing parts of a person come closer to each other in the process of sharing with someone who cares. Dr. Alfred Margulies asked what it is that makes this particular experience so difficult to share, so needing to be witnessed. He wondered if it differs from natural disasters in its "theological" aspect, i.e., having to

cope with the concept of evil. If so, one needs to bear witness for humanity, not just for oneself.

Dr. George Klavens alluded to an analytic patient who was the daughter of survivors and who found it difficult to grieve over a pain her parents could not speak about. This patient could act out her distress symbolically by crying or tearing paper and spreading it around, but she could not find words for her grief. Another vignette was about a Jewish patient who dared to speak of an identification with the Nazis, which was seen as a defensive identification with the aggressor (in this case, the anti-Semitic schoolmates who had taunted him in childhood).

Dr. Rena Hrushovski-Moses mentioned the trouble that some Germans still have in trusting their own parents' reports of their roles during the war, and how noncommunication plays as central a role in restricting the working through process for them as it does in Jewish families. Strong feelings have been expressed about the claim of Germans to consider themselves victims. Dr. Cornelis Heijn suggested that "to prevent its happening again, we need to understand how it did happen. Thus we need to study the perpetrators as well as the victims, and it is very difficult to do that with sufficient neutrality."

Dr. Rafael Moses read a summary of one of the small group sessions that was held in Jerusalem, which included Jewish and German members. A central theme was of the differing expectations brought by the participants to the meeting. One survivor said, "Our lives are broken. Bring the wholeness back." This desire for the German participants to make restitution led to a realization that there cannot be such a thing. Other survivors wondered why they would ask for restitution to be made from the outside, particularly from Germans, and what they felt they were lacking to recreate it for themselves.

Dr. Evelyn Schwaber selected an excerpt from *The Survivor* by Terrence des Pres (New York: Pocket Books, 1977, pp. 182-183), of which the first portion read: "To be of use, the psychoanalytic method, which is that of interpretation, must be applied to actions which have more than one meaning *on the level of meaning*. But that is not the case with extremity. When men and women must respond directly to necessity, when defilement occurs at gun-point and the most undelayable of needs determines actions, or when death itself is the determinant—then behavior has no 'meaning' at all in a symbolic or psychological sense."

Dr. Ana-Maria Rizzuto added that "at the very second the survivor survives, the multiplicity of meanings of civilization returns," creating a tension in the survivor's life between the need to live with meaning in the present, and yet to remember a past when meaning was obliterated. This discontinuity defies the ever-present "longing to put it all back together again."

GARY GOLDSMITH

March 22, 1989. **THE PAST UNCONSCIOUS AND THE PRESENT UNCONSCIOUS: TOWARDS A THEORY OF PSYCHOANALYTIC TECHNIQUE.** Joseph Sandler, M.D.

Dr. Sandler proposed a developmental view of the unconscious and explored the clinical relevance of this model. He began with a historical overview of psychoana-

lytic theory that emphasized the vitality of its evolving theoretical concepts. He noted, however, that this evolution has been encumbered by resistance to discarding concepts that may no longer fit current psychoanalytic theory, and he described a widening gap between our explicit theory and our clinical technique. After reviewing the limitations of both the structural and the topographic theories in encompassing clinical materials, Dr. Sandler proposed an elastic concept of the unconscious to bridge both models. He suggested that his model would to some extent make explicit the problems that are implicit in the gap between current theory and clinical observations and technique. Dr. Sandler outlined his concept of the unconscious as divided into a past and a present. He defined the past unconscious as the inner world of childhood wishes, defenses, fantasies, theories, structures, and object relationships, as well as a preoperational thought process which becomes relatively inaccessible with the development of the repression barrier and the infantile amnesia at about the age of five. Terming the past unconscious the "child within," he stressed a three-dimensional development concept that is more complex than a concept of a purely instinctual id. Further, he noted that the past unconscious can normally be known only by clinical reconstruction, as it is never directly accessible to consciousness.

In contrast to the past unconscious, which Sandler placed topographically at a deeper level, he formulated a higher level unconscious which has similarities to the preconscious of the topographic theory and to the unconscious ego of the structural theory. He stated: "Whereas the past unconscious acts and reacts according to the past, the present unconscious is concerned with maintaining equilibrium in the present." Dr. Sandler suggested that the present unconscious involves a second censorship like that described by Freud between the Systems Preconscious and Conscious which prevents the entry of uncomfortable childlike fantasies into awareness. He posited a layering of wishful fantasies in the present unconscious at its deepest level which mirror those in the past unconscious and are progressively modified as they approach the surface. He assigned to the second censorship the task of resisting final access to consciousness, motivated by avoidance of shame and humiliation and by the fear of being "silly" or "stupid." Thus, wishes modeled on childhood fantasies and impulses that arise in the here and now are updated and modified by the present unconscious but must pass the second censorship before they can be allowed entry into consciousness. Nevertheless, allusions to the fantasies and thoughts that are held back by the second censorship are contained in what the patient brings to the analysis.

Dr. Sandler went on to tie these concepts to clinical technique. He emphasized transference allusions as a special window for gaining access to and understanding of the patient's present unconscious conflicts and the resistances arising from them. He stated that the analyst must first take up what is going on in the here and now in order to avoid collusion with intellectualization and other resistances that will inevitably arise if the analyst first attempts to tackle genetic reconstructions in the past. Patients must be helped by the analyst to be "on friendly terms" with the childlike and unacceptable aspects of themselves as they arise in the present, especially in the transference. Only when these have been made acceptable to patients in their cur-

rent form can reconstruction of the past help them become even more tolerant of the adult version of the child within themselves.

DISCUSSION: Dr. David Reisen asked whether feelings of shame and humiliation are culture-dependent or universal as they enter into the second censorship in childhood. Dr. Sandler responded that losing face is more important in some cultures than in others, citing the Japanese culture as an example. However, he noted that the major cognitive maturation around age five, from preoperational to operational thought, coincides with "don't be silly" concerns and the massive reinforcement of the repression barrier. He suggested that the extent of cultural differences would be an interesting area to investigate. In response to Dr. Laurie Raymond's question about the application of his concepts to dream interpretation, Dr. Sandler noted that dreams essentially reflect current preoccupations and conflicts in the present unconscious. Dr. Sandler disagreed with Dr. Lewis Kirshner who suggested that Dr. Sandler's point of view seems to have changed over the past twenty years—from an emphasis on conditions of safety and vulnerability to a focus on anxiety having more to do with narcissistic concerns with objects. Both Dr. Michael Charney and Dr. Alfred Margulies questioned the postulation of two agencies of the unconscious as opposed to one agency in continuity as development proceeds. Dr. Sandler responded that he uses past and present for schematic purposes "as a framework to emphasize the distinction in the clinical situation between constructions in the present and past reconstructions." His is a developmental view of the unconscious divided for convenience and clinical relevance into that which can be recalled and that which cannot. In response to a query by Dr. Anton Kris, Dr. Sandler discussed the relationship of creativity to a reduction in the second censorship, and he agreed with Dr. Nancy Parsons Harris that his two levels of the unconscious would be applicable to understanding the countertransference.

STEPHEN D. KERZNER

The Philadelphia Psychoanalytic Society and Institute and the Jefferson Medical College announce the 22nd ANNUAL MARGARET S. MAHLER SYMPOSIUM, to be held Saturday, May 18, 1991, at the Hershey Philadelphia Hotel. The title will be "Tears That Lie Too Deep for Words: Non-Verbal Manifestations of Unresolved Separation-Individuation in Adult Analysis." For further information, contact: Selma Kramer, M.D., Jefferson Medical College, 1201 Chestnut St., Ste. 1400C, Philadelphia, PA 19107-4192.

An International Conference, to be held March 24-28, 1992, in New York City, will mark the 50th Anniversary of the founding of the AMERICAN PSYCHOSOMATIC SO-

CIETY. For further information, contact: American Psychosomatic Society, 6728 Old McLean Village Dr., McLean, VA 22101.

The 12th ANNUAL CAPE COD INSTITUTE, a summer-long series of postgraduate courses for mental health and health science professionals, will be held June 24-August 30, 1991. Sessions are from 9:00 a.m. to 12:15 p.m. on weekdays, leaving afternoons free for leisure and study. The program is sponsored by the Department of Psychiatry of the Albert Einstein College of Medicine. For further information, contact: Dr. Gilbert Levin, Cape Cod Institute, Albert Einstein College of Medicine, 1303A Belfer Bldg., Bronx, NY 10461. Phone: 212-430-2307.