The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

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To cite this article: Jacob A. Arlow (1991) Methodology and Reconstruction, The Psychoanalytic Quarterly, 60:4, 539-563, DOI: 10.1080/21674086.1991.11927322

To link to this article: https://doi.org/10.1080/21674086.1991.11927322

Published online: 27 Nov 2017.

Psychoanalytic Quarterly, LX, 1991

METHODOLOGY AND RECONSTRUCTION

BY JACOB A. ARLOW, M.D.

The challenges presented in treating patients with so-called borderline and narcissistic personality disorders have revived interest in the subject of reconstruction, because many analysts believe that these difficulties originate in the events of the earliest preverbal phase of development. They feel that contributions from direct observation of neonates and knowledge gained from "infant psychiatry" may enable analysts to effect reconstructions that previously appeared to be only speculative. The methodological problems in applying this approach, however, may lead to foisting upon clinical observation preconceived paradigms of pathogenesis. Reconstruction depends upon a disciplined interpretation of the dynamic record of the patient's associations, which demonstrate how the past is embedded in the present. The validity of the reconstruction depends upon the application of appropriate and disciplined psychoanalytic methodology. Reconstructions constitute a special form of interpretation and are part of the psychoanalytic process.

What has happened over the course of time to the concept of construction, or reconstruction, is paradigmatic of the fate of many terms in the history of psychoanalysis. Essentially, a scientific term is an agreed upon convention, a word that defines or sets limits to a concept and indicates how the concept should be used. When differences arise in connection with issues closely related to such concepts, the essence of the scientific term may be broadened or altered, in order to make it accommodate to other issues. Certainly this applies to the current revitalization of reconstruction as concept and as technical procedure.

Valenstein (1989) attributes this development to the therapeutic challenges involved in treating patients with borderline

and narcissistic disturbances. These conditions, which, according to him and many others, originate in difficulties of the preverbal or earliest phase of development, have "led to speculative analytic formulations and intersubjective transferential explorations of what had been thought of previously as the inchoate neonatal and infantile period of development" (p. 434). He believes that the recent contributions from direct observations of neonates and the knowledge gained from "infant psychiatry" may enable analysts to effect reconstructions that previously appeared to be only speculative. The methodological problems involved in such therapeutic effort, I believe, are enormous. For this and for other reasons, we must confront the challenge of the nature, the meaning, and the methodology of reconstruction (Arlow, 1981).

Freud (1937) introduced the term "construction," or "reconstruction," in a very definite context and for a very specific purpose. He was defending and clarifying the propriety of the process of interpretation in psychoanalysis. In fact, his paper, "Constructions in Analysis," could very well have been titled or subtitled "On the Validation of Psychoanalytic Interpretation."

Freud's purpose was to demonstrate that when a patient was unable to recall a certain event, one that was fraught with crucial psychological consequences for the patient, given the evidence, it was technically appropriate and scientifically correct to infer that such an event had indeed taken place, to say so to the patient, indicating how that event affected the patient thereafter. Reconstructing an event, instead of having the patient remember it, represented to Freud a very serious challenge to his views on the theory of technique and the process of pathogenesis. He stated this quite explicitly in that paper:

> . . . the work of analysis aims at inducing the patient to give up the repressions . . . belonging to his early development and to replace them by reactions of a sort that would correspond to a psychically mature condition. With this purpose in view he must be brought to recollect certain experiences and the affec-

> tive impulses called up by them which he has for the time being forgotten. We know that his present symptoms and inhibitions are the consequences of repressions of this kind: thus they are a substitute for these things that he has forgotten (pp. 257-258).

Freud went on to say, "What we are in search of is a picture of the patient's forgotten years that shall be alike trustworthy and in all essential respects complete" (p. 258). Finally, and most significantly, Freud said:

> The path that starts from the analyst's construction ought to end in the patient's recollection; but it does not always lead so far. Quite often we do not succeed in bringing the patient to recollect what has been repressed. Instead of that, if the analysis is carried out correctly, we produce in him an assured conviction of the truth of the construction which achieves the same therapeutic result as a recaptured memory. The problem of what the circumstances are in which this occurs and how it is possible that what appears to be an incomplete substitute should nevertheless produce a complete result—all of this is matter for a later enquiry (pp. 265-266).

As far as I know, Freud never pursued the subject again.

In many respects, these represent a puzzling set of statements. The idea that pathogenesis results from repression and that the task of therapy is to get the patient to recall forgotten experiences in order to get well would fit much better with the simpler formulations Freud put forward in 1895. By 1936 Anna Freud's *The Ego and the Mechanisms of Defence* had already appeared. In that volume it was well recognized that repression is not the only defense, and we know that Freud played a great role in the writing of that book. It is possible that Freud overstated the case in order to validate the process of interpretation, whereby the analyst is justified in saying that something of major psychological significance had happened to the patient, even though the patient continues to deny any memory of the event.

The issue, therefore, appears to be one of method, not of

definition. Reconstruction is not an artificial process in the sense that one reviews the history and tries to fit the pieces together, as in Freud's analogy to the work of the archaeologist. In fact, reconstruction is only another aspect of interpretation. It is a particular kind of interpretation. Reconstruction becomes possible when one analyzes derivatives of a persistent unconscious fantasy organized in response to a specific event or to a set of interpersonal relations. The derivatives of this persistent unconscious fantasy can be understood, i.e., interpreted, in the context of specific associations. From time to time, the patterning of these associations occurs in a form which relates them to the historical events. But it is not the actual "historical" events that are reconstructed; instead, they are inferred from their psychological consequences in the present, as observed in their derivative expressions in the analytic situation. This view of reconstruction, which I believe is in keeping with Freud's approach, is not shared by all our colleagues, an issue which will be discussed later in this paper.

As Freud described it, construction, or reconstruction, is a special type of interpretation, proffered under specific circumstances on the basis of reliable evidence. It may be a more encompassing interpretation than the elucidation of an association, a parapraxis, a character trait, or a dream, but, insofar as it explains the meaning of the patient's mode of behavior, of segments of the patient's life and of the text of his or her associations, it qualifies at least for the dictionary definition of interpretation. Over the years, however, the significance of the term has been blurred, as well as subjected to hair-splitting distinctions. It has been confused with conjecture, inference, and intuition, and subdivided into interpretation, construction, reconstruction and renovation (Greenacre, 1980).

It is possible for the experienced analyst, during the first interviews or the early days of an analysis, to recognize certain patterns in the patient's history and certain configurations in the associations which suggest a particular kind of trauma or childhood experience, but this is not yet a construct or an interpre-

tation. It is a hunch, a conjecture which ultimately may prove to be correct or incorrect. To be sure, one starts each analysis with certain expectations that are based on previously acquired knowledge. Formulations about the deeper nature of the patient's difficulties may appear very early in the therapeutic interaction, but with each patient one must wait until the evidence appears that either justifies or invalidates such assumptions. This is what makes the issue of methodology crucial for the problem of reconstruction. The questions arise: How self-critical must one be? How much evidence is enough? On what basis does one decide that the conjectures and expectations are correct or incorrect? You cannot build a structure before the teamster delivers the lumber, but you can, if you wish, picture a magnificent edifice, tightly put together. However, you cannot live in it. This remark bears directly on certain problems of methodology that derive from the use of reconstruction to validate certain theories of pathogenesis and to justify therapeutic procedures that follow upon these assumptions. I refer specifically to the extrapolation of meaning from model situations and to the interpretation of experiential phenomena outside the context of the flow of associations in the psychoanalytic situation.

Some analysts believe that this is indeed the fundamental base for interpretation in psychoanalysis. Cooper (1988) states: "Each of us approaches the patient with a limited array of mental templates that predetermine the shape that we give to the communications we have received from the patient" (p. 1). He maintains that every analyst patterns the patient's associations according to the analyst's inner vision of the infant's early life. That approach seems alien to me. I had always thought that matters were the other way around, namely, that, from the associations, we get an insight into the early life of the patient. Lichtenberg (1988) articulates the same view as Cooper. He conceives of psychoanalytic methodology as operationally embedded in the use of model scenes, only, like Valenstein, he hopes to find new and better models in our growing knowledge

of development during the earliest period of life. Lichtenberg says,

> Since Freud was forced by the associations of his patients to reconstruct the sources of adult psychoneuroses through an understanding of childhood, all psychoanalysts have worked with what I call "model scenes" of infancy. These include the presumed oral bliss of the nursing infant or the incorrectly presumed autistic or narcissistic isolation or solipsistic state of the neonate, the conflict of the toilet training toddler caught between retention and expulsion, and all the variants of the oedipal child's sexual pursuits and rivalries. These initial efforts to conceptualize the early infantile past of the adult are by contemporary consensus inadequate and, especially for the first two years of life, inaccurate. My premise is that research and direct observation provide us with a *set of model scenes closer to the living experience of the child* and that these normal and pathological prototypes facilitate the analytic process (p. 1, italics added).

To me, this represents a fundamental error in the psychoanalytic methodology of interpretation (Arlow, 1979, 1987). It is what I have called the phenomenonological error, a variant of what Hartmann termed the genetic fallacy, namely, foisting upon the patient's associations an interpretation based upon a model concept of pathogenesis (Arlow, 1981). This methodological approach is not new to analysis. In the past, interpretations of surface phenomena were made, based upon standard scenarios relating to the different levels of psychosexual development, i.e., oral, anal, phallic. It is just as possible to impose upon the data scenarios based upon infant observation. The issues involved were discussed in *Psychoanalytic Concepts and the Structural Theory* when we (Arlow and Brenner, 1964) noted how voracious eating may be a derivative expression of an oedipal wish and not necessarily genetically related to the vicissitudes of the oral phase of development. Similarly, Nunberg (1938) described a patient with coprophagic fantasies that derived not from the anal stage, but from the oedipus complex. Manifest

behavior and symptomatology are not necessarily genetically related to the developmental phases of their dominant drive representation.

At issue in these controversies are matters fundamental to psychoanalytic theory and methodology. It may be argued, and with justice, that all analysts are theory-bound in how they make inferences about the data of observation. However, in applying theory, one must address at least two basic questions: First, to what level of conceptualization is the theory being applied? Second, what method of interpretation does one employ? Cooper, Lichtenberg, and others who depend upon "model scenes" of infantile experience conceptualize from a preconceived version of pathogenesis. According to Cooper, the particular theory of pathogenesis one employs "predetermines the shape that we give to the communications we have received from the patient." For Lichtenberg, a set of model scenes forms the normal and pathological prototypes that facilitate the psychoanalytic process. Thus, in both instances, observations within the psychoanalytic situation are interpreted as latter-day derivative expressions of an established, predetermined model.[1] Essentially, what is required as evidence is a detailed record, given in context and in sequence, of what actually took place in the analytic situation, i.e., a *dynamic* record of the patient's productions. It is on the basis of such evidence that one can make inferences concerning pathogenesis or reconstruction. The principles employed constitute the basis of the psychoanalytic method, i.e., dynamic conflict and compromise formation. The psychoanalytic situation is organized in keeping with these principles and they serve to validate conclusions at the level of clinical interpretation (Waelder, 1962).

To illustrate the principles involved, I am going to cite data from two separate analyses. One set of data has been published previously in a paper entitled "The Revenge Motive in the Pri-

[1] For a discussion of some related issues, see my paper, "Theories of Pathogenesis" (1981).

mal Scene" (Arlow, 1980). The material illustrates the kind of observations that made possible a reliable reconstruction of the precise time and place that the patient was traumatized by a primal scene experience. The second set of clinical data, from another case, demonstrates the methodology of the reconstruction of a patient's violent reaction to the birth of a younger sibling. The material from the second case will be presented in greater detail. In both instances the conceptualizations involved are at the level of clinical interpretation. The methodology departs only slightly from the principles we employ in deriving meaning in ordinary conversation. It involves paying special attention to the context in which the patient's productions appear, the contiguity of the elements in the patient's thoughts, and such special features as bizarre juxtaposition of elements, lapses in continuity, striking metaphors, unusual choices of words—the list can be extended at great length.

Such an approach does not involve the evocation of a model scene or a standard paradigm of pathogenesis. One does not have to posit a universally or biologically predetermined oedipus complex to conclude, in the case of the first patient, that at a certain time at his uncle's home in another city, the patient witnessed the primal scene, that he did not like what he saw, and that it evoked in him feelings of hostility together with fears of punishment. Likewise, in the second example, one does not have to accept a theory of drives to conclude from the data that the patient was unhappy when his younger sibling was born, that he wanted to destroy his brother, and that his attitude toward his mother and toward women in general was specifically affected by the experience and by the fantasies it evoked in him. Such conclusions do not depend upon a model scene of sibling rivalry. Both the essential elements from the past and the impact of these events in the present are all articulated in the material. The theoretical assumptions involved do not go beyond the basic postulates upon which the psychoanalytic situation and the psychoanalytic method are founded.

To summarize, what makes any interpretation of the past

possible, what makes reconstruction possible, is the fact that the past is embedded in the present. Certain aspects of the past remain dynamically active in the patient's current life. They become apparent in many forms—character development, dreams, symptoms, parapraxes, fantasies, etc.—but they become understandable in the psychoanalytic situation by virtue of the persistent derivative manifestations as they appear in context, in patterns of contiguity, in repetition, figurative language, metaphor, similarities and opposites, etc. (Arlow, 1979). The interpenetration of the past into the present, however, is not a matter of simple displaced repetition, a frequently mistaken view of the transference. What we discern in the flow of the patient's associations and the analysis of the transference are defensively distorted derivatives of some traumatic experience or object relations, and the manifold compromise formations of the conflictual unconscious fantasies generated by those experiences. It is not a matter of simple repetition of some untoward event. What appears to be repetition in the transference most often constitutes repetitions of earlier experiences that, even in childhood, were derivative, acted-out manifestations of the unconscious fantasy, elaborated in connection with a traumatic experience or relationship.

Most discussions of the importance of reconstruction in psychoanalytic technique emphasize the role of screen memories. The concept of screen memories is not a well-defined one. It covers a wide range of phenomena, from memories that are patently false or impossible, to clearcut fantasy formations, to mixtures of fact and fantasy that are experienced as memories, and ultimately to clearly recollectible incidents or a collection of incidents often appearing in a stereotyped fashion. Different observers emphasize different characteristics indicative of the presence of a screen memory: an unusually vivid detail, a totally irrelevant detail, an impossible detail. That there should be such difficulty in trying to distinguish screen memories from regular memories is not at all surprising. Screen memories are indeed compromise formations, but so are almost all of the memories

that one can bring to mind. Memory is a self-serving function, and its distortion by the process of defense and compromise formation is ubiquitous. What the different kinds of screen memories all have in common is, as their name indicates, their screening or defensive function. They are all substitute presentations to consciousness, a mechanism for trying not to remember what the individual cannot forget. As such, screen memories represent compromise formations. Their origin in some trauma and the fantasy resulting therefrom become dynamically manifest through the material selected to organize the screen memory. In some way, the screen memory is usually thematically related to the nature of the unconscious fantasy connected with the trauma; or a peripheral fragment of the memory or derivative of the unconscious fantasy may be incorporated into the manifest nature of the screen memory (Freud, 1899).

From the point of view of the methodology of psychoanalytic technique, however, what matters most is the context in which the screen memory appears and the nature of the contiguous associative elements. In this respect, it may be worthwhile to compare screen memories with transference phenomena. If one carefully observes the evolution of the patient's associations during treatment, one may observe how transference derivatives appear at a certain critical juncture in the course of the patient's associations. At the point where material indicating the prospective emergence of some conflictual wish regarding a primary object begins to appear, there is a sudden shift of associations away from the primary object and onto the analyst. This is what Freud (1912) meant when he stated that, in analysis, transference makes its appearance as a form of resistance. Instead of recollection, what we get is transference. The same process holds true for the emergence of screen memories. At the point where the patient seems ready to recall some event or fantasy which threatens unpleasure, instead of recollection we get a screen memory.

In this sense, therefore, screen memories represent struc-

tured defenses. Sometimes, as in the case to be described below, the defensive use of screen memories may be highly structured, involving not one, but a series of substitute or derivative recollections, organized in a repetitive pattern.

In a previous publication, "The Revenge Motive in the Primal Scene" (1980), I presented the kind of clinical data upon which a reliable reconstruction can be made. Essentially, the material consisted of the following. The reconstruction of a primal scene trauma became possible from the analysis of a dream. Two events that took place during the day were the significant stimuli for the dream. First, the patient had heard of a catastrophic fire in which several firemen had lost their lives. Second, he attended a performance of Mozart's *The Magic Flute*, where he saw a couple he knew who were having an adulterous affair. That night the patient dreamed of being caught by his wife while embracing a friend of theirs. The setting of the dream was in a specific bathroom in an uncle's home, where the patient and his parents had visited when he was four years old. Across the street from his uncle's home, there had been a fire in which several firemen had lost their lives. The patient's associations contained many screen memories of that visit to the uncle's home. These memories involved seeing things that were exciting and sometimes frightening, police threatening to take the patient's air rifle from him, and his finally discovering evidence of his parents' sexual activities. On the basis of the data, it was possible to ascertain the exact time and place when the patient witnessed the primal scene, as well as the angry, vengeful, guilt-laden fantasies it evoked in him. The data presented in my 1980 publication were intended to demonstrate how motives of revenge entered into response to the primal scene trauma. The same data, however, illustrate the methodological principles that enable one to make a reliable reconstruction.

What follows now are the clinical data from another patient, illustrating the methodology and problems connected with reconstruction. In the material from both of these patients, screen

memory, dream, and transference combine to make a historical and psychological reconstruction possible. This is the material from the second patient.

On approaching the analyst's home, the patient noticed in front of the suburban house a young boy on a tricycle. The thought occurred to him that this must be the analyst's son, and he had a momentary impulse to upset the tricycle so that the little boy would fall and injure his head severely. The patient was embarrassed by that quick fantasy, but nonetheless began the session by relating its content to the analyst. During his recitation, the analyst moved in his chair, and the patient had a momentary flash that the analyst was about to slap him across the face.

This occurred in the context of various expressions of a wish to be loved by the analyst that had been appearing in the material. The analyst noted that the hostility toward the young boy arose in the context of the wish to be loved by the analyst, and he emphasized the competitive element. The patient responded with associations which indicated that he did indeed wish to be loved, that he had a need to be loved and felt he had not been loved as a child. In this connection, he recalled several characters from literature who became monstrously aggressive and destroyed people only after they felt that they were not loved.

At this point, there occurred to him a memory from childhood, one that he had not thought of previously. The family lived in an old Victorian house. They had a cat named B. When the cat was about to give birth to a litter, a cardboard carton, lined with the remnants of an old blanket, was placed on a slightly raised platform in the cellar. The cellar had rough-hewn walls and the floors were usually damp and that is why the carton was placed a few inches above the floor on the platform. At the center of the carton, his parents had made an opening so that it would be easier for B., the cat, to get in and out of the box. After the kittens were born, the patient went down to visit them. One of the kittens must have fallen out of the carton. It was lying helplessly on the floor, piteously meowing. The pa-

tient bent down to pick up the kitten, with the intention of putting it back into the box, but at that moment the mother cat jumped out of the carton and headed directly for the patient's face. He was so frightened by the threatened assault that he got up quickly to move away. In doing so, he stepped on the kitten, and to this day he is not sure whether or not he killed it.

How much of this story represents an actual historical event or a fantasy, whether it is a screen memory composed of several different elements from various times in the patient's life and reading, or whether it is something that actually happened *in toto* as described is difficult to ascertain. The hostility toward the young boy whom he imagined to be the analyst's son—that, however, was clear enough.

In the next session, the patient began by calling attention to the fact that he was going to a meeting which signaled an advance in his business. He was to be promoted, and he was dressed in his Sunday best. He hoped the analyst appreciated how well he looked and the progress that he had been making. He felt that the analyst should be proud, since he feels he owes so much of his success to the therapy. He enjoys being successful, especially when he triumphs over competitors. To be the preferred one has always been important to him, but he knows that it cannot last forever. Perpetual victory is impossible.

At this point, his mood began to change and he reported a discussion that he had had with his wife the night before. She had been pressing him to consider their having a child. He has mixed feelings about it. He feels that the time is ripe, and he would like to have a child, but he fears that it would interfere with his current way of life. He is only now really beginning to enjoy the fruits of success. Recently, he had been buying new clothes and planning trips to foreign countries. Having a child would mean spending money on the child, not being able to travel, having to give up the opera season, and having to devote a great deal of time to taking care of the child.

He then recalled that, coming into the session, he had a feeling that we were beginning a minute or two earlier than usual,

but now he wanted to relate a dream that had been on his mind. Instead of reporting the dream, however, he continued with the discussion that he had with his wife about having a child. The fact is that his wife is late with her period, and this has upset him very much. While he would like to have a child, he does not want to have his plans interfered with. Changing from one way of living to another, depending on whether or not his wife was pregnant, was upsetting. In fact, to be honest, if it turns out that she is really pregnant, he thinks she should have an abortion. Besides, the financial situation is unstable. The mother-in-law had been very generous to them, giving them each year the maximum allowable tax-free gift. As a result of the recent crash in the market, however, she has notified them that she will no longer be able to continue giving them this money. He is very angry with his mother-in-law. He feels that the sum is not that large for her and that, if she wanted to, she really could give it to them. He wants his wife to take the issue up with her mother, but she is reluctant to do so, and this also made the patient very angry with his wife.

"The stock market crash," the patient said, "really changed everything."

At this point, the patient reported the dream. In it, the patient is with an older but still attractive woman. She stays with him after another woman has abandoned him. He has a feeling of revenge against women, and he wonders if he will practice the same kind of revenge on the woman he is with. They go to the basement of the building where they are. It is the building in which he grew up, only instead of the rough, unfinished nature of the original cellar, this basement is really like a dining room. The fittings are elaborate and richer than the ones he knew as a child, and the walls seem to be lined with a soft, red velvet material. He proceeds to become intimate with this woman.

The woman in the dream reminds him of one of his superiors. The day before, she had been presiding over a conference. She is perhaps the one who was instrumental in his recent advancement. She is about twenty years older, but still quite attractive, at

least to him. The other people in the group found her inadequate and, when she left the room for a while, they criticized her clothes and her bearing. He felt that she had been excellent, that she had given so much of herself and had demonstrated generosity as well as leadership ability, not at all, he said, like the analyst, who gives him very little and does not treat him as special.

The patient commented next on the plush dining room setting. In recent months, as a result of the increase in his fortunes and also from the money he had been receiving from his mother-in-law, he and his wife had begun to frequent fancy restaurants. He enjoys having good food in elaborate surroundings. It makes him feel superior to his friends, who cannot afford this kind of dining. He is puzzled, however, by the fact that the setting of the dining room is in the basement of his old home, where he grew up. The cellar was nothing like that at all. It was chilly and damp and the walls were rough-hewn, nothing like the smooth, red plush interior that he sees in the dream. He never really liked that house, especially that cellar. It was there, he recalled, that the incident with the kitten falling out of the cardboard box took place. He began to wonder why he was so greedy for food, why he wanted so much, and why he felt so rejected and isolated, and then he said, almost as if in passing, "Could this have to do with the time when my younger brother was born?"

In the light of the foregoing material, it is possible to make a reconstruction. The general theme of being displaced and becoming angry and destructive when unloved, and the screen memory about the kitten, attest to a certain psychological event in this patient's life in and around the time when his brother was born or about to be born. That event was his catastrophe, like the stock market crash. We can certainly conclude that he wanted to dislodge the baby from its comfortable setting and to destroy it. It is most improbable that the patient would be able to recall seeing his mother's protuberant abdomen when he was three years old and wishing to attack it or actually attacking it, or

recall his wish to be in the "plush dining room" of the womb. Did he make a sharp jab at his mother's belly and did she strike him or threaten to strike him by slapping him in the face? From such material, such a reconstruction can indeed be made safely. More than the historical event, however, is reconstructed. The patient's wishes and fears, his attitude toward women and sibling substitute figures, his character traits, and his inhibitions are, in a sense, part of the reconstruction that is possible. What is reconstructed is not a historical event, such as could be recorded by some omnipresent video camera. What is reconstructed is an event in the psychological history of the individual. In the mind of the young child, perception and fantasy are inextricably intertwined and what remains dynamically active, as either memory or fantasy, is an amalgam of what was wished and what was experienced as "externally" viewed (Arlow, 1969).

In all respects, then, the process involved corresponds to Freud's description of what constitutes a reconstruction. To paraphrase Freud's statement in his paper on reconstruction in terms of the present experience of this patient, one might say, "Up until your third year, before your brother was born, you regarded yourself as the sole and unlimited possessor of your mother. At the age of three, you had a terrible blow, a catastrophe, when your brother came along. You felt you would lose both your mother's love and the food and support that she gave you. When you knew the baby was coming, or shortly after, you had an impulse to attack your mother's abdomen and dislodge the baby or to kill the baby after it was born. Perhaps you pushed your mother's belly. She became very angry and slapped you. Thereafter, you felt threatened and unloved, distrustful of women, anxious about having enough to eat, etc." From the technical point of view, this intervention does not differ at all from the interpretive process generally used. It pertains only to a special kind of material relating to a forgotten incident which could now be understood as a result of the data made available. Many of the derivative manifestations were already known and had been analyzed in the course of the treatment. In other

words, the process involved in this bit of analytic work corresponds in all of its essentials to the mode of interpretation as generally practiced. Reconstruction does not require any special methodology for interpreting the data. The same criteria for interpretation which I have outlined elsewhere (Arlow, 1979) apply to the analysis of the effect of forgotten events and fantasies which we call reconstruction.

The process of reconstruction is not *creatio ex nihilo*. It is here that Freud's archaeological metaphor falls short. A reconstruction is not put together from scattered bits and pieces that seem to fit together into a logical whole. It requires more than that. The essential material has to be drawn from the dynamic configurations as they appear in the psychoanalytic situation in context. This is the criterion that accords screen memories their special significance in the process of reconstruction. The unforgettable, but unrecallable, events of the past are dynamically embedded in the patient's psychic functioning in the here and now. They become understandable as part of the ego's function of defense. What is reconstructed is not an objective event as viewed by an outside observer. It is the historic dynamism that is reconstructed. Recollection and reconstruction become significant only when they are placed in direct connection with the persistent psychological consequences that ensued. The evidence for such reconstructions evolves out of the dynamic configurations of the patient's associations. This is different from the idea that a reconstruction is the nearest acceptable substitute for the undoing of amnesia. Such a concept of reconstruction has special appeal to those whose theory of technique is based on Freud's earlier concept that tied pathogenesis to the consequences of the repression of traumatic events.

At this point, it would perhaps be useful to note that, in my opinion, the interpretation of the transference has often been given undue weight in the process of reconstruction. Transference represents one of the ways in which the past impinges upon the present. By itself, however, without contiguous associative data, screen memories, and derivatives of unconscious

fantasy, transference phenomenology can only suggest a type of speculation. Without the surrounding material, reconstruction based on the phenomenology of transference represents a bias rather than an interpretation. Transference, furthermore, is not a literal revival of the past. It represents a re-enactment in the present of a scenario that developed in consequence of childhood psychic events, whether traumatic object relationships or pathogenic fantasies. The patient is not aware of this scenario, because it represents a derivative expression of conflictual wishes that were initiated by the painful experience and were elaborated in the unconscious fantasy. It is the unconscious fantasy as scenario that is recapitulated in the transference, not the historical events. For example, in "The Revenge Motive in the Primal Scene" (Arlow, 1980), the enactment of a revenge scenario is described. In this scenario the roles of the central characters are reversed. The disappointing parent is cast in the role of the humiliated outsider, while the patient is the center of the sexual activity. Thus, if a patient, in the transference, arranges matters so that the analyst walks in on him or her in the bathroom, this is not a re-enactment of the original experience. It is an actualization of a fantasy of revenge, of a wish that grew out of the primal scene trauma.

Sometimes it appears that the transference represents an actual repetition of events earlier in the patient's life. It is my opinion that, if the data are examined carefully, one finds that, even at the earlier period, those real events represented the acting out of some derivatives of an unconscious fantasy connected with antecedent conflictual wishes. Even those patients who tend to act out repetitions of the primal scene, e.g., entering the analyst's consultation room during another patient's session, are actually living out a fantasied wish to interrupt and embarrass the primal couple. In fact, in many instances, the intrusion of the child into the primal scene is not the original source of the child's knowledge of what goes on in the parents' bedroom, but rather the consequence of having come to understand the significance of the marriage bed.

In the light of what has been said, the problem of reconstructing traumatic events from the preverbal period or, to put it more correctly, the analysis of the persistent effects of experiences of the earliest months of life becomes a problem of methodology. What constitutes adequate evidence for such reconstructions? What criteria for interpretation does one employ? Much of the difficulty resides in the fact that the child's capacity for symbolization, structuralization of memory, and fantasy formation is limited, compared to how these capacities develop after the second and third years of life. The concept advanced by certain object relations theorists is that specific sets of early interactions with objects come to have a dynamic thrust of their own, so that they are compulsively repeated in later life in situations in which they prove to be inappropriate.

To begin with, such formulations seem to deny the concomitant effect of drive derivatives. An object relationship without some drive investment is inconceivable. Furthermore, since new experiences are psychologically processed in relation to the memories of earlier experience, it seems impossible for the memory and the significance of early object relations not to undergo some transformation in the course of time. Consider, for example, the manifold vicissitudes of the derivatives of the unconscious fantasies and wishes connected with the oedipal phase. The developmental overlay of later experience on the earliest object relations has to be enormous.

Convincing evidence for a simple repetition of derivatives of the earliest object relations in later life has not been forthcoming, nor have I found such material in my own experience. There are any number of situations which seemed convincing to me of the plausibility of such a hypothesis, except for the fact that the element of family myth or legend played a role in the associations. For example, one borderline patient, upon receiving news that her husband had failed to receive a very important promotion, sank to the floor in a deep depression and kept scratching vigorously at the carpet. She did this for many hours on end. In her associations, she thought of the carpeting as

made of wool and wool as representing the skin of a sheep. She then mentioned that, when she was a few months old, she developed an allergy to milk, resulting in an intractable itching eczema. To prevent her from excoriating her body, her legs and arms were tied to the side of the crib. This went on for several weeks before the skin was completely healed. This, however, was not a recollection of an event. It was a recollection of what she had been told several times in the course of growing up. One of the patient's persistent character traits, however, was an inability to tolerate unpleasure, which was accompanied by violent anger.

Another patient, a physician, "recalled" how his mother weaned him abruptly at the age of one in order to continue her professional studies. She left the patient in the charge of the grandmother. The patient, however, found the mother's absence unbearable. He was inconsolable and cried all the time. In desperation, the grandmother gave him her dry breasts to suckle on. Another "memory" of the patient's was of his standing near his grandmother while she was grinding meat for hamburgers, and he would eat the raw meat as it came out of the grinding mill. Here again, these associations of the patient, very dramatic in context, were nevertheless not recollections from childhood, but part of the family story that was communicated to him. In the same context of associations, the patient recalled other incidents of abandonment and lack of nurture by his mother from later periods of his life. It is not difficult to imagine how, during the analysis, in recollecting these events, he would also incorporate part of the family legend. This patient was depressed and chronically pessimistic.

What was striking about both cases is the fact that the residual effects of the earliest experiences seemed to be most dominant in character formation. The overlay of later experience and the role of the family legend made it difficult to tease out the specific influence of what might be reconstructed as a traumatic object relationship before the age of one or two.

Why, then, is there controversy about preoedipal and preverbal reconstruction? The origins of the problem, as has been

indicated (Arlow, 1981; Valenstein, 1989), relate to the development in recent years of new views concerning the origin of mental illness, many of which stress the etiological significance of the psychic consequences of events in the earliest period of life. Some theories establish a causative link between symptomatology and an early stage of psychic function or object relationship because of a perceived similarity in the phenomenology. For example, the fetishist clings to the fetish in order to alleviate anxiety and thus secure sexual gratification. The young child clings to the transitional object in order to secure protection from separation anxiety. Therefore, it is argued (Greenacre, 1969), fetishism is based on a regression to the phase of the transitional object. This is a plausible hypothesis, but it remains a suggestion to be verified by evidence. Similarity per se is not sufficient. It does not constitute evidence. It was this sort of reasoning that led Hartmann (1959) to caution against the genetic fallacy in psychoanalysis. One is perforce particularly skeptical of preverbal reconstructions. For one thing, a knowledge of embryology, neuroanatomy, neurophysiology, and neuropathology in the human as well as in other animals warns against the danger of adultomorphizing infantile mental life.

Others exploit the valid findings of psychoanalytic observations of child development. For example, there is little doubt of the genuine pleasure the very young child experiences in the process of mirroring (Mahler, 1967; Spitz, 1955). Kohut (1971) has used this finding as one of the cornerstones of his theory of the origin of narcissistic personality disorders and, consequently, for specific technical maneuvers to correct this deficit. Clearly, it must be enormously difficult to obtain reliable evidence in the analytic situation of what the patient's mirroring experience was like in the early months of life. An a priori approach to clinical phenomena can only result in circular reasoning, that is to say, the presence of the phenomenon is taken as proof of the theory of its cause.

Much of the same can be said in connection with Winnicott's (1953) views on the etiological role of the less than adequate

mother. Except in cases of extreme neglect, it is difficult to establish the adequacy of the mothering person. The fact that the infant may have some problems is taken as evidence that the mothering is less than adequate. In the same spirit, narcissistic insecurity is taken as evidence that the infantile experience of mirroring was faulty. Such formulations are part of a tradition in psychoanalysis, one that I have called the quest for the villain (Arlow, 1981). This trend goes back to the very beginnings of psychoanalysis, although the identity of the villain has changed over the years. First there was the abusing father, then the seductive brother, then the threatening nurse, then the schizophrenogenic mother, and, finally, the inadequate mother usually failing in her function because she was depressed, thus giving rise to a psychopathology of the infant that may be labeled borderline or narcissistic disorder.

A striking example of the interpretation of surface phenomenology in terms of genetic antecedents is offered by Greenacre (1975). She says:

> . . . there are many ways of nonverbal and preverbal communication that are particularly apt to be aroused and available to both analyst and analysand. These are matters of posture, restlessness, special muscle tensions, changes in facial expression, blushing, interferences with speech, changes in tone of voice, lacrimation, sweating, excessive salivation, weeping, urinary and defecatory pressures, changes in respiration, sighing, and so forth and so on. . . . The analyst may regard them simply as indicative of upsurges of mild anxiety and treat them accordingly, unless they are extreme, bizarre, or conspicuously repetitive. But they also indicate that the current anxiety contains quite specific regressive pulls to preverbal troubled conditions in the early period between the total dependence on preverbal body language and the acquisition of speech (pp. 703-704).

To be sure, the body participates in experiences of stress throughout the individual's life. However, the argument just cited appears to me to be reasoning by analogy. One could continue to cite such examples from the literature. These are all

good theories, more or less plausible, and in large measure compatible with what we intuitively feel might be correct. Unfortunately, unless one has supporting evidence demonstrating the dynamic effect, through derivatives of these early experiences and conflicts in the current associative material, it is impossible to draw reliable conclusions. Furthermore, reconstructions of this kind, divorced from any representation in the patient's current experience, can only further the process of intellectualization. They have to be taken on faith. Basically, interpretations of this sort are not analytic; they are subtly didactic, although they may be temporarily effective because of the patient's compliance in the transference situation.

But, after all is said and done, is it really essential for the patient to recall the traumatic incident? Most evidence and experience would seem to indicate that the interpretation of the persistent effects of early childhood experiences, which is the equivalent of a reconstruction, is an effective mode of treatment even without recollection of the trauma. Kris (1956) carefully noted the limits of what can be and what is reconstructed or recovered in the course of an analysis. The emphasis on recollecting precise, historical events is a procedure of questionable value, and it represents a discarded, now obsolete view of pathogenesis and therapy. Reconstruction, like any other interpretation, is a dynamic instrument. It demonstrates how the past influences the present and leads to a deepening of insight. All substantive interpretations, in one way or another, demonstrate the effect in the here and now of persistent conflicts, and this insight serves to illuminate the past. As Blum (1980) states:

> The reconstructive integration identifies patterns and interrelationships rather than isolated conflicts and experiences, and the intrapsychic configurations, consequences, and developmental influences are far more important than actual historical facts. The past is transformed to new meanings and reorganized on new levels of development (p. 51).

The process of reconstruction is a continuous element of the

work of interpretation during analysis, and it has its dynamic effect whether or not the analyst at the moment is aware that he or she is actually effecting a reconstruction.

What do constructions or reconstructions accomplish? Accurate reconstruction is effective in two ways. First, it integrates and synthesizes various trends of the material into a coherent interpretation, which strengthens the patient's insight into his or her conflicts. Second, an accurate reconstruction serves as a base for the elaboration of the patient's unconscious fantasies, facilitating the emergence of additional material, thematically associated or consonant with the nature of the reconstruction. In effect, it does what any good interpretation does. To quote Freud (1937),

> The analyst finishes a piece of construction and communicates it to the subject of the analysis so that it may work upon him; he then constructs a further piece out of the fresh material pouring in upon him, deals with it in the same way, and proceeds in this alternating fashion until the end (pp. 260-261).

This is as apt a description of the therapeutic process in psychoanalysis as one can find anywhere.

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120 East 36th St.
New York, NY 10016

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

A Reading of Freud's *Papers on Technique*

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To cite this article: Lawrence Friedman (1991) A Reading of Freud's *Papers on Technique*, The Psychoanalytic Quarterly, 60:4, 564-595, DOI: 10.1080/21674086.1991.11927323

To link to this article: https://doi.org/10.1080/21674086.1991.11927323

Published online: 27 Nov 2017.

Psychoanalytic Quarterly, LX, 1991

A READING OF FREUD'S *PAPERS ON TECHNIQUE*

BY LAWRENCE FRIEDMAN, M.D.

Freud's Papers on Technique *(1911-1915) is the canonical description of the psychoanalytic procedure. It is a puzzling work because it is dominated by the original paradigm of treatment as memory-retrieval, while at the same time it introduces a new picture, more consistent with Freud's emerging theory of passions, according to which treatment is the stirring up and integration of wishes. I suggest that* Papers on Technique *becomes less puzzling if we assume that, when he wrote it, Freud was mainly concerned not with theory but with a crucial problem of practice. In exchange for some theoretical inconsistency Freud acquired an important practical advantage, and* Papers on Technique *uses that advantage to teach analysts how to divide the patient's consciousness into a passionately committed experience, on the one hand, and a detached contemplation, on the other hand, without worrying about the element of manipulation that is involved. The lesson is that a theoretical ambivalence of this sort is essential to the analytic stance.*

INTRODUCTION

Neither his own later theorizing nor subsequent generations of psychoanalytic practice have elbowed Freud's early *Papers on Technique* (1911-1915) into obsolescence. Rich in detailed wisdom, spoken in that irresistibly congenial voice, this work is probably our most succinct definition of the psychoanalytic profession. But it is also puzzling in many ways.

Before it appeared, Freud defaulted again and again on his

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promise of imminent publication and discarded several initial compilations, as though an unspoken problem held him back (Gay, 1988). What he finally wrote does not look like a technical handbook. In some ways it resembles a postural armature for analysts rather than a treatise on technique, although, as we shall see, that appearance is deceptive.

One thing is certain: if this work is a technical manual, it is a most peculiar one. It does not apply a settled theory to the aims of treatment. On the contrary, as we follow the discussion we become aware that a major theory shift is underway, assimilating an old treatment paradigm to a new one. Before our very eyes a scheme for retrieving memories is gradually overlayered with a plan for integrating wishes.

TWO ASPECTS OF TRANSFERENCE

For the moment I will skip over the first and least ambitious paper in the series, "The Handling of Dream-Interpretation in Psycho-Analysis" (1911). The second paper, "The Dynamics of Transference" (1912a), is the strangest, and its strangeness sets the stage for the work as a whole. It begins with the insistence that no matter how indistinguishable transference is from real love, "the part [it] plays in the treatment can only be explained if we enter into its relations with resistance" (p. 104); but the paper ends with the declaration that the phenomena of transference "do us the inestimable service of making the patient's hidden and forgotten erotic impulses immediate and manifest. For when all is said and done, it is impossible to destroy anyone *in absentia* or *in effigie*" (p. 108).

Between the first assertion that even if it is love, transference is chiefly important to treatment as resistance, and the second assertion that because it is love, it gives treatment access to its object, Freud leaves a record in this one short essay of persistent vacillation between his two treatment paradigms. I will suggest a reason why he did not simply switch from one paradigm to the other, erasing the first before publication.

THE OLD THEORY: *STUDIES ON HYSTERIA*

The old treatment paradigm is a version of the grandfather model proposed in *Studies on Hysteria* (Breuer and Freud, 1893-1895). In that work Freud suggested that the hysterical mind contains partially isolated complexes of repressed pathogenic memories and ideas, encapsulated in concentric layers of related memories and ideas which are so arranged that the more accessible to consciousness are the more deceptive. The treating physician and the patient are both engaged in freeing up the underlying memories so that the sequestered memories may rejoin the natural march of ideas into consciousness, come into contact with each other, and "discharge" themselves.

It happened that Freud's patients sometimes developed romantic feelings for him as they worked to free up their memories. Faithful to his model, Freud believed that those romantic feelings were just like all the other deceptive associations among the nexus of ideas marching toward consciousness, except that these "transference" associations had slipped out of their intrapsychic network and attached themselves by mistake to the person of the analyst. Freud wrote that the romantic feelings disappeared as soon as they were directed to their proper associative links. At that time Freud used the term, transference, in a simple, literal sense. Transference was simply an occasional, unimportant, and neutral *slip*. (This seems to be the meaning of transference that connects most directly with its prepsychoanalytic meaning. See Kravis [In press].)

A little more experience must have quickly taught Freud that transference is neither occasional nor accidental and that, far from being easily redirected, its power is almost beyond belief. By 1915 he will warn beginning analysts that the tasks of interpreting and dealing with reproductions of the repressed are as nothing compared to the difficulties encountered in managing the transference, which are "the only really serious difficulties he has to meet" (1915, p. 159).

THE MISSION OF *PAPERS ON TECHNIQUE*

What *Studies on Hysteria* had to say about transference could not withstand the test of even a short span of time. No honest practitioner could enjoy such complacency about transference for very long. But in addition to supplying an education in difficulty, the passage of time also brought an increasingly sophisticated account of mental functioning. In the interval between *Studies on Hysteria* and *Papers on Technique* Freud's thinking gave a wish-oriented tilt to a theory that, in the earlier work, had been tilting toward ideas. We might suppose that Freud would want to update his concept of transference and all the rest of treatment theory.

Which of these factors generated *Papers on Technique*? Was Freud trying to square his account with the hard facts of experience? Or did he revise the description of treatment used in *Studies on Hysteria* because it was based on an obsolete, idea-processing model of the mind, now upstaged by his new model which emphasized lurking *wishes* (*Interpretation of Dreams*, 1900) and enduring *attachments* and *desires* (*Three Essays on the Theory of Sexuality*, 1905b)?

We naturally assume that Freud would be concerned about the mismatch between his old, ventilating rationale of treatment and his new, appetitive theory of the mind. We suppose that he would feel obliged to map the new picture of the mind onto the rationale of treatment when he next wrote about that subject. We expect *Papers on Technique* to be a systematic tidying-up of treatment theory; we are prepared for a theoretical next step. Expecting that, we find ourselves in confusion. The great puzzle of *Papers on Technique* is that Freud refuses to use that work for the systematic purpose we expect.

Papers on Technique shows us a changing theory but—against all expectation—it turns out not to *be* a programmed revision. I suggest that Freud's alterations in *Papers on Technique* were inspired by practice difficulties: he revises theory only in order to

help with problems of practice and only insofar as the revision helps to solve those problems, and no further. Systematizing for its own sake is avoided. We must ask why.

In answer to this question a disappointingly trivial possibility suggests itself: students of Freud cannot escape the impression that he found treatment the least interesting aspect of psychoanalysis. We can speculate about why that was so. Most likely the challenge of treatment was overshadowed by his larger ambition to be a conquistador—the discoverer of a new world of mind. And some part of his indifference may have been the result of his native wisdom that let him understand treatment too easily and too "instinctively," making it seem unworthy of serious effort and pride: Freud appears to have become an "old" therapist all too soon.

Whatever the reason, Freud's relative indifference to treatment theory requires us to consider the possibility that he thought it unnecessary to formally revise his 1895 picture of treatment because he knew that the hammer of common, clinical hardship would do a good enough job of pounding out the old views to fit the new, appetitive theory of the mind. Some weight must be given to this possibility because in the years between *Studies on Hysteria* and *Papers on Technique* Freud was experiencing the direct impact of his patients' strivings and becoming viscerally aware that he was not just witnessing their memories. For instance, in an 1897 letter to Fliess, Freud identified resistance as a distinct (and distinctly unattractive) subpersonality representing "the child's former character, the degenerative character," which is marked by that frustrated, infantile "longing" which, if unrepressed, would have rendered the patient a "so-called degenerative [case]" (Masson, 1985, p. 274). Of course these words must have been shaped by the theory he was working on (the theory of sexuality), but Freud's tune in this passage conveys an *experience* of unwelcome pressure. And if we are deaf to the tune, we can find it set to words in Freud's statement that the patient who was initially "such a good, noble human being becomes mean, untruthful, or obsti-

nate, a malingerer . . ." (p. 274). Freud would know that even if he did not revise his theory, analysts would soon enough learn that there was more to resistance than silence.

Was Freud, then, content to let the common-sense experience of the encounter bring treatment theory up to date? That is an unlikely explanation for his nonchalance. Although he might well have assumed that any prolonged experience with patients would independently correct the overly sanguine teachings of *Studies on Hysteria*, one would have expected Freud to be so proud of how specifically his new theory of wishes predicted the actual details of what he was discovering in practice, that only a significant restraining motive could keep him from publicly showing the fit and utility of his new ideas, as he did privately in a letter to Fliess in December 1895 (Masson, 1985), where he wrote:

> A hysterical attack is not a discharge but an *action*; and it retains the original characteristic of every action—of being a means to the reproduction of pleasure . . . . aimed at *another person*—but mostly at the prehistoric, unforgettable other person who is never equaled by anyone later (pp. 212-213).

And five months later, again to Fliess,

> A second important piece of insight tells me that the psychic structures which, in hysteria, are affected by repression are not in reality memories—since no one indulges in memory activity without a motive—but *impulses* that derive from primal scenes (p. 239).

A few weeks later he wrote that "symptoms . . . are *the fulfillment of a wish*" (p. 251).

The 1897 letter to Fliess (cited above, p. 568) which shows Freud's personal, attitudinal reaction to resistance also emphasizes the impressive therapeutic leverage he obtained from his new theory of the mind. The new theory allowed him to revisualize resistance both as sexual ("longing") and as the person's actual (infantile) personality—not a stubbornness *related* to sex but sex and personality themselves. Freud had discovered

that the secret to clinical success with resistance is to acknowledge its appetitive nature—its positive desires—and not to regard it as a shutting down.

Thus, while Freud was preparing *The Interpretation of Dreams*, he was also rethinking patients in treatment. And his students who read his new libido theory went on to explore its implications for treatment. We see that direct effect in the work of Ferenczi and Rank (1924) and Sachs (1925).

But even after fifteen years of rethinking treatment in terms of his new theory of the mind, Freud did not undertake to formally and publicly revise it in his *Papers on Technique*. Specifically, he did not promptly paste an up-to-date, appetitive theory of treatment over the old, ideational one found in *Studies on Hysteria*. For example, he did not publicly announce what he had privately written to Fliess, that both theory and practice show that resistance is not a maneuver but an infantile personality. In *Papers on Technique*, Freud is not a theoretician reworking old concepts for the sake of consistency; he is a clinician who has met trouble and, like all clinicians in such circumstances, is calling on both old and new theory for all the help he can get. What trouble had he encountered?

"THE DYNAMICS OF TRANSFERENCE"

The problem presents itself to Freud chiefly in the phenomenon of transference. As he works on the problem his conception of transference changes. In *Studies on Hysteria*, he had described transference as an insignificant mistake. By 1912, writing "The Dynamics of Transference," he has to grant that transference is no more mistaken than any other love. My point is that the revision occurs in the course of trying to solve a problem. It is of secondary importance to Freud in this work that the revision is demanded by his new theory of wish and love. What concerns him is that, in practice, transference love cannot be *handled* by the analyst as though it were an error. His beginning problem in these papers is an uncomfortable piece of empirical knowledge:

Freud had discovered that a treatment designed to aid memory *finds itself* mainly tied up in difficulties of love. One *finds* that the transference is the guts of treatment trouble. That is a portentous discovery because, as it happens, what one makes out of the fact will decide one's model of treatment.

Faced with the brute fact that transference is intimately connected to trouble in treatment, Freud calls on theory to explain why that should be so. In "The Dynamics of the Transference" he applies libido theory and scrutinizes the result: libido, besides being frustrated by the circumstances of the patient's life, fundamentally resists new attachments ("The libido . . . had always been under the influence of the attraction of . . . unconscious complexes . . . and it entered on a regressive course because the attraction of reality had diminished" [1912a, p. 103]). Freud reasons that, whenever analysis threatens to disrupt the patient's infantile scene, the hidden libido is transferred to any "suitable" (resembling) features of the analyst as a last-ditch "compromise between [the demands of resistance] and those of the work of investigation" (p. 103). In other words, under pressure of novelty, conservative forces use compromise formation to hold onto earlier aims. Perhaps this is analogous to the way a dream finds a day residue to express a repressed content.

Such a situation would seem to have three aspects: if the hidden libido which was attached to archaic objects becomes associated with the current image of the analyst, we might expect that (1) its archaic meaning will be masked, (2) its aim will be (obscurely) fulfilled, and (3) the patient's attitude toward the analyst will be changed. But as yet Freud is not equally interested in all of these consequences. More than halfway through "The Dynamics of Transference" he still seems to be working with his earliest model of treatment, according to which disguised ideas and memories spontaneously file into consciousness when the patient's affection for the doctor neutralizes their blockage. Because he is thinking in terms of the memory-retrieval paradigm, Freud makes no comment about the implication that transference is (1) a disguise and (2) a covert satis-

faction; he probably takes it for granted that *all* ideas are more or less disguised, and that satisfactions come and go with memories. What is important for treatment, according to the memory-retrieval paradigm, is that memories and ideas should keep marching into consciousness where they can be deciphered. And that is why Freud's only interest at this point is the third implication—that the transference compromise hinders cooperation with the analyst. In other words, what is important to Freud is that the transferred libido affects the patient's attitude toward the analyst in a way that stops him from reporting ideas and memories.

In writing this, I have deliberately oversimplified Freud's earliest views. He was always aware that he needed more from his patients than their memories. But during the reign of the memory-retrieval paradigm, the rest of the patient's work was referred to parenthetically. We will see his attitude change drastically within the space of two pages of "The Dynamics of Transference," but his change of attitude will not lead him to reject the older paradigm.

That is because, even though his new libido-theoretical formula—the formula that transference is a compromise between the work of investigation and the purpose of resistance—gives Freud potential access to almost every view of transference that will later be developed, the way he *uses* this formula at any given moment naturally depends on what at the moment he takes to be "the work of investigation." According to the memory-retrieval paradigm, which is what he is using in the first half of "The Dynamics of Transference," the work of investigation consists of *letting* ideas and memories rise into consciousness. So Freud at this point naturally thought of the transference compromise as a "stoppage" (specifically, a stoppage that exploits a resemblance between the analyst and old imagoes).

Again, this is oversimplifying Freud's view. What he actually writes is, ". . . transference is carried out; it produces the next association, and announces itself by indications of a resistance—by a stoppage, for instance" (1912a, p. 103). "For instance" im-

plies that resistance can show itself in other ways than by stoppage. But my oversimplification is also Freud's momentary oversimplification, as witness his next question: "How does it come about that transference is so admirably suited to be a means of resistance?" (p. 104). That this question remains outstanding shows that Freud is still thinking of resistance simply as stoppage; otherwise he would have considered the question answered. After all, he had just stated that transference disguises its source and (partly) expresses an infantile wish, and that would be explanation enough of how transference is so admirably suited to be a resistance *if* "resistance" has the broad meaning that it eventually acquired. But Freud knew he had left a question unanswered since he was thinking of resistance as a stoppage of thoughts, and he had *not* explained *why* transference regularly stops thoughts. All he had done was to report that a thought about the analyst *is* followed by a stoppage.

Not only is Freud right in considering the question unanswered, it turns out that it is unanswerable on theoretical grounds. As a formula for intrapsychic equilibrium, transference cannot account for such a specific behavior as a refusal to talk. Only an affect would be specific enough to even roughly suggest a predictable behavior, and for that reason Freud says, "The answer to the question which has been repeated so often in these pages is not to be reached by further reflection but by what we discover when we examine individual transference-resistances occurring during treatment" (p. 105). What he finds in the consulting room is, in effect, that some transferences are marked by antagonism and some by unconscious, erotic conflict—and Freud seems to want to rely on common sense to explain why *these* make a patient uncooperative.

Common sense agrees that an angry patient is likely to refuse the analyst's request. But common sense does not tell us that repressed, erotic impulses regularly silence a patient. Freud's forays lead him only deeper into the woods. Repressed erotic impulses will not automatically show themselves in any single action, such as silence, and Freud knew it.

That is not to say that Freud was wrong in suggesting that patients *may* use repressed, erotic impulses to produce stoppage. In a sense, this hypothesis anticipates the one he will later use in the theory of signal anxiety. The hypothesis is that the patient employs a possibly irrelevant (1912a, p. 104, n.) sample of repressed, erotic attachment to warn himself away from a dangerous exposure of his major libidinal investments. And on a purely observational level every therapist has seen patients deploy troubled sexuality to halt free development of other awareness.

But what is important for our purpose, and even more important to Freud in "The Dynamics of Transference," is that, as stated, his theory simply is not true. As stated, the theory is that repressed erotic impulses are peculiarly suited to stop the patient's remembering and reporting. But repressed erotic impulses are no more useful for stopping reports than they are for starting them or continuing them. In 1911 it is reported that Freud told a meeting of The Vienna Psychoanalytic Society, "The *transference which otherwise—so long as it is in the unconscious—serves the healing process*, becomes conscious to [a fleeing patient] in order that she may be able to stay away" (Nunberg and Federn, 1974, p. 204, italics added). And in "Remembering, Repeating and Working-Through" (1914) he indicates that during the phase when transferences become "hostile or unduly intense and therefore *in need* of repression, remembering at once gives way to acting out" (p. 151, italics added), implying that transference tends to convey such sensitive information that it becomes the matter protected rather than a way of protecting the matter. Furthermore, by repeating his thematic question, Freud has already indicated that the inclusion of repressed desires in the transferential compromise formation does *not* explain why it results so regularly in *stoppage*. Finally, it stands to reason that if repressed, erotic impulses can be counted on by themselves to bring reporting to a halt, the patient would not need to *invoke* any resistance. The resistance would simply *be* those repressed erotic impulses that the analyst

is seeking, a conclusion very close to the one Freud reaches at the end of the essay.

It looks as though this attempt to explain the connection between transference and stoppage had reached a dead-end. And I suspect that Freud knew it, since he suddenly shifts his attention from the phenomenon of stoppage (so central in the memory-retrieval model) to the stormy, self-righteous, demandingness of a patient under the influence of transference resistance, whom he describes as

> flung out of his real relation to the doctor . . . at liberty . . . to disregard the fundamental rule of psycho-analysis . . . [forgetting] the intentions with which he started the treatment [and regarding] with indifference logical arguments and conclusions which only a short time before had made a great impression on him . . . (1912a, p. 107).

The patient is acting as adversary in a "struggle between the doctor and the patient, between intellect and instinctual life, between understanding and seeking to act. . . . It is on that field," Freud writes, "that the victory must be won . . ." (p. 108). With this dramatic picture, the paper concludes fast and powerfully, shaking completely out of the reader's mind the whole preceding discussion of stoppage and leaving only the famous, vivid, digressive afterthought: "[I]t is impossible to destroy anyone *in absentia* or *in effigie*" (p. 108).

It might be objected that the paper had been building to this conclusion; that the original topic was not stoppage but resistance, which "announces itself by a stoppage, for instance" (p. 103). It might be argued that in his peroration Freud was simply turning to another, even more important, "instance" of the effect of resistance, for example, "acting in." It is important to decide whether that is the right way to read "The Dynamics of Transference," because reading it that way teaches a very different lesson than the one I shall propose.

WHAT IS THE RELATIONSHIP BETWEEN THE END OF "THE DYNAMICS OF TRANSFERENCE" AND ITS BEGINNING?

Freud introduces this last section of the paper by writing "[W]e must turn our attention to another aspect of the same subject" (1912a, p. 107). After painting his vivid picture of transference-resistance, he declares that anyone who has observed it will "look for an explanation of his impression in other factors besides those that have already been adduced [i.e., besides its usefulness in stopping free association]" (p. 107). We might call this "other aspect" of transference its positive side. This aspect is not the absence of an action (stoppage, silence), but a florid action itself, a passionate demand. It is this demand that makes the patient's unconscious impulses "contemporaneous and real" (p. 108) and gives the analyst something more than an effigy to deal with. Transference may be the perfect resistance insofar as it brings reporting to a halt, but it is also the necessary (and troublesome) vehicle conveying unconscious material into the field of analytic operation.

Now, if Freud is here winding up his original explanations of the relationship of transference to resistance, why would he call this last consideration "another side" of the issue? Isn't the patient's passionate demand just what it means for the libido to attach itself to the analyst in a disguising and obstructive fashion—the definition of transference resistance already given? Rather than "another side," the "contemporaneous and real" passion of transference seems to be just a more graphic elaboration of this formula. In fact, we have noted above that in his earlier letter (1897) to Fliess (Masson, 1985) Freud had painted this picture not as "another side" of the issue, but as a *definition* of resistance!

Suppose that Freud simply wanted at last to gather up the other two implications of libido theory—that transference not only alters the patient's attitude and interferes with his cooperativeness, but also disguises repressed wishes and partially ful-

fills them. Suppose Freud had noted that those aspects, though largely irrelevant to a memory-retrieval theory of treatment, point to another theory of treatment more consistent with *The Interpretation of Dreams* and *Three Essays on the Theory of Sexuality*. Suppose, in other words, that theoretical completeness had inspired "The Dynamics of Transference," and his intention was to revise his account of treatment and transference so that it would conform with those landmark books. If that had been the case, he could have solved the puzzles of transference and resistance without all the backing and filling we find in this paper. All he needed to do was bring what he wrote on the last page to the beginning of the essay:

> The doctor tries to compel [the patient] to fit these emotional impulses into the nexus of the treatment and of his life-history, to submit them to intellectual consideration and to understand them in the light of their psychical value (1912a, p. 108).

From that description of what the doctor is trying to do it would have been instantly clear that the doctor can be thwarted in *many* ways. Putting that definition at the beginning of his paper, Freud could have advised us right away not to visualize resistance narrowly as stoppage but broadly as a refusal to fit emotional impulses into the nexus of the treatment and life-history, or a refusal to submit them to intellectual consideration, or to understand them in the light of their psychical value, a refusal that is neatly embodied in transference. Indeed, after all is said, the paper leaves us with no doubt that the conservativeness of a patient (his resistance) lies not in his refusing a procedure but in his avoiding a necessary attitude. *In effect*, Freud succeeds in tracking down non-cooperation from its spoor in non-productivity to its lair in non-integration. And yet despite that net accomplishment, most of the paper labors to connect transference and stoppage. In short, this paper resists being read as a systematic effort to catalogue the meanings of transference.

I believe that the only way to understand the structural consistency of "The Dynamics of Transference" is to take Freud

seriously when he says that in discussing passionate transference wishes, he is turning away from the *resistance* significance of transference (which he is still thinking of as stoppage) and turning toward another aspect of transference which he thinks of as a treatment "difficulty" that *accompanies* resistance. In other words, whatever Freud's purpose is in *Papers on Technique*, it is a purpose that is served more specifically by the memory-retrieval paradigm and its definition of resistance than by theoretical consistency, which would simply call for a different definition of resistance.

Our task is to discover that purpose. When we know Freud's purpose, we will know why he declined to build a new theory of resistance and a new theory of treatment entirely out of the effigy-killing material contained in the final two pages of "The Dynamics of Transference," and I think we learn some other useful lessons in the process.

WHAT WAS FREUD'S SITUATION AT THE TIME?

Freud's situation should help us decipher his purpose, and here I will venture my own imaginings: Freud began his design of psychoanalytic treatment with a search for memories, but painful experience finally made him doubt that patients were pounding on him so relentlessly just in order not to remember something. A theoretician at his desk might stubbornly stick to that doctrine, but, as Freud indicates (1912a, p. 107), no one on the scene could believe it.

I imagine Freud to have been pondering the fact that treatment, as it is experienced in real life, cannot be visualized as clearing the way for a spontaneous welling up of memories. It is not memories that well up; it is wishful efforts. (Transference is always obtruding itself.) The analyst's job is not to facilitate a natural surfacing of memories; he does not *free* memories. His struggle is to *persuade* the patient to remember—a persuasion that is just part of a larger effort to engage the patient in a

reflective activity. In this struggle what opposes the analyst is the patient's preference for a non-reflective action (the fulfillment of unintegrated wishes). Strictly speaking, then, although it is not something that Freud spelled out, what "resistance" resists is the analyst, not the emergence of memories (*cf.*, Gill, 1982). The analyst's persuasion is not exercised on behalf of the patient's frustrated, natural process. The analyst is not, in this first instance, an ally. (Needless to say, the later development of ego theory and split-ego hypotheses will complicate the formula, but I think dynamic understanding of how and why the analytic enterprise is taken over by the patient has progressed since 1912 more in words than in ideas.)

By itself, this discovery would logically have led Freud to renounce the ideas we find in the main body of "The Dynamics of Transference," redefine resistance as the patient's natural disinclination to be lured away from infantile wishes, and dispel the mystery of why transference is such a perfect resistance by simply pointing out that transference is a perseverative reach for a compartmentalized childhood goal, inherently opposed to contemplation, synthesis, and re-contextualization.

Because the theory does not move in this *logical* fashion, we should look for a *practical* incentive that would motivate Freud to cling to his earlier view—the view that resistance is a force opposing a natural inclination to remember, and that transference is the chief resistance because it is the best *incentive* for not remembering, tacking on as a mere addendum the discovery that the desires embodied in transference are important to treatment in their own right, and that resistance is a wish to act, and not just to be left alone.

DIVIDED CONSCIOUSNESS: A GOOD REASON TO KEEP THE OLD MEMORY-RETRIEVAL MODEL

I believe that, compared to the newer model of attitude-induction, the memory-retrieval model has an important advantage that persuaded Freud to preserve it together with its nar-

row view of resistance. The advantage can be described in several ways: (1) The memory-retrieval model allows the analyst to see himself as relatively passive and therefore objective, since his main action is blocking a blocker (resistance).[1] (2) According to the memory-retrieval model, the analyst is on the side of a natural process, not the inventor and manipulator of an artificial process. (3) For that reason the analyst can fit himself into the traditional role of the physician who accepts help from a limited, natural rapport in order to foster normally occurring healing processes. In contrast, the analyst of the new model does not deal with normally emerging memories but deliberately encourages the unusual elaboration of profound wishes and enlarges and sustains the patient's personal attachment, something that would be considered unethical by other physicians. (Freud faces that fact frankly in the last of the papers on technique, "Observations on Transference-Love" [1915].) (4) The fundamental rule, which is the linchpin of Freud's technique, was invented for the memory-retrieval model, and the memory-retrieval model gives the fundamental rule its simple reasonableness, allowing it to be assigned and accepted as a rule. (5) The belief that resistance-free memories appear spontaneously at the defile of consciousness is a useful tool even as a myth. Like a Buddhist *tanka*—a diagram that guides the viewer into an altered state of consciousness—the picture of thoughts and memories parading in front of one's grandstand is a schematism that

[1] In describing transference interpretation, Freud may have recalled his struggles to convince critics that his interpretations of verbal associations were not arbitrary. In the Postscript to the report on Dora (1905a) he had written that handling transference is "by far the hardest part of the whole task. It is easy to learn how to interpret dreams, to extract from the patient's associations his unconscious thoughts and memories, and to practise similar explanatory arts: for these the patient himself will always supply the text. Transference is the one thing the presence of which has to be detected almost without assistance and with only the slightest clues to go upon, while at the same time the risk of making arbitrary inferences has to be avoided" (p. 116). Freud may have regarded inferences from behavior as less publicly demonstrable than those made from verbal associations, and that may have contributed to his reluctance to abandon the memory-retrieval model.

the patient can use *to divide his consciousness*. He can parade and watch at the same time. The myth was already effective in the first cases of *Studies on Hysteria* (Breuer and Freud, 1893-1895). Breuer's patient, Anna O., invented an elaborate version of the myth for her own use.

These advantages converge on that last consideration, which I believe is the decisive one. Ever since its inception psychoanalytic treatment has been characterized by the division of consciousness. I believe that in order to promote the division of consciousness, Freud found it useful to keep defining resistance as a blockage of naturally emerging memories and memory-related ideas, even though he had discovered that what he was dealing with had the character of demand rather than the quality of memory and forgetting.[2]

Studies on Hysteria had provided an image of a naturally rising order of memories, and that remained an invaluable prop for the analyst who has to coach his patient in the difficult act of reflecting on purposes while speaking without purpose. It would be hard to describe, define, advise, or accept this basic analytic procedure if one lost touch with the early memory-retrieval model.

In other words, the memory-retrieval model is an image of disinterested reporting. I suggest that the reason so much of "The Dynamics of Transference" is devoted to the memory-retrieval paradigm is that its mission is to prevent the impressive phenomenon of passionate transference from overwhelming the image—the confidence in—and the demand for—disinterested reporting.

If this hypothesis is correct, one might imagine Freud's thoughts to have progressed in the following way as he moved through the argument presented in "The Dynamics of Transference": "I see that transference always lies behind treat-

[2] What he had discovered was that memories are a means of dealing with desire; in the new paradigm we suffer not from memories but from wants, which are modified during treatment by the act of remembering.

ment difficulty. I think it's an excuse for the difficulty. Yes, I'm sure it's an excuse, but why do patients keep using *that* particular excuse? I guess it's a good excuse because it is a small, vivid sample of their genuine reason for non-cooperation. But patients seem too frantically dedicated to that excuse for it to be merely an example of what they're afraid of. Actually, I have to admit that transference is not an excuse at all: it is a basic demand which is honestly opposed to our effort, and because it is honest, we must encourage it. But let's still say that it's *also* an excuse, because then we can counter the transference demand with our own demand in the form of the fundamental rule, persuade the patient (just as we used to) that our demand is actually his wish (i.e., we only want his ideas to follow their normal course), and thereby *transform* the transference into an excuse (for not taking the required distance from its demands)."[3]

THE IMPLICIT, NEW THEORY OF TREATMENT

As the argument in *Papers on Technique* proceeds, a new goal of treatment appears. The new goal is derived from the merger of two theoretical models. In the first model—the world of *Studies on Hysteria*—treatment is memory-retrieval. It is a hunt for forgotten events and unintegrated memories, pursued in partnership with a patient who, though he may be discouraged by the pain and difficulty of the search, obtrudes no other enduring purpose. The new model of treatment that Freud is superimposing in these papers is a hunt for inflexible wishes, undertaken against the will of a patient who is motivated in other directions. The patient wants something else from the analyst than a cure, and his other wish is not just to be left alone. The

[3] Thus one consequence of the double-track model of attention (wishing and reporting) is to make it possible to view behavior (communication) as both an evasion and a demand. And that is characteristic of psychoanalysis.

patient is not simply torn between discovery and concealment. The analyst is not the only persuader in the room.

ADJUSTMENTS REQUIRED BY THE NEW THEORY

The new hybrid model affects all aspects of treatment, and *Papers on Technique* follows out its influence. To be sure, the work includes many useful, miscellaneous suggestions. But there is an observable continuity: In one crucial area after another, Freud is finding a way to think in terms of the earlier theory of treatment (ventilating memories) while heading toward the new treatment goal (the integrating of freshly enlivened wishes). Thus he is required to redefine repressed *memory* in terms of persisting *desires*. And then, as we have seen, he must redefine *resistance* so that it suggests *revelation*. Next he has to touch up the picture of psychoanalytic *integration* so that it portrays *enactment* without losing its family resemblance to *remembering*.

FIRST PAPER: "THE HANDLING OF DREAM-INTERPRETATION IN PSYCHO-ANALYSIS"

The central message of "The Handling of Dream-Interpretation in Psycho-Analysis" (1911) is that the analyst cannot afford to make dreams dear to himself any more than he can afford to make himself hostage to other withholdable or distracting material. We also find practical arguments for not dwelling overmuch on dreams, such as the danger that prolonged dream analysis might displace fresher material. But the familiar theme shared with the rest of *Papers on Technique* is the need for disciplined heedlessness on the part of both patient and analyst, the obligation to maintain a not-caring attitude, the avoidance of goal-directed attention, and the stifling in the analyst of any wish that the patient might satisfy other than obedience to the fundamental rule.

THIRD AND FOURTH PAPERS: "RECOMMENDATIONS TO PHYSICIANS PRACTISING PSYCHO-ANALYSIS" AND "ON BEGINNING THE TREATMENT"

The commitment to passive receptivity and the forswearing of goals and ambitions by both patient and analyst is discussed further in "Recommendations to Physicians Practising Psycho-Analysis" (1912b) and "On Beginning the Treatment" (1913). These two papers describe how the patient is encouraged by the fundamental rule to abandon wishful action and discover the peculiar skill of experiencing passionate interests dispassionately. (We might compare the data obtained in this way to memories recollected in tranquility.)

FIFTH PAPER: "REMEMBERING, REPEATING AND WORKING-THROUGH"

The following paper, "Remembering, Repeating and Working-Through" (1914), describes a very different kind of experience, parallel to the first but with memories recollected in anything but tranquility. In this paper we are told that *strivings* may be considered memories, represented as a compulsion to repeat, and moreover that striving is indeed the way that memories are most likely to appear in treatment. "As long as the patient is in treatment he cannot escape from the compulsion to repeat . . ." (p. 150). In this paper, even the old stoppage is considered to be a memory in the form of repetition (p. 150). ("He is silent and declares that nothing occurs to him. This, of course, is merely a repetition of a homosexual attitude which comes to the fore as a resistance against remembering anything" [p. 150].) But the memory paradigm remains a necessary orienting paradigm in treatment even if it does not describe what actually happens.

> For [the physician], remembering in the old manner—reproduction in the psychical field—is the aim to which he

adheres, even though he knows that such an aim cannot be achieved in the new technique (p. 153).

Not only does this paper revise the meaning of memories, making them seem more like wishes, it effectively strips individual memories of their role as separate agents. That is, the revision does not simply reassign individual memories to individual wishes. Wishes, having amplified the meaning of memories, now present themselves as aspects of a striving *person*, or part of the person's personality, or part of his neurosis. Memory is now seen as a *facet* of a general structure of idea and wish.[4]

THE IMPLICIT, NEW THEORY OF RESISTANCE

The healing movement in treatment used to be the march of memories and related ideas into consciousness, and, accordingly, resistance was pictured as the force that stopped that movement (Freud, 1904, p. 251). The new theory holds that the natural flow is not toward memory per se but toward unmodified enactment. (I overstate the case for the moment to highlight the shift in theory.) What now, according to this theory, is the resisting force that must be overcome? Logically, it would be the force of the unconscious wishes themselves. Implicit in the new theory is the doctrine that the resistance is the wishes themselves in their unintegrated form. Or perhaps it would be better to say that it is the tendency of the wishes to express themselves without integrative modification, or that resistance is a bad attitude in respect to recontextualization, or even that resistance is the patient as he is. (In view of the fact that this implication is never explicitly published, we are surprised to see how explicit Freud had already made it in 1897, in the letter to Fliess cited on p. 568 above.)

[4] Many analysts (e.g., Ferenczi and Rank, 1924; Sachs, 1925) will, in a one-for-one fashion, replace the hunt for concealed memories with the effort to dislodge hidden libido from concealed actions. It is a simplification that Freud will object to precisely because it neglects the double-track of consciousness (see Grubrich-Simitis, 1986).

THE NEW THEORY OF CURATIVE WORK

Since for all practical purposes resistance now means something different than it did in the old theory, the *work* needed to overcome it must also be viewed differently. As we have noted, the analyst's job is no longer to clear the way for upwardly pressing memories. Rather, the analyst is required to encourage a divided awareness in the patient, separating active aspirations from passive observation. The effort toward the double awareness is called *working through*.

> One must allow the patient time to become more conversant with the resistance that is unknown to him, to *work through* it, to overcome it, by continuing, in defiance of it, the analytic work according to the fundamental rule of analysis. Only when the resistance is at its height can the analyst, working in common with his patient, discover the repressed instinctual impulses which are feeding the resistance . . . (1914, p. 155 and p. 155, n.). [*Pace* Strachey, I use Freud's revision of the first sentence because it makes more sense to me.]

Just as wishes replace memories in the new theory of treatment, the act of working through replaces the act of remembering: instead of recovering memories *simpliciter*, treatment cultivates current wishes and finds memories that fit them. (Freud wrote that working through in psychoanalysis performs the function that catharsis performs in hypnosis.)

NEW PROBLEMS OF PASSIVITY AND THE NEW FUNCTION OF THE FUNDAMENTAL RULE

Working through is simply adherence to the fundamental rule insofar as it operates against resistance. So it is not surprising that the implicit change in the meaning of resistance gives a new significance to the fundamental rule. Let us examine that change now.

The defining characteristic of the fundamental rule is disciplined passivity, actively utilized. As a step toward the active

uncovering and identification of memories, the fundamental rule requires, first, a quietistic passivity in both analyst and patient. The passivity required of the patient is explicit in the rule. That of the analyst is implicit: in effect, the analyst suppresses all other wishes save that the patient follow the fundamental rule. He asks no love gratifications. He suspends his wish to conquer knowledge frontiers (there is also a heuristic principle in that, of course). He does not try to impress the patient or inspire him. He does not seek confirmation of his kindness in being empathic. (He is like a surgeon doing his job in a humble, matter-of-fact fashion, aspiring to no role that could be denied him.) He asks only one thing: that the patient follow the fundamental rule. One notes that it is only through the fundamental rule that the patient can please the analyst.

Since the fundamental rule originated in the earlier memory-retrieval model, it carried with it the notion of a built-in order of recall. The fundamental rule was tailored to suit a supposedly predetermined march of memories, which both patient and analyst could witness passively in line with their mutual, active purpose of reconstruction.

In the new model the rule has taken on a different quality. As regards activity, there is no simply statable objective that both parties can strive for. Thus it would no longer make sense for the analyst to put his hand on the patient's head. (If he were employing suggestion, what would he suggest would happen? More puzzling still, what would he *want* to happen?) What can the patient and analyst be *trying* for when they are no longer searching for memories? For practical purposes, the process has become the goal, and that is harder to define and to pursue.

As the goal becomes less definable, passivity becomes more problematic.

THE PARADOX OF THE ANALYST'S PASSIVITY

The analyst's passivity becomes problematic because his activity is no longer limited to preserving the patient's own initial wish

(to discover the pathogenic memory). Now the analyst must inspire a new, overt, personal longing that the patient never anticipated when he started treatment. And, probably of greater concern to Freud, the analyst now must also put himself in opposition to what he has invited—in some ways opposing an appeal by the patient that is expressive and not just obstructive—whereas in the past the analyst only opposed what he regarded as interference.

In these circumstances, it would seem that no theoretical handling can make the psychoanalyst's passivity comfortably straightforward. But his model of treatment will determine just how painful it must be. It is less painful when the analyst can refer to Freud's early model. *Papers on Technique* takes advantage of that fact. It recommends that analysts adopt a non-interfering style of attention. In line with that recommendation most of the instructions in *Papers on Technique* are negative: don't do this and don't do that. A reader can easily overlook the active, goal-directed behavior that Freud is also suggesting. For instance, it turns out that free-floating attention and suspension of formulations are recommended for only part of the analytic field. Quite a different approach is recommended in dealing with *resistance*. Resistance is handled more deliberately both by the analyst and (in the course of working through) by the patient.

How does Freud reconcile these two attitudes toward impulse? By appealing to the memory-retrieval model. A rule that respects the natural order of memory-thoughts reassures the analyst that he is being appropriately passive even when he is actively policing the right-of-way needed by the patient's independent thought processes. The analyst's interventions are initiated only to facilitate the natural progression of the patient's own memories. Stoppage is a logical and mutually accepted signal for the analyst to cease musing and start thinking on behalf of his patient in an active, practical way.

As long as Freud can borrow from the memory-retrieval model the idea that resistance is stoppage, the paradox can be overlooked: the analyst is active only when the patient offers

nothing to attend to in a passive way. If the analyst were to give up the memory-retrieval model and see himself principally as a seducer and controller of the patient's active wishes, it would be hard for him to recover the balance between passive contemplation and active provocation. These implications become apparent in *Papers on Technique*, and as we read it, we understand better why Freud wanted to retain the memory-retrieval model.

Thus, we can see the usefulness of the double model as we observe how the concept of working through sharpens the paradox: on the one hand, impulses responsible for the patient's productions are non-judgmentally *allowed* to emerge; on the other hand, the same impulses, when responsible for resistance, are not simply allowed to emerge but are immediately inspected, deciphered, and judged.

> The first step in overcoming the resistances is made, as we know, by the analyst's uncovering the resistance, which is never recognized by the patient, and acquainting him with it. . . . One must allow the patient time to become more conversant with this resistance with which he has now become acquainted. . . . Only when the resistance is at its height can the analyst, working in common with his patient, discover the repressed instinctual impulses which are feeding the resistance . . . (1914, p. 155). [This time I use Strachey's translation of the first edition, as best illustrating the paradox.]

PARADOXES OF THE PATIENT'S PASSIVITY

As for the patient's passivity, that also is newly paradoxical because transference is no longer an associative error that he can simply *watch*. The patient no longer has an unequivocal assignment.

In the days when obeying the fundamental rule meant entertaining memories and ideas, the patient could detach himself from the resistance by attaching himself to the analyst (who is memory's ally). The analyst could be relied on to overcome the resistance and let memory speak its piece. But in the new theory

(where resistance is almost a synonym for impulse) the fundamental rule requires the patient to sustain a connection with the resistance as well as with the analyst's viewpoint. The impulses must come to life and be owned by him. Now attachment to the analyst plays on both sides of the net: love for the analyst (1) induces desire, (2) focuses it on the analyst, (3) commits the patient to his demand (so that he can experience it consciously), and (4) persuades him to disown his demand (so that he can contemplate it).

The fundamental rule now means that, for love of the analyst, the patient must express his desire while distancing himself enough to relinquish efforts at satisfaction. As we have noted, a corresponding change occurs in the analyst's free-floating attention: it is no longer a simple receiver of surfacing memories; it is also the analyst's suppression within himself of any wish that the patient might use to settle transference longings.

THE NEW VIEW OF THE PATIENT'S ATTENTION

The conclusion of "The Dynamics of Transference" was that the patient has to experience his wishes alive in order for them to be changed (i.e., in order for them to be integrated with the rest of life). Implicit in that paper, and explicit in the later paper, "Observations on Transference-Love" (1915), is the principle that treatment requires a simultaneous conscious activation of repressed wishes and a cool contemplation of their significance, so that they are experienced both as wishes and as objective features of the conflicted self. The patient must feel both "I want . . ." and "it is a (troubling) feature of my mind and my life that I (conflictedly) want. . . ." Correlatively, the patient must feel, "The analyst has and won't give me . . . ," and "I carry with me an unsatisfiable wish for. . . ." The fundamental rule compels these pairs to go together. Their going together is called *working through*.

This new model is familiar to all analysts. It is the combination

of involvement and distancing that grossly identifies the analytic project. *Papers on Technique* teaches how to achieve a dual consciousness. Seen that way, the work reveals itself as a technical manual after all, and not a secretive shell game, always saying what not to do but never telling what to do.[5]

THE FINAL PAPER, "OBSERVATIONS ON TRANSFERENCE-LOVE," AND THE ANALYST'S NEW POSITION

The suggestion that transference is a libidinal revival was left dangling at the end of "The Dynamics of Transference." Now, in "Observations on Transference-Love" (1915), the final paper of the series, we see Freud pick up the theme again and work out the details. At last the animating function of the transference is fully acknowledged. But the special significance of the paper does not lie in a theoretical exegesis that could as well have been written at the beginning of *Papers on Technique*. What Freud accomplishes in this paper is something subtler and riskier, and something that could only be done properly at the conclusion of the work. In effect, "Observations on Transference-Love" is a study of the analyst's new role and perilous new responsibility, and for that reason it is appropriately reserved as a capstone for all of the paradoxical considerations of the preceding papers. In particular, this paper is designed to prevent

[5] Discussing Freud's determination to make reference to an objective reality notwithstanding his recognition of the transferential nature of perception, McLaughlin (1981) writes: ". . . Freud had to make the distinction between two realities in order to create the unique circumstances of the analytic situation, without which there would be no analytic process. Freud's operational set was that within the analytic situation the patient would experience the transferences as real; yet the analyst (and eventually the patient) would consider them objectively as nonreal anachronisms. This artifice provided an enormously facilitating and constraining therapeutic dialectic for the analyst and patient. It was indeed a stroke of genius to hit upon a mode that allowed freedom and protection for both parties in a real-unreal intimacy, a simultaneity of close hovering and distancing from, of seeking of likeness and difference, of cursive merging and discursive objectifying" (p. 643).

the analyst from taking up any facile position in regard to the transference.

> . . . I shall state it as a fundamental principle that the patient's need and longing should be allowed to persist in her, in order that they may serve as forces impelling her to do work and to make changes, and that we must beware of appeasing those forces by means of surrogates (p. 165).
>
> It is, therefore, just as disastrous for the analysis if the patient's craving for love is gratified as if it is suppressed. The course the analyst must pursue is neither of these; it is one for which there is no model in real life (p. 166).
>
> The lay public . . . will doubtless seize upon this discussion of transference-love as another opportunity for directing the attention of the world to the serious danger of this therapeutic method. The psycho-analyst knows that he is working with highly explosive forces and that he needs to proceed with as much caution and conscientiousness as a chemist (p. 170).

According to the old theory, the analyst could claim to be championing the patient's effort to recover memories. He could think of his manipulativeness as strengthening one side of the patient's internal battle. In that theory the fundamental rule was merely a formalization of memory's intrinsic nature. In the new theory, by contrast, the fundamental rule reflects not the patient's (memory's) wish, but the analyst's professional identity: indeed, the power of the fundamental rule lies in the fact that the analyst's advocacy of the rule is his only self-disclosure and his single communicated wish. In the new theory the analyst actually seduces the patient's wishes and, by being a seducer with only the fundamental rule as a desire, requires the patient to frustrate himself to please the analyst. The analyst is now responsible both for luring the patient's wishes and for luring the patient to betray them. To please him the patient must partially forgo even the reach for satisfaction.

Later, Freud will make this a natural function of the observing ego (see Schafer, 1990). Subsequent literature will refer to split

egos and therapeutic alliances, etc. The analyst will again be able to imagine himself as strengthening a natural inclination of the patient. The onus that falls on the analyst as a consequence of the new theory of treatment will then be obscured. But in 1915 the onus is still clear. And it is the burden (in both senses of that word) of "Observations on Transference-Love." No wonder that Freud was proudest of this courageous paper.

CONCLUSION

Speech is naturally provocative and manipulative (see Austin, 1962). But "working through" requires the analysand to speak non-manipulatively about his manipulative intentions. He is supposed to report his wishes without letting them compose his report. If the wishes authored his report, the report would disguise the wishes in ways that implemented their thrust. Non-manipulative reporting is an asymptotic goal to which the patient can bring a certain kind of effort, a resolution to forgo the manipulative power of communication under intense pressure to manipulate. The inevitable failure of the effort is called "resistance."

The effort to associate freely requires one to identify with one's striving and also with a self that could dispense with that striving. Obviously this double-track experience is both a cause and a result of living beyond one's momentary means. Larger possibilities are already available to anybody who can perform such strange gymnastics, and exercise will surely stretch those possibilities further.

Freud's *Papers on Technique* are instructions for dividing attention this way. His formula was discovered by painful trials with a treatment originally tailored to an earlier rationale. The cardinal features of that earlier treatment (free association; the reconstruction from memories, etc.) proved to be so vital to the new treatment, and so difficult to write a prescription for, that their original rationale (clearing away of blocked memories) re-

mained a useful adjunct even after the grand treatment strategy had outgrown it.

Freud had a way of cornering experience into *demonstrating* usable structure within the seemingly ineffable powers of mind, and nowhere is his dissection more revealing than in the conceptualizing of psychoanalytic treatment. The odds could not have been very great that these early descriptions of the intangibles of treatment would survive almost a century of stressful testing. Watching Freud use theory to meet and match the practical problems of treating people, one wonders why psychoanalysts feel the need to fall back monotonously (and therefore unconvincingly) on Freud's abandonment of the seduction hypothesis to make a case for the empirical nature of psychoanalysis.

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129B East 71 St.
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Routledge
Taylor & Francis Group

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

The Biblical Book of Job: Advice to Clinicians

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To cite this article: Owen Renik (1991) The Biblical Book of Job: Advice to Clinicians, The Psychoanalytic Quarterly, 60:4, 596-606, DOI: 10.1080/21674086.1991.11927324

To link to this article: https://doi.org/10.1080/21674086.1991.11927324

Psychoanalytic Quarterly, LX, 1991

THE BIBLICAL BOOK OF JOB: ADVICE TO CLINICIANS

BY OWEN RENIK, M.D.

Study of the Book of Job clarifies the particular adaptation to trauma that underlies the suffering of certain difficult patients. In addition, the misdirected efforts of Job's comforters in the Bible story help us understand why, with such patients, an analyst's attempts to address unconscious guilt and defenses against it will prove counterproductive. A case example is presented.

As psychoanalysts we can speculate that the great Biblical tales endure in popularity because they provide appealing ways of looking at common human situations. The Job story, for example, cogently portrays a particular kind of adaptation to trauma. I find that study of this chapter of the Bible illuminates the psychology of a group of difficult patients. Moreover, if we look at how the relationship between Job and his comforters is depicted, we can understand why an analytic approach commonly taken in the treatment of these difficult patients—though very effective in other apparently similar cases—is not productive with them.

The Book of Job can be divided into two separate narratives. The first portrays events on earth. In it the protagonist is Job, a pious and honest man, also a prosperous man. Suddenly, inexplicably, Job's good fortune is catastrophically reversed. His property is all stolen; his family is killed; and finally his good health is replaced by affliction with painful and incurable boils. Job complains bitterly about the injustice of his fate to God. Job wishes he had never been born.

Three friends learn of Job's misfortunes and come to offer their help. After silently and respectfully hearing Job out, they

assure him that his suffering must be the result of some hidden guilt. They advise him not to justify himself, but to admit his guilt instead.

Job's response to these suggestions is to become outraged. He accuses his friends of underestimating him to an insulting degree, and tells them that their theories are in error because they fail to realize that God's reasons are beyond human understanding. The friends, in turn, accuse Job of arrogance and an unwillingness to listen. The argument is ended when God appears in a whirlwind and speaks, vindicating Job's view and rebuking Job's friends. Finally, Job's family is restored, his health mended, and his property returned double.

The cause for these dramatic events on earth is explained in a second narrative depicting an encounter in the supernatural realm between God and Satan. Thus, the omniscient reader is privileged to know happenings that profoundly influence Job and his friends, while they remain completely unaware. The second narrative tells of God bragging to Satan about the devotion of Job, God's faithful servant. Satan is skeptical, hypothesizing that Job is merely grateful for his good fortune, rather than truly devoted to God. In response to this challenge, God allows Satan to deprive Job first of his family and worldly goods, and then of his health, to see what will happen to Job's devotion in the absence of material benefit. Since Job, despite all his complaints about God's cruelty, never loses faith in God's unknowable rightness, he proves God's boast to Satan correct.

There are some patients whose conscious experience of their lives is very much that which is described in the earthly narrative of the Job story. These people try to be as good as they can, but are always suffering. They do everything that others require of them, only to be let down and abused. In analysis they apply themselves assiduously to their appointed tasks, but never really get anywhere. One way or another they eventually feel victimized by their analysts, as they felt victimized in childhood by the important people upon whom they relied. Like Job, they com-

plain bitterly (though in some instances their complaints may be veiled by superficial disclaimers); and, also like Job, while they may express the wish that they had never been born, they do not commit suicide—nor do they quit their analyses.

The analyst will have reason to think that the suffering of such a patient is based on an unconscious sense of guilt. Time and again it is clear that the misfortunes about which the patient complains are ones that he or she has arranged himself or herself. From this repetitive pattern, the analyst can easily infer a need for punishment on the patient's part. All around, in other people, the patient finds cruelty and selfishness. The analyst may think it very likely that the patient's perceptions, however correct they may sometimes be, serve to project aspects of character about which he or she feels guilt. By identifying these traits in others, the patient avoids being aware of them in himself or herself.

In many cases, an understanding of the patient's problems based on the inference of defenses against unconscious guilt is valid, and an analytic approach informed by it produces a positive result—perhaps slowly, haltingly, and with much *Sturm und Drang*, but progressively nonetheless. However, with certain Job-like patients the situation is very different. An analyst who attempts to address unconscious guilt and defenses against it becomes a Job's comforter. The analyst will find, as did Job's friends, that instead of alleviating suffering, he or she exacerbates it, and is regarded as hurtful rather than helpful. Although the analyst may be convinced about the patient's deeply buried guilt, a stalemate will result, because the patient, like Job, is intractable in experiencing the analyst as wrong and insulting. Even if this perception of the analyst is covered over by ostensible acceptance of the hypothesis of unconscious guilt, and by an absence of explicit criticism, underneath the patient feels misunderstood and hurt.

For these patients, the real meaning of what is happening in their lives corresponds to the real meaning of what happens to

Job, as described in the Biblical story's second, supernatural narrative. Just as Job is unconscious of the encounter between God and Satan, so these patients are unconscious of the fantasy that causes them to think and act as they do. The second narrative of the Job story reveals that things are not at all what they appear. While God may seem to be neglecting or abusing Job, actually God loves Job especially. Job's complaints about God, in turn, while they may seem hostile and destructive, are actually proofs of Job's love for God, since they are the measure of the extremity Job endures while remaining devoted. Thus, from an earthly, manifest, conscious perspective, the relationship between Job and God is one of pained protests reciprocated by silence and withdrawal; but from an unconscious, supernatural perspective, their relationship is one of extraordinary, secret, mutual love.

The crucial matter in the analysis of a Job-like patient is that enactment of an unconscious fantasy of magical, hidden love within the treatment relationship must be clarified if the patient's suffering is to be relieved. As far as an effort to address unconscious guilt and defenses against it goes in such cases, the analyst soon finds, as did Job's comforters, that it is counterproductive.

A woman went into analysis to find out why her love relationships always ended in disappointment. Either she stayed too long with a man who was beneath her, or she pined hopelessly for someone wonderful who would never become available. Her mother had been severely chronically ill, so that as a girl, the patient had early turned to her father and identified strongly with him. He was an extremely accomplished and highly admirable man. The patient felt very close to him, sometimes being his escort or confidante when her mother was not available; but she also resented the strict demands for achievement her father placed upon her, as well as his sometimes abrupt rages and withdrawals. She saw her analyst as very much like her father.

She looked up to him and longed for him. She accused him of being ridiculously psychoanalytically orthodox, and therefore needlessly cold and constrained in his dealings with her.

A significant amount of analytic work eventually unveiled the patient's fantasy of oedipal triumph. Ultimately, she believed that her analyst's reserve and technically justified abstinence were efforts to protect himself against his powerful, upsetting, forbidden love for her. This had been the real meaning, too, of the times when her father had seemed to be inconsiderate, neglectful, or mean. While she recognized that her belief in her analyst's internal struggle was an unrealistic transference of past into present, it remained her judgment that her childhood assessment of her father's behavior—though wishfully motivated in part, to be sure—was basically accurate. Her mother had been debilitated and tragically unsatisfying to her father, as well as to the patient. In the same way as the patient had turned to her father in childhood, he had turned to her; and some of the feelings stirred up in him by his closeness with his daughter had given him trouble, interfering at times with his ability to parent.

It seemed that this was one of those cases in which traumatic events came too close to wishful oedipal fantasy, causing excessive and difficult-to-manage conflict. The patient had loved her mother and felt terribly guilty about usurping her place. The fact that her father had behaved in a way that indicated to his daughter that he had misgivings about their mutual affection only augmented the patient's guilt. Because of these traumatic circumstances, she had been unable to resolve her oedipal conflict. Therefore, she could only seek a compromised form of oedipal satisfaction. Relationships with men too much like her father had to be sabotaged. She allowed herself to feel sexually free only with unsuitable men.

Unfortunately, this understanding produced no real change in the patient's life. While ostensibly pleased and grateful for the insight she had gained from her analytic work, she continued to suffer quietly and compliantly in analysis. The analyst concluded that investigation of unconscious guilt had not gone

deep enough. He addressed the patient's denial of her pleasure in triumphing over her mother, her sadism and her disapproval of it in herself, and other related issues. Over time the patient came to feel condemned by her analyst. She was angry and disappointed in him for reacting badly to his frustration at their lack of progress.

As the analyst maintained his line of investigation and the patient continued to complain, a certain subtle cast to her ideas about the treatment relationship could be discerned. In her description of her fantasies of how the analyst was becoming frustrated, desperate, and irritated, the patient's assumption was usually that the analyst was upset because his drive to help her was being thwarted. She rarely pictured the analyst as reacting to deprivation of entirely selfish needs—his wish to succeed, to feel competent, to enhance his reputation, or the like. This emphasis drew the analyst's attention to an implicit idealization of him by the patient that had continued even in the latest phase of the treatment during which she vociferously expressed her disappointment in him. Consistent with the covert idealization was the fact that no matter how disappointed she claimed to be, she never seriously considered seeking another analyst or a different kind of treatment. The patient offered various explanations for her loyal perseverance: analysis takes a long time, nothing else really helps; her analyst—though temporarily faltering—was really very skilled, etc. However, these explanations eventually wore thin. They did not account for her extreme patience and the fact that she was quite reluctant even to consider any alternative to the status quo. After this attitude on her part had been addressed for some time, the patient began to seriously consider terminating her analysis. Now the analyst had to show her that her urge to leave was as much of a resistance as her willingness to stay interminably had been. In either case she was trying to avoid an examination of the motives behind her implicit idealization of the analyst and her determination not to picture him as acting selfishly.

With great reluctance the patient was able to turn her atten-

tion to the analytic task at hand. It caused her to become painfully, almost intolerably sad. Although she had given lip service to the idea that her relationship with her analyst was based in their work together, she never completely accepted it. She did not really believe she would ever be able to find satisfaction with a boyfriend or husband, and she hoped somehow her analytic relationship would function as a love relationship in her life. Sometimes she imagined her analyst declaring his love for her—it had happened to others—but more often she expected his love to go unspoken, but to be enacted through a treatment that would never end.

She had never actually given up the fantasy that her analyst, like her father, struggled internally with his forbidden love for her. She had only disclaimed the fantasy. When her analyst had begun to question why she remained with him despite the lack of progress and seemed to be suggesting that she ought to regard him as selfish, she had interpreted his remarks as a signal that he was losing ground in his struggle with his own impulses and wanted her to leave. He was covertly communicating that even greater distance would have to be maintained if their unspoken, unacknowledged—indeed, unconscious—illicit love were to be preserved. She believed her analyst needed to separate from her for the same reason her father had needed to separate from her.

Analysis of this transference fantasy permitted emergence of a perception of her father that she had been warding off for many years. With great difficulty she admitted to herself that, in fact, the evidence, when she looked at it clearly, did not support her conviction that her father had struggled painfully with his forbidden love for her, drawing back when it became too intense for him. Rather, he clearly had contact with her only when it served his own needs—when he required a hostess, or someone to listen patiently to his self-pitying tales of woe—and left her alone without any regard for her feelings whenever he had no immediate use for her. When his daughter made any demands

on him, she found him coldly unavailable, or irritatingly dismissive of her if he was inconvenienced.

Since she had been deprived of her mother by illness, the little girl's father had been all she had left. His narcissism and exploitation of her had been intolerably painful. Wishfully, she had transformed them into a story of tortured, secret, incestuous love. But beneath her carefully cherished oedipal triumph fantasy, there always lay a terrible conviction that she had never been loved, and must be unlovable. It was this conviction that really caused her difficulties with men. Not until it was all reenacted with her analyst, exposed, and reviewed could she develop the basic self-confidence and trust needed to pursue a satisfying romantic relationship. Over time in her analysis she thought through the extent of her father's lack of real involvement, what it meant about him, and what it meant—and did not mean—about her. It was a long and effortful, but rewarding project.

This patient's initial *conscious* experience of her relationship with her analyst was a replay of her relationship with her father: a loving and obedient patient/daughter was neglected and left to suffer by an uncommunicative analyst/father. Thus, her life on earth was similar to Job's. The consoling *unconscious* fantasy by which the patient explained her life on earth to herself—first with her father, then again with the analyst—paralleled the Biblical narrative of supernatural events of which Job was unaware: what appeared to be neglect and abuse by the unseen, unavailable caretaker was actually a mark of his special love. The patient's faith had sustained her in a time of unbearable pain, as Job's faith sustained him. What she believed in, like what Job believed in, was not rational and could not be demonstrated; but that, of course, was the point. She maintained a belief that what one concludes on the basis of rational observation need not be considered true. A faithful daughter became a faithful analysand.

It was crucial in this analysis, as in many others, to uncover the

patient's fantasy of oedipal triumph and her associated sense of guilt. Such a fantasy always protects the child who forms it from the painful feeling of not being loved in the way that he or she would wish to be. Ordinarily, exclusion from the mature sexuality of the parental couple is the extent of the traumatic disappointment being managed. However, in the case I have described, the perception of being utterly abandoned by two entirely self-absorbed (for different reasons) parents was what had to be denied. Usually, the warded-off perception of reality is threatening because it brings with it a measure of envy, resentment, and the like. However, deprived of her fantasy of oedipal triumph, my patient had to face overwhelming despair and rage. In other instances, the patient's unconscious sense of guilt connected to a fantasy of oedipal triumph is a central problem. It arises from intense conflict between the wish to triumph over a rival parent and love for that parent. However, my patient's sense of guilt toward her mother was only a consoling fiction. As a child, the patient had known all too well that there was no competition to cause conflict and guilt, since neither female mattered very much to her father, except as a convenience.

I want to emphasize that the woman whom I have chosen as an example represents an extreme case in point. Her childhood was exceedingly traumatic, so that her fate as a whole and the magical unconscious fantasy by means of which she reconciled herself to her fate corresponded to the Biblical story of Job. But the same picture applies to moments in almost every childhood: What parent does not prefer to persuade a child by means of rational explanation to do those things that are, though painful and difficult for the child, in the child's best interests? And yet we all know that there are some things a child is simply incapable of understanding. Then it becomes a matter of insisting that the child do it "because I said so!"—dread words that no well-meaning parent believes, a priori, he or she will ever find himself or herself saying. To the child, what is required seems like arbitrary torture; and the child complies only because he or she loves the parent and has *faith*—since within the child's limited

comprehension, rational evidence does not exist—that the parent has some loving purpose in mind.

These are universal Job-like episodes. If life is kind, there are relatively few of them, and those that transpire are eventually brought within the domain of reason. The child comes to understand, retrospectively, the previously incomprehensible reasons for the parents' behavior, so that the child, while growing up, need not retain a belief in the unknowable in order to maintain the image of a loving parent. However, if there are too many such episodes, and if a consoling explanation of them, in fact, does not exist, then the child clings to an unconscious Job fantasy for dear life, and later the adult does the same. That is what happened to the woman in my clinical example.

As a psychoanalyst, I have great sympathy for Job's comforters. They approached Job respectfully, listened in silence as he described his plight and his feelings about it, and in due time offered observations that were designed to help. I have done the same, many times. Their advice to Job that he could help himself by admitting his unacknowledged guilt was sound, in that it was advice that had helped many other people in similar situations. I, too, have helped numerous patients turn their attention to unadmitted guilt, to their benefit. Nor can I blame Job's comforters for persevering in the face of Job's objections, suggesting to him that he was being narcissistically stubborn when he expressed outrage at their interpretations that he was suffering from guilt. There have been many times that I persevered similarly with a line of interpretation in the face of a patient's objections, and it has turned out to be helpful to the patient that I did so.

However, the Bible tells us that Job's comforters were wrong, and the clinical vignette I have presented describes how the analyst went similarly wrong in addressing what he was sure was his patient's unconscious sense of guilt. Perhaps we can think of Job's comforters' error as their being too wedded to their preconceptions, and say that the moral of the Book of Job—from a clinical psychoanalytic point of view—is that when a thor-

ough investigation of unconscious guilt fails to produce the desired result, then it is time to look elsewhere. The advice to clinicians contained in the Book of Job need not be taken in a mystical vein. An analyst will not—and should not—base his or her actions on a conviction about the unknowable, but he or she can retain a healthy respect for the unknown.

Analytic study of the Book of Job is very scant. Jung's (1952) *Answer to Job* is essentially a religious work in which Job's criticism of God's inscrutability is seen as a valid indictment, which God eventually acknowledges by appearing in human form in Christ and sharing Job's pain. We might consider Jung to be delivering a symbolic critique of too distant parents, or of the analysts who believe they can do clinical work as completely detached observers. Reid (1973) has written a very interesting study of the Book of Job as a portrayal of internal struggle with a harsh superego.

Aside from these two contributions, there are only passing references to Job in the analytic literature. Outside the analytic literature, few if any single stories have been more commented upon. This may make the Book of Job seem too familiar and its psychoanalytic implications obvious. However, any clinical analyst knows the dangers of not looking past the psychoanalytically obvious and familiar. It puts us at risk, when dealing with Job-like patients, of encountering the same difficulty that Job's comforters did. To have the courage of one's convictions when necessary, while at the same time remaining ready to question one's convictions when necessary, is quite difficult. Both are surely called for in analytic work.

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The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

The Analysis of an Adult with Night Terror

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To cite this article: Donald V. Stevenson (1991) The Analysis of an Adult with Night Terror, The Psychoanalytic Quarterly, 60:4, 607-627, DOI: 10.1080/21674086.1991.11927325

To link to this article: https://doi.org/10.1080/21674086.1991.11927325

Published online: 27 Nov 2017.

Psychoanalytic Quarterly, LX, 1991

THE ANALYSIS OF AN ADULT WITH NIGHT TERROR

BY DONALD V. STEVENSON, M.D.

The author discusses the analysis of a woman with night terror, a condition rarely seen in adults. The analysis revealed the pathogenicity of splitting mechanisms which had developed under the influence of an overstimulating environment and exposure to the primal scene, followed by the separation and divorce of the patient's parents.

The literature on night terror goes back to one of Freud's early papers (1894) in which he referred to night terror as "a variant of the anxiety attack." He distinguished "[*w*]*aking up at night in a fright* (the *pavor nocturnus* of adults), which is usually combined with anxiety, dyspnoea, sweating and so on" from the pavor nocturnus of children which combines "anxiety with the reproduction of an appropriate experience or a dream" (p. 95). He later stated (1900) that pavor nocturnus, as seen in adults and in some children, is a nocturnal anxiety attack with hallucinations, the anxiety being the result of repressed sexual impulses (anxiety neurosis). This view has been supported by Jones (1931), Schoenberger (1946) and Waelder Hall (1946). Waelder Hall considered pavor nocturnus essentially a childhood phenomenon different from the nightmare of the adult. M. Klein (1932) stressed the role of aggressive impulses.

Sperling (1958) differentiated three types of pavor nocturnus in children: (1) the psychotic type, in which sexual impulses predominate as a result of chronic sexual traumatization; (2) the traumatic type, considered the "traumatic neurosis" of childhood, in which aggressive impulses predominate; and (3) the

neurotic type, originating in the conflicts of the oedipal phase and similar to the "nightmare syndrome" of the adult.

Stern (1951), focusing on the physiological reaction that accompanies pavor nocturnus, concluded that the experience constitutes a shock reaction to the revival of the primal scene.

Mack (1965), studying nightmares and terrors in children, related the intensity of the nightmarish anxiety to the fears of earlier developmental periods that are reactivated by the regressive and isolated conditions of sleep. He pointed out that children's nightmares and terrors can be the result of traumatic situations, but he also emphasized that these anxiety phenomena often herald or perhaps even stimulate a developmental advance.

Until the late 1960's, no clear differentiation had been made between the phenomenon of night terror and other dream disturbances. Stern (1951) called attention to the confusion that resulted from the indiscriminate use of the terms pavor nocturnus, anxiety dream, anxiety attack, and nightmare in reference to the same phenomenon. Hartmann and his co-workers reported that sleep laboratory studies (e.g., Broughton, 1968; Fisher, et al., 1968) "have made it possible to differentiate two distinct phenomena within the group of conditions loosely called 'nightmares': (1) nightmares, which are long, frightening dreams awakening the sleeper from a long rapid-eye-movement (REM) period . . . usually late in the night, and (2) night terrors, which are sudden arousals associated with fear, terror, and screaming, sometimes associated with sleepwalking episodes, but with either no dream content or a single frightening image, that awaken the sleeper from stage 3 or 4 sleep early in the night" (Hartmann, et al., 1987, p. 49).

Waelder Hall (1946) reported the analysis of a seven-year-old boy with night terror. Deutsch (1930), Stern (1951), and Sperling (1958) have all reported vignettes of child and adult cases. Jones (1931) referred to numerous adult cases, but his well-known triad of agonizing dread, sense of constriction of the chest, and helpless paralysis applies mainly to nightmares. Night

terrors, as defined by E. Hartmann and his co-workers, are accompanied by increased motility, not paralysis. Both the study of Kales, et al. (1980) of personality patterns and the psychophysiological study by Fisher, et al. (1974) reported "extensive psychopathology" (neurotic, borderline, and personality disorders) in adult patients with night terrors. As far as I have been able to determine, however, the detailed psychoanalytic treatment of an adult with night terror has not been previously reported.

The following is a report of the analysis of a graduate student who developed night terror at age twenty-seven, shortly after she married the man she had been living with for almost a year.

CASE MATERIAL

Ms. D came to see me three months after her wedding. She said her worries began a few days before the wedding, when she experienced a recurrence of an anxiety dream she had had repetitively at age fourteen, around the time of her sister's wedding. In the dream, Ms. D was getting married but changed her mind at the last minute in order to prevent a tragedy.

Her current problem consisted of two symptoms, night terror and frigidity, which she suspected were related to one another. She had been aware of her frigidity since she had become sexually active in college. But the night terrors began just after her wedding, and consisted of suddenly waking up early in the night, two or three times a week, terrified, her heart pounding, sweating profusely, and screaming at the top of her lungs. Sometimes after waking up she "felt a presence" in her room, but most of the time she saw the blurred figure of a man standing in the middle of the room. Once the patient woke up screaming in front of the bathroom mirror. This was significant because she generally avoided mirrors where she feared she would see the devil. In the evening, her level of anxiety rose and she was easily frightened by noises or by shadows beyond her bedroom door. She often felt she was losing her mind.

In addition to the above symptoms, Ms. D was tortured by a sense of physical inferiority, compared to both men and women, which often stimulated feelings of envy and jealousy. She could not understand why so many people liked her. She was attractive and came across as friendly, bright, and competent, but her attire and tomboyish manner betrayed a need to minimize the appeal of her delicate feminine features.

Ms. D thought her symptoms were an aggravation of the anxiety that she had in college. She had several affairs then and, like the men she knew, she enjoyed thinking about them as "conquests." But when she got involved with Karl, a man as cruel as her brother, she had several panic attacks while waiting for him. Psychotherapy at that time helped her to stop dating Karl.

When Ms. D was born her brother was ten and her sister was eight years old. She suspected her parents wanted a third child in order to save their marriage, but she was a disappointment because her mother had wanted a son. They lived on a farm until the patient was four years old, then moved to town. She thought father was both seductive and stern, while mother was self-centered, overly concerned with appearances, and insensitive to her needs. Both parents were inconsistent about sexual matters. They overstimulated the patient by displaying their bodies carelessly and by allowing the patient to roam around the farm, among the animals, with little supervision. Yet if the patient expressed sexual curiosity or jealousy, her father scolded her severely and her mother criticized her for being unladylike. Mother's favorite disapproving remark was: "That's not you."

The patient's early memories are organized around a primal scene experience and each memory is a sample of conflict between libidinal or aggressive drive derivatives and the threat of parental disapproval or punishment. They reflect a superego *in statu nascendi*. For instance, when she was about three years old, she was jumping around in her crib, full of excitement, when the maid told her that if she didn't stop, a man would come

through the window and "get" her; not long afterwards, her father spanked her because she had urinated on the floor. Another memory refers to enjoying eating asparagus and butter with her father, then getting a fishbone stuck in her throat. Once she walked into the bathroom and found her parents taking a bath together; when they asked her if she wanted to join them, she felt embarrassed. She also recalled having dreams about mummies walking around the house, and she remembered going through a phase of being tormented by the thought: "What if God died and the devil took over?"

As a child, the patient thought herself ugly compared to her mother and sister, and she felt excluded by them. So she devalued their femininity and did not want to be like them. By contrast, the patient felt very close to her father. She was in awe of his athletic, muscular body which he enjoyed showing to her. He would have her trim his chest hair, which she also found very exciting. They went fishing and "skinny-dipping" together, and she loved to "horse around" with him in his bed.

But her father began to distance himself gradually from the family and moved out when the patient was eight years old. He divorced his wife when the patient was ten, and remarried when she was eleven. Her mother became so depressed and bitter over the divorce that she did not allow the patient to express loving memories of her father or grieve over his absence. The patient identified with her "betrayed" mother for she, too, felt betrayed by her father. But the break-up of the family unit led the patient to further devalue her mother, whom she blamed for the divorce, and to form a greater idealization of her father with whom she more strongly identified. She began to sleep in her father's old bed and became her mother's companion and protector.

Conflict arose when father came to take her out, however. The patient felt excited but thought that there was something wrong. The resulting anxiety led her to conceal her excitement from mother. She thought her father was very romantic. He

called her "princess" and referred to their outings as "dates." Thus, the patient developed parallel identification with both parents, which she kept dissociated (Blum, 1983).

When I completed my initial evaluation, it was apparent that the patient's pathology was the result of conflicts related mainly to phallic-oedipal strivings. However, it was not easy to determine then to what extent preoedipal factors, such as the repetitive hypnopompic phenomena, were the result of ego deficiencies and not just regression. This uncertainty, the alarming intensity of the patient's anxiety, and her limited financial resources led me to recommend that we begin with twice-a-week psychotherapy, stressing the importance of changing to psychoanalysis as soon as possible.

During the third hour of treatment the patient reported her first dream:

> I was in a session with you, but it was like a living room or lobby instead of your office. There were many people around: professionals, big shots. I complained that I wanted more privacy, but you said that's the way you worked. Then I had to lie down and you lay on top of me. I was angry with you.

Talking about this dream led to another recent dream:

> My husband kills someone and is putting the dismembered body in a trash can. Concerned that people might find out, I ask my husband what he is going to do with the body. Then I realize I have become an accomplice.

Following on her associations, I clarified that she seemed upset about my sharing a waiting room with other doctors. The patient agreed and said that she was particularly concerned about a woman she saw in the office next door (a casual acquaintance of hers); the woman might find out that Ms. D was coming to see me. This reminded her of how she had concealed from her mother the excitement that she felt when she went out with her father. Then the patient recalled that when she was five years old, while playing in bed with her father one morning, she felt

his erection through the covers. She suddenly realized that she was alone with her father and ran out to find her mother.

The dreams appeared to be a pair of complementary transference dreams (Alexander, 1925) in which the patient expressed oedipal wishes, feelings of castration, and the fear of being excluded and abandoned. After my interpretation that what she was experiencing in my office (anxiety about being alone with me) repeated the two memories of anxiety about being alone with her father, Ms. D became more anxious and the night terror episodes became more frequent. Sometimes she imagined that I was going to kill her, and other times that I was going to rape her. One day she reported a particularly terrifying episode of night terror in which she saw a figure covered with hair, like a gorilla. Associations led to her father's hairy body and to two memories that were both exciting and frightening. One was the tactile experience of feeling her father's erection while playing with him in bed. The other was seeing the genitals of her father's friend, as he changed clothes in front of her.

The patient struggled with this material for many hours before she was able to integrate the two experiences cognitively and affectively. I repeatedly interpreted her defense of keeping these memories affectively disconnected. It finally dawned on her that what she had touched and what she had seen were the same thing: a penis. When I reconstructed that she might have also seen her father changing clothes, she vaguely remembered seeing his penis when they went skinny-dipping.

Following this work, the patient was able to recover a number of childhood memories. She recalled that, after observing a cat with its new litter, she placed an actively sucking kitten to her own nipple and was frightened by the sudden sexual stimulation that she experienced. Once, her vulva became extremely bruised and sore from horseback riding, but she did not tell her mother, fearing the mother might then know of the patient's secret sexual pleasure from riding. On another occasion, she enjoyed letting her dog lick her genitals. The dog was later killed by a car. She also remembered lying on the attic floor with a boy

from her class and letting him touch her. This boy died from accidental electrocution when the patient was eight. The patient had been so afraid that he would reveal their secret game that she felt relieved when she heard of his death. Echoing her mother's criticisms, after recalling each of these memories the patient repeated: "That's not me, that's not me." This struggle both to recognize and to deny reality, a manifestation of defensive splitting (Freud, 1940), was very intense throughout the treatment.

Subsequently, the patient reported a dream which coincided with her menstrual period:

> I go to a doctor's office. A nurse examines me on a table that looks like your couch. As I walk out, pieces of meat fall off of my vagina.

When she associated mainly to the cat and its litter, I interpreted the patient's repressed wish to be a mother.

The patient then began to undergo a transformation in her appearance. Instead of her usual "neutral" clothes, such as plain slacks and blouses, Ms. D began to wear attractive dresses and skirts, and to show concern over her hair and makeup. Initially, she was apologetic for wearing a dress. But she soon confessed that she had found herself wishing to be the most beautiful, interesting, and intelligent of my patients. She externalized the humiliation engendered by these wishes and thought that I was secretly laughing at her. These conflicts became almost intolerable when the patient realized, while I was on vacation, that she was feeling sad because I was absent. She felt defeated. I interpreted that the wish to be with me had exacerbated her sense of shame about being a woman. The following weekend the patient became very concerned with her body and examined her genitals repeatedly. While checking herself in front of a mirror, she had the distinct feeling that she knew exactly where her penis had been. She reported that she felt "crazy talking this way, yet it feels so real!" The patient thought this conflict was similar to the way she felt during her night terror episodes: that there is really a man in her room while she knows this is not true.

She added that it would be perverse for her to enjoy sex because it would be like enjoying a wound or a scar.

Because of her shame, Ms. D expressed the defensive wish to be a man, and she fantasized "shaving off" her breasts and everything that showed she was a woman. Then she reported a dream in which she was a strong woman sailing. Her associations over several sessions referred to feeling better about her body. That feeling was similar to the way she had felt as a child in a repetitive dream where she was drowning, only to discover at the last minute that she could breathe under water. She recalled an omnipotent childhood belief that she could get anything she wanted by just wishing it. Then she was able to accept my interpretation that she was defending against the shame stimulated by her womanly desires by returning to the early childhood belief that she had a penis.

Ms. D now began to show symptomatic improvement. Her anxiety decreased considerably, the episodes of night terror stopped, and she became a more willing sexual partner to her husband. However, in order to follow through with the sexual act she had to fantasize that she was fourteen years old, or a prostitute, and that her husband was an old man fondling her genitals while other people watched. This was also her most exciting masturbatory fantasy and, for a while, a recurrent theme in her dreams.

For two years the treatment had consisted of face-to-face psychotherapy twice a week. I had kept a psychoanalytic stance throughout the treatment, there was a strong therapeutic alliance, and the transference was becoming more intense. The night terror episodes had stopped. The original alarming intensity of the patient's anxiety had toned down considerably, and there had been some controlled therapeutic regression. In addition, the patient was doing well at a higher level job, and her financial situation was better. I therefore recommended that she consider entering psychoanalysis proper. The thought of a more intense emotional involvement with me frightened her. She thought of analysis as a battle between two suns that grav-

itate around each other, and only one can survive. One of us was going to die. The patient's associations were to her conflict over oedipal rivalry. A memory recovered at this time was symbolic of the conflict and became an important point of reference in my interpretations: in the third grade, she was on stage ready to begin a recitation, but she got so frightened when she saw her mother in the audience that she ran to her and was unable to perform. Associations over a number of sessions related this memory to other experiences, such as running from her father's bed in search of her mother after she felt his erection, concealing her excitement when going on "dates" with her father, and wanting more privacy in my office.

I interpreted to the patient that these incidents were samples of the conflict between her wish to replace mother in order to have father all to herself and the threat of losing mother as a result. I emphasized how consistently she had been defending against the anxiety stimulated by that conflict and how this time the anxiety had been brought on by the prospect of changing the treatment to psychoanalysis. The patient thought "submitting" to psychoanalysis meant that she was going to be killed. I reminded her that she had previously felt ashamed whenever she experienced wishes to be with me and that she had defended against that shame by re-activating the childhood fantasy that she had a penis. I added that, in her mind, being killed was equivalent to losing her fantasied penis if she allowed her passive longings for me to return. Following these interpretations the patient agreed to come four times a week and began to use the couch. The transition to analysis exacerbated her anxiety. She was restless and again feared that I might rape or kill her, but she was not as anxious about it as she had been initially. She had several episodes of anxious awakening (with the fantasy that someone was in her room), but without terror, screaming, or the autonomic signs of panic.

The patient recalled that her mother had been a beautiful, buxom woman while she had felt small, skinny, and unattractive. Clearly, she had been so conflicted between her murderous

rivalry with mother and her envy of father's penis that she devalued mother, repressed her own feminine urges, and turned to her father and brother with whom she identified. This was interpreted. Her relationship with her brother was basically positive, but with sadomasochistic undertones. They had played "cops and robbers" or war games, during which he often pinned her down to the ground, tied her to a tree, tickled her, or otherwise "tortured" her. The patient had a crush on her brother and feared him at the same time. He would stare at her for long periods just to scare her. She once awakened to find her brother standing at the foot of her bed staring at her, a frightening experience similar to her night terrors. The patient was aware of some sexual excitement involved in these games. She figured her brother had learned these games from some sex magazines that she found under his mattress. Most of the stories were about soldiers raping or seducing voluptuous women. The patient enjoyed the excitement to some extent, but also felt shortchanged. Then, identifying with the aggressor, she became bossy and cruel like her brother. For instance, she liked to form clubs of which she made herself president, then enjoyed ordering friends around and demanding difficult tasks of them.

A memory and a childhood dream strongly suggested that some of the patient's childhood sexual activities were primal scene re-enactments (Panel, 1978). They brought to the surface contrasting aspects (positive and negative) of the oedipus complex. The memory was that of being in bed with her mother at age five, and trying to grab mother's breast while being kept at arm's length. In the dream she was also in bed with her mother and had her mouth pressed against mother's genitals. In addition to expressing the patient's regressive oral attachment to mother, her associations revolved around primal scene and related experiences. I told the patient that the material suggested she had seen or imagined her parents engaged in various kinds of sexual relations. I added that some of her childhood sexual activities seemed to be re-enactments of those experiences. Some re-enactments, such as grabbing mother's breasts and

pressing her mouth against mother's genitals, involved an identification with father as he fondled mother's breasts or engaged in cunnilingus. Other re-enactments, such as letting the dog lick her genitals, letting a friend touch her body, and fantasizing that an old man was fondling her genitals while others watched, involved an identification with her mother "submitting" to father's love-making. The patient responded by recalling a repetitive dream about an old man giving out lollipops to little girls. This led to fantasies of fellatio and cunnilingus. She felt sure she must have wanted to do this with her parents after seeing them together, but could not remember details of their sexual activities. The patient knew she had repeatedly seen her parents having sex when they lived on the farm, but she thought she probably imagined a great deal, too. She further stated that perhaps some of her fantasies were also modeled after her exciting experience with the cat nursing its kittens and other experiences with farm animals. Following this intervention, the patient remembered tender moments with her father, especially projects when she felt "feminine." For instance, they collaborated in nursing wounded birds back to health and taking care of various animals. These early sublimations of her maternal strivings, an important aspect of her oedipal romance, seemed to have been interrupted when her father left.

Up to this point, the patient had seemed unconcerned about her husband's evening activities and the distance which had been growing between them. Now she began to worry and, when she questioned him about his tardiness one day, he confessed that he had been having affairs for some time. The patient was crushed, but soon realized that she had contributed to the problem by avoiding her husband. They managed to stay together and began to relate to each other in a more frank and open way.

As the analysis continued, the patient found herself having embarrassing sexual thoughts about me and disturbing violent images involving her husband. Sometimes she thought of jumping on me, wishing to sit straddling my lap, like she used to do

with her father when playing with him in bed. At other times she wanted to get me sexually aroused and imagined that I was silently masturbating behind her. She also had flashing images of her husband lying in a puddle of blood. The conflict between oedipal strivings and feelings of castration intensified in the transference. Her sexual wishes toward me precipitated feelings of self-depreciation, competitiveness, and the wish to defeat me. She berated me over and over again, compared me unfavorably to other psychiatrists, criticized my work, laughed at my background (which she had looked up in a professional directory), and said anything else that she thought could hurt my feelings. She also threatened to quit and provoked her husband in such a way that he tried to stop the treatment.

When I interpreted that the pleasure she got out of attacking me was similar to the pleasure she felt when she hurt and devalued her mother, she acknowledged it was the result of envy. As a child, she had been envious of her father for being a man and of her mother for being his wife. She knew she was also envious of her husband and thought she was hurting him by being frigid and childless. Perhaps, she thought, this was her way of "castrating" him, thus rendering his penis useless. I interpreted that her wish to stop the analysis, too, was an expression of the wish to castrate me by destroying my work. She said she wanted me to suffer the same pain and humiliation that she felt.

A stroke suffered by her mother at this time precipitated an intensification of the patient's ambivalence toward her. Just as she had done when her father left, the patient took good care of her mother. But gradually her concern for her mother's well-being gave way to repressed death wishes. Her murderous fantasies surfaced along with the fear of actually losing her. This wish/fear conflict was traced back to mother's hospitalization for a broken leg when they were still living on the farm. She also related the conflict to mother's depression when father left home. Mother had wanted to die then and had held on to the patient as a substitute for her husband. The patient slept in her

father's old bed in order to watch over her mother. Thus, the positive and negative aspects of the oedipus complex continued to surface in alternating sequence.

Working through her conflicts seemed to allow the patient to improve her life. For the first time, she developed close friendships with other women. At work, the patient began to face situations she had previously avoided because of anxiety, although she had several panic attacks, and once even walked out of a meeting because she was afraid of fainting. At home, she was able to relax with her husband, and sexual relations became pleasurable, though orgasm was possible only with manual stimulation of her clitoris. In the transference, the patient became more spontaneous and aggressive. She felt sexually aroused during the sessions and was openly seductive, then angry with me for not responding to her wishes.

Ms. D now reported that, while trying to relax enough to have an orgasm during intercourse, she was frightened by the thought that she might lose control of her bladder if she had an orgasm. This reminded her of her father's spanking her for urinating on the floor and of the shock she experienced when she first saw her brother urinating. Her associations led me to interpret that her global fear of "messing up," an expression of regression to the anal-urethral level, was a way of defending against the anxiety stimulated by oedipal urges. This interpretation was confirmed when the patient recalled that urinating on the floor had not been an accident, but a "show" for her parents in the living room. It was her way of both identifying with her brother and reversing the primal scene, thus making herself the performer and her parents the observers (Arlow 1961, 1980). It was interpreted at this point that, unconsciously, the patient equated the genital lubrication from sexual stimulation with anal messiness. She clarified that she had always felt that the male genitals were very clean whereas the female's were very messy. This clarification led to the analysis of rigid work habits and other anal traits which she used defensively in order to protect herself against the anxiety generated by both passive libidinal strivings and murderous impulses. For instance, keep-

ing rigid working hours in the evening helped her control the anxiety stimulated by being alone with her husband.

Sometime later, while in bed with her husband, the patient found herself fantasizing that she was with me. She thought she might "go crazy" with an orgasm and "really" see me instead of her husband if she opened her eyes. She recognized the wish fulfilling aspect of this fantasy and again recalled how convinced she was, as a child, that she could get anything she wanted just by wishing it. She added that the man she imagined in her room was probably an expression of this kind of magical wish-come-true. Attempting to integrate the dissociated elements the patient had related to the night terror image at different times, I interpreted that the man in her room was a condensation and projection of several conflictual wishes, such as her wish to have a penis, her wish to reverse the primal scene (as in the fantasy of the old man fondling her while others watched), and her wish for punishment as expressed by a childhood maid's threat, now remembered, that a man would break into her room to "get" her.

The patient became aware of murderous wishes toward an older woman at work and talked anxiously about attending a social function which she thought my wife and I were also attending. When I interpreted that her murderous wishes were really directed toward my wife, the patient began to laugh. She had been fantasizing about going to that function escorted by me and related the incident to the repetitive wedding dream she had when her sister got married. She now recalled romantic fantasies about her sister's fiancé. I interpreted that, just as she wished to be escorted by me, thus taking my wife's place, this dream expressed the wish to get rid of her sister in order to marry the fiancé. The patient said she had had the same wish when her father had remarried. She then recalled the pleasure and subsequent remorse she experienced as a child when she killed insects, which she fancied were people she hated. She reported old dreams in which people or animals had been dismembered or decapitated. I interpreted these earlier dreams and fantasies as expressions of murderous wishes toward her

mother in order to have her father to herself. I added that the projection of such wishes was also a powerful component of her night terror experiences.

She responded that seeing "that man" in her room was like facing the devil. Associations led her to remember a girl in the sixth grade who supposedly had had sexual intercourse with a brother. This reminded the patient of her sexual wishes toward her own brother. It was in connection with these wishes that she had the worst time differentiating fantasy from reality. For a while she was almost certain she had actually been sexually involved with her brother, but she finally concluded that she had had a wish to be touched by her brother as she had been touched by her friend in the attic. The patient could remember similar fantasies stimulated by her father, earlier in her life, when she had enjoyed so much playing with him in bed.

Ms. D began to show interest in children. She decided to visit her sister for a few days and was delighted by her five-year-old niece. The little girl had jumped in bed with her, talked about her parents in the bedroom, and tried to get into the bathroom while the patient was using it. Ms. D was anxious at first, then was able to identify with her niece and realized that her avoidance of children had been due to anxiety about reviving childhood memories. Her wish to have a baby became fully conscious and stimulated new memories and associations. She recalled her mother telling her she had been a breech birth and not a pretty sight. New elements of castration, shame, and anger directed toward mother were worked through; then Ms. D decided to stop using contraception hoping to get pregnant within a year.

Following this decision the patient began to show concern over issues of separation and the analysis entered its termination phase.

DISCUSSION

Mack's view (1965) that the night terrors of children are usually normal developmental phenomena is generally accepted. Due

to the immaturity of their egos, anxiety, fear, and regression can be observed frequently in children. Night terrors in adults, however, are rare occurrences. They are a manifestation of psychopathology (Fisher, et al., 1974; Kales, et al., 1980) even when they are precipitated by a developmental advance, such as marriage in the case of Ms. D.

The clinical picture presented by Ms. D conforms to the definition of night terror given by sleep researchers (Hartmann, et al., 1987). It consisted of repetitive episodes of sudden arousal early in the night, associated with terror, screaming, tachycardia, profuse sweating, and hallucinating the single image of a man standing in the middle of her room. At least once, when the patient woke up screaming in front of the bathroom mirror, the episode was associated with sleepwalking. The clinical picture also conforms to Freud's (1900) definition of pavor nocturnus as "night terrors accompanied by hallucinations" (p. 585) and to the view shared by most psychoanalytic writers that the nightmarish anxiety is the result of repressed sexual impulses often related to primal scene experiences.

The importance of exposure to the primal scene in the pathogenesis of Ms. D's night terror was evident throughout the treatment. The central organizing function of the memory of her parents taking a bath together, the dream in which many people disrupt the privacy of our session, and the fantasy and dreams in which an old man manipulates her genitals while others watch all point to primal scene exposure. But these manifestations are not enough to establish a direct etiological connection. The pathogenicity of the actual exposure to the primal scene "must be assessed within the framework of both developmental factors and the ways in which these experiences may have combined and interacted with other genetic-dynamic forces in the total mosaic of the individual's experience" (Harley in Panel, 1978, p. 134). We must discern, then, the developmental and environmental circumstances which may have contributed to the pathogenic effect of Ms. D's primal scene experiences.

Greenacre (1956, 1967) and Isay and Wangh (in Panel, 1978)

observed that the repetitive experience of watching the parents during sexual intercourse is usually followed by the child's repetitive re-enactment of the sexual activities that have been observed. These repetitions usually occur within an environment that includes other types of sexual overstimulation. This is consistent with Ms. D's experience. In addition to repeated exposure to the primal scene, Ms. D was frequently exposed to her parents' nudity, her father's in particular when she went skinny-dipping with him. Playing with a seductive father and with a much older brother (who made her the object of his unconscious games of seduction) was also very stimulating to her.

According to Edelheit (in Panel, 1978, p. 140), the central feature of the primal scene schema is the simultaneous or alternating identification of the viewer with both members of the copulating pair: "This double identification, with its ready reversibility of roles, results in the expression of multiple polarities—male/female, victim/aggressor, active/passive." Arlow (1961), Hunter (1966), Lower (1971), Myers (1973, 1979), Stamm (1962), and Stewart (in Panel, 1964), all reported cases of depersonalization connected to primal scene exposure. Myers (1973, p. 537) stated that the primal scene "may serve as one of the possible prototypical splitting experiences which predispose the ego to the later use of such mechanisms." This polarization was evident throughout Ms. D's analysis, particularly in reference to the alternating sequence of active/passive and masculine/feminine strivings in the transference. The viewer/exhibitor polarity, too, was repetitive in her fantasies and dreams. An example is the theme of the old man manipulating her genitals while others watch. This theme is also a re-enactment of the primal scene in which the viewer/exhibitor polarity is reversed. By being the exhibitor instead of the viewer, the patient gratified her incestuous wishes and inflicted upon the viewer the same exclusion and humiliation which had been inflicted upon her (Arlow, 1980).

The primal-scene-induced masculine/feminine polarity is cen-

tral to Ms. D's conflicts. Warding off libidinal and aggressive "feminine" impulses protected her against feelings of castration. Penis envy had been particularly intense due to repetitive exposure to both her father's genitals and the primal scene during the phallic phase. The stimulation of "feminine" impulses during the oedipal period reactivated intense feelings of castration and penis envy. "Masculine" impulses were then mobilized defensively, thus reversing the polarity.

In early latency, the patient was able to achieve some sublimated gratification of "feminine" libidinal impulses, such as sharing with father the nurturing of animals and other phase-appropriate activities. However, the break-up of the family unit when her father left home interrupted this developmental advance and stimulated a defensive regression. Wangh's interesting observation (in Panel, 1978, p. 138), that the "primal scene memory may be evoked . . . to express the wish to see the separated parents together again, to be with them once more as an only child," is relevant here. The "fracture of the child's object world and social surround" (Blum, 1983, p. 321), created by the divorce of Ms. D's parents, provoked a regressive reactivation of primal scene memories which re-established the split.

Splitting enabled the patient to be relatively free of anxiety and depressive affect for long periods. She was able to maintain a fairly stable relationship with a man as long as she remained frigid, single, childless, and able to think about the relationship as a "conquest." This allowed her to feel equal to men while maintaining a heterosexual object choice. But marriage meant truly becoming a woman and having to face her "feminine" sexual wishes, murderous urges, fear of punishment, and feelings of castration and inferiority. Thus marriage forced Ms. D to face the split-off impulses which ultimately appeared to her as a terrifying hallucination. Analysis mended the split, stimulated the assimilation of a stable feminine identification, and promoted the development of more adaptive compromise formations.

SUMMARY

This paper described the treatment of a twenty-seven-year-old frigid woman who developed frequent episodes of night terror immediately after her wedding. It showed that repetitive exposure to the primal scene in early childhood prompted the patient to identify simultaneously with both parents as they engaged in sexual intercourse. This double identification resulted in the expression of multiple polarities (i.e., male/female, active/passive, viewer/exhibitor), which led, during the oedipal phase, to the dissociation of "feminine" impulses as a defense against the castration complex. The separation and divorce of the patient's parents during her latency provoked a regressive reactivation of primal scene memories, which reinforced the propensity to use splitting mechanisms. Splitting enabled the patient to remain relatively free of anxiety and depressive affect until marriage precipitated episodes of night terror and forced her to face the split-off libidinal and aggressive impulses.

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The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

The "Dissolution" of the Oedipus Complex: A Neglected Cognitive Factor

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To cite this article: Eugene J. Mahon (1991) The "Dissolution" of the Oedipus Complex: A Neglected Cognitive Factor, The Psychoanalytic Quarterly, 60:4, 628-634, DOI: 10.1080/21674086.1991.11927326

To link to this article: https://doi.org/10.1080/21674086.1991.11927326

Psychoanalytic Quarterly, LX, 1991

THE "DISSOLUTION" OF THE OEDIPUS COMPLEX: A NEGLECTED COGNITIVE FACTOR

BY EUGENE J. MAHON, M.D.

Repression and identification are two of the crucial psychological strategies that pave the way for the dissolution of the oedipus complex. While this major realignment of the mind is being forged psychologically and emotionally, a cognitive revolution is also taking place in the developing psyche. Six-year-olds are learning to wean themselves from a perceptually bound preoperational view of phenomena and to embrace a new conceptual operational view of the world. The mental work involved in bringing about this new cognitive world view has received insufficient attention even though it bears a striking resemblance in some crucial ways to the ego psychological tasks involved in the dissolution of the oedipus complex and the promotion and maintenance of the state of latency.

In 1924 Freud wrote: "To an ever-increasing extent the Oedipus complex reveals its importance as the central phenomenon of the sexual period of early childhood. After that, its dissolution takes place; it succumbs to repression, as we say, and is followed by the latency period. It has not yet become clear, however, what it is that brings about its destruction" (p. 173).

Freud went on in this paper and in subsequent ones to describe the details of the demolition, and others have written extensively on latency. The consensus of opinion since Freud's time would suggest that the dissolution or demolition of the oedipus complex is not as absolute as Freud suggested.

A similar revision of thought has taken hold in regard to the

infantile neurosis that was at first viewed solely as pathological but later began to be seen more as developmental achievement. These changes in emphasis reflect the emergence and expansion of psychoanalytic developmental ego psychology over the past fifty years. It is not that pathology has diminished but that developmental knowledge has expanded and phenomena can be viewed through a lens with a wider angle. Regardless of their angle of perspective, most if not all analysts would agree that the oedipus complex does succumb to a relative repression and deemphasis in latency, a period of quiescence that lasts until adolescence revives the complex and insists on finding a place for it in the normality or pathology of everyday adult life. An immense amount of development has been glossed over in the last few sentences. This is intentional, since only one issue will be addressed in this paper: the role of a particular cognitive factor in the dissolution of the oedipus complex and in the "maintenance" of the state of latency.

Because of disappointment, frustration, and fear of castration, boys and girls abandon their incestuous ambitions, identify with their parents, and repress former wishes for sexual gratification and competitive dominance. Repression of both positive and negative oedipal strivings and identification with both parents lead to crucial structural development of ego, ego ideal, and superego. The infantile amnesia and the new structures, superego and ego ideal, which are the heirs of the positive and negative oedipus complexes respectively, maintain the state of latency and afford the six-year-old a relative respite from drives, which makes grade school learning possible. The fruits of the culture are transmittable and psychic structure is enriched by all the new experiential and intellectual ferment that education in society's institutions promotes. From a psychological point of view repression and identification would seem to be the cornerstones that will support the edifice of latency and maintain the infantile amnesia. Let us look at what is happening cognitively at this same developmental moment.

Simply stated, the mind of the six-year-old is in the process of weaning itself from preoperational logic and embracing the new order of operational intelligence. That latency is the time in which operational intelligence holds sway is hardly news. However, if one scrutinizes the process as preoperational thinking is becoming operational, one becomes aware of the mental work involved in bringing about such a cognitive transformation. Closely examined, this cognitive mental work bears a striking resemblance to the psychological work of repression and identification, a fact which seems to have been insufficiently emphasized, if not totally neglected heretofore.

If the major developmental achievements of the six-year-old from a psychoanalytic point of view are defensive and adaptive (repression, identification, and the construction and maintenance of the infantile amnesia), the major developmental achievements from a genetic epistemological point of view are cognitive. These two points of view are often seen as alternate rather than complementary descriptions of latency. When they are compared rather than contrasted, certain similarities in the Piagetian and the Freudian view of latency are striking. A close look at operational intelligence reveals how the cognitive can assist the rest of psychological and emotional development.

Take, for example, the acquisition of number concepts: to learn that $3 + 3 = 6$ and that $6 - 3 = 3$, an abstract operation and its reversibility have to be grasped. The abstraction 6 is the result of a transformation and does not spring up overnight, so to speak. In preoperational thought which precedes the typical latency achievement of operational thought, 6 baseball bats are bigger in number than 6 toothpicks. Why? Because the preoperational mind is perceptually bound rather than conceptually informed. Seduced by its own perceptions, the mind assumes that size and number are the same. The mind has not yet learned how to ignore all perceptual sidetracks in the service of a *conceptual* goal. Yet it is precisely this *relative repression* of the perceptual that allows the utter abstraction 6 to

emerge from the perceptual distractions of baseball bats and toothpicks.

Suppose, instead of baseball bats and toothpicks, we shift to the more psychoanalytically charged metaphors of penis, gender, and anatomical sexual difference, and try to imagine a six-year-old's struggle and the assistance his new-found operations will offer him as he tries to advance his development. A perceptually bound five-year-old comparing the size of his penis or the size of his body to his father's must suffer a painful oedipal defeat every time he opens his perceptual eyes. When at age six or seven, he can open his *conceptual* eyes, so to speak, he can repress the perceptual, relatively speaking, and think to himself, "All penises regardless of size are members of a conceptual category penis; in a way I am the equal of my father." This transformation, the cognitive leap from the preoperational to the operational, leads not only toward repression but toward identification as well. By diminishing the power of the perceptual in favor of the conceptual, the child has *repressed* one way of thinking and has *identified* with a more abstract, a more mature confederacy of thought not unlike his parents'. This cognitive transformation gets taken for granted, but the components of the transformation, if looked at very carefully, shed light on the mutual influences of the cognitive and the psychodynamic.

While it would be impossible, perhaps, to say which has the greater influence on the other, the developmental line of cognition and the developmental line of ego psychology share striking similarities. Cognitively speaking, development demands renunciation of perceptual gods in favor of the new order of conceptual authority; ego psychologically speaking, development demands dissolution of the oedipus complex and its replacement with identifications. In other words, one has to wean oneself from *actual* incestuous gratification and settle for displacements of desire, a new *conceptualization* of oneself in society, society no longer meaning family alone, but school, peer groups, best friends, etc. The two processes, the ego psycholog-

ical and the cognitive, are so intertwined, so complementary, so obviously integrated, why deconstruct them at all? Because these transformational processes, once they take over, seem to cover their tracks, so to speak, the *nouveau riche*, developmentally speaking, denying their pedigree, unless they are reminded of their origins.

Piaget does not use such terms as repression and identification, but he does emphasize that for development to proceed children must *decenter* themselves from one cognitive *Weltanschauung* and clear a psychological space for another. This remarkable liberation of one's mind from all that is familiar in the service of brave new worlds of development is not unlike the creative leaps described by Kuhn (1962) in *The Structure of Scientific Revolutions*; the difference, of course, is that the one is developmentally expectable, but the other remains a hallmark of unusual creative daring. If Piaget does not use psychoanalytic parlance, it is clear, however, that the concept of "decentering" is very close to psychoanalytic ideas about narcissism and infantile omnipotence. For Piaget, a perceptually bound child will not be able to grasp concepts until he or she can remove the perceptual self to the side and begin to see the error that perceptual narcissism, to coin a term, insists on in resisting the conceptual way of looking at phenomena. When the child grasps that 6 baseball bats and 6 toothpicks share the same abstract concept 6 regardless of the perceptual "noise" that would lead the mind astray, the act of decentering in this manner reflects the birth of a higher, newer order of reality testing. Piaget would not use the concept "reality testing" in the previous sentence: probably he would have said "epistemology" or "intelligence," but I think it is clear that if one were attempting to compare rather than contrast the Piagetian and the Freudian, the points of similarity would be arresting.

Interesting as the points of comparison may be from a theoretical vantage point, the linking of the Piagetian and the Freudian has important clinical implications as well. It is well known

that latency is the developmental phase when learning problems surface. In fact, symptoms related to academic performance may well be the most frequently heard "cry for help" in a child therapist's consulting room. The task of sifting the "psychological" learning disabilities from the "cognitive" learning disabilities is often arduous if not impossible. Frequently, one acknowledges with a humility born of experience rather than ignorance that the psychological and the cognitive are so intimately connected that they cannot be deconstructed, so tangled are the knots that intertwine them.

I would like to suggest that the comparisons I have drawn between the Freudian and the Piagetian shed further light on the mutuality of the two processes, not solely in matters of learning but in matters of development in general. A "Freudian" seven-year-old who is using repression and identification to keep oedipal conflicts relatively resolved and "quiescent" will be ably assisted by the conceptual framework of his or her newly acquired "Piagetian" operations that drown out the magical perceptual preoperational world that preceded them. Similarly, a "Piagetian" seven-year-old who is struggling to maintain a conceptual grip on the new cognitive world by "decentering" from the old perceptual model will undoubtedly be assisted by the new developmental resolutions that *repress* the archaic incestuous omnipotent infantile psychology through *identification* with parental restraint and authority and renunciation of instinctual impetuosity.

The cognitive and the psychological seem to mesh and complement each other when development proceeds smoothly. If either the cognitive or the psychological is compromised by neurosis or constitutional disability, it is easy to see how one might influence the other maladaptively. It is easier to repress desire and identify with society's dictates when the ego's psychological skills and cognitive skills join forces in a developmental alliance that paves the way for the progress of mental health and the process of adaptation. If latency is the age of reason, Oedipus

can lean on cognitive shoulders, it would seem, as he steers his emotional cargo through this phase of development.

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The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

The Middle Years. New Psychoanalytic Perspectives. Edited by John M. Oldham, M.D. and Robert S. Liebert, M.D. New Haven/London: Yale University Press, 1990. 300 pp.

Calvin A. Colarusso

To cite this article: Calvin A. Colarusso (1991) The Middle Years. New Psychoanalytic Perspectives. Edited by John M. Oldham, M.D. and Robert S. Liebert, M.D. New Haven/London: Yale University Press, 1990. 300 pp., The Psychoanalytic Quarterly, 60:4, 637-701, DOI: 10.1080/21674086.1991.11927327

To link to this article: https://doi.org/10.1080/21674086.1991.11927327

Published online: 27 Nov 2017.

BOOK REVIEWS

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THE MIDDLE YEARS. NEW PSYCHOANALYTIC PERSPECTIVES. Edited by John M. Oldham, M.D. and Robert S. Liebert, M.D. New Haven/London: Yale University Press, 1990. 300 pp.

The central conceptualization of *The Middle Years* which emerges from a reading of the whole, rather than any single article in this edited volume, is that normal and pathologic development in midlife is increasingly influenced, as the years pass, by the growing awareness of time limitation and personal death. Oldham and Liebert (to whom the book is posthumously dedicated) suggest in their preface, correctly so it seems to me, that this growing, normative preoccupation with death may explain why "remarkably scant attention has been given to the middle years as an entity for psychoanalytic exploration . . . because . . . the elements of waning and loss that are intrinsic in this period—the very things that bring many of our patients into therapy and analysis—have been discordant with the generally optimistic outlook of the field" (p. 2).

However, this recognition of the importance of aging as the most powerful developmental stimulus in midlife is balanced by the recognition by several authors that, to quote Arnold Modell, "for many people the middle years are the best years of their lives" (p. 25). Elizabeth Auchincloss and Robert Michels (Chapter 4) relate this good feeling to the stability of the middle years which offer comfort and security to many, while Milton Viederman (Chapter 16) speaks of "a mutative effect of experience that decreases vulnerability in the system of self-esteem regulation and increases resilience to narcissistic injury" (p. 224).

A recognition of the need to integrate these two polarities in our theory-building and clinical practice is beginning to emerge in the psychoanalytic literature. It is evident in this book, not only in the several places already noted, but also in the chapters by Carol Nadelson (8), Lila Kalinich (9) and Otto Kernberg (15).

Before beginning a discussion of some of the eighteen chapters, I would like to mention two negative criticisms I have of the book. The first has to do with form and the second with content. Approximately half of the chapters in *The Middle Years* were originally offered as presentations at a symposium on the middle years that

was sponsored by the Association for Psychoanalytic Medicine and the Columbia University Center for Psychoanalytic Training and Research. The remainder were solicited. This may be the reason for the book's somewhat disjointed organization. The chapters touch on many subjects, too many perhaps, which are loosely connected to one another in five sections of dissimilar length. A discussion of the individual chapters or of the five sections by the editors would have added a needed cohesiveness.

The criticism of the content is more substantive. Many of the articles are written from a narrow, somewhat outdated psychoanalytic perspective which does not include or consider the burgeoning adult developmental literature of recent years. For example, the most frequently mentioned article in the book is Elliott Jaques's "Death and the Mid-Life Crisis," which, although extremely influential in stimulating thinking on the middle years, is twenty-five years old. Particularly missing, with the notable exception of Chapter 13, "Biological Considerations in the Middle Years," by Steven Roose and Herbert Pardes, is any attempt to integrate the large body of information about the adult years that is available from related disciplines. For instance, the well-known work of David Gutmann on the effects of androgyny on male and female relationships in midlife is not referred to anywhere in the book.

Paul Ornstein suggests the following explanation for this rather parochial attitude:

> Thus, although ideas regarding the presence of developmental potentialities throughout the life cycle have been around for some time, psychoanalytic thinking remains only marginally influenced by them until very recently . . . due to the fact that these revised ideas did not originate in the recognition of special features of forms of the transference and were not derived from psychoanalytic constructions. They were garnered from observations outside the clinical situation. Psychoanalysts, with their interpretive eyes riveted on the transference, did not know what to do with this new knowledge imported into the psychoanalytic treatment process (p. 29).

The remainder of my review will consist of a brief discussion of selected chapters which I found particularly new or informative. In Chapter 3, "Self Psychology: The Fate of the Nuclear Self in the Middle Years," Paul Ornstein presents a very interesting formulation of self psychology's developmental perspective. He describes Kohut's interest in development as arising from the clinical situa-

tion, particularly from reconstruction of selfobject transferences, through introspection and empathy. Kohut offered a new view of child development by emphasizing the paramount importance to the infant and child of the "lived experience." He demonstrated an interest in adult development through his belief that we live in a matrix of selfobjects from birth to death. Although he died before evolving a comprehensive developmental theory of adulthood, Kohut did suggest that a detailed mapping of selfobject needs throughout the life cycle was one of the paramount goals of self psychology in the immediate decades ahead. Ornstein and his colleagues are currently working on this task.

Those individuals who are interested in George Vaillant's work on the maturing of defense mechanisms in adulthood will be pleased to find, in Chapter 5, detailed case histories that add an in-depth clinical dimension to his ideas. They convincingly underscore his conviction that the adult psyche is significantly influenced by the effect of adult experience. I was most impressed with his last paragraph, which considers exciting new neurological research (described in more detail by Roose and Pardes in Chapter 12) that indicates that the human brain may continue to undergo dynamic change well into midlife. Vaillant underscores the importance of these ideas for adult developmental theory by suggesting that elucidation of the phenomena of adult maturation during the next half century will depend on a joining of hands by neurobiology and psychoanalysis.

In "The Third Individuation: Middle-Aged Children and Their Parents" (Chapter 7), John Oldham suggests that the involution and death of parents contributes to significant intrapsychic structural change. The process can be normative, leading to the replacement of previous parental object representations with more contemporary ones and a true sense of autonomy, or it can be pathologic, leading to avoidance of attachment to aging parents or to melancholia rather than mourning. Oldham's contribution is new and valuable, adding a needed dimension to the developmental line of object relations and separation-individuation processes in adulthood. However, I think the involution and death of parents is only one of several central aspects of the "third individuation." I recently described another aspect in a paper entitled, "The Third Individuation: The Effect of Biological Parenthood on Separation-

Individuation Processes in Adulthood."[1] The aging body, intimacy, friendships, and work are only a few of the other influences which need to be examined in order to further elaborate this concept.

Oldham's work is followed by two fine chapters which integrate concepts of normal female development in early and middle adulthood with clinical work. Carol Nadelson's "Issues in the Analysis of Single Women in Their Thirties and Forties" (Chapter 8) and Lila Kalinich's "The Biological Clock" (Chapter 9) illustrate the new levels of clinical and theoretical sophistication resulting from the recent understanding of the relationship between child and adult experience that has been made possible by the emergence of a comprehensive adult developmental theory.

Next in order are companion pieces by Martha Kirkpatrick and Robert Liebert (Chapters 10 and 11) on homosexual experience in midlife. In "Lesbians: A Different Middle Age?" Kirkpatrick describes the desire for intimacy, a central developmental task of young and middle adulthood, as the primary reason that some married women leave their husbands to begin lesbian relationships for the first time. In a similar manner Liebert describes the lives of middle-aged homosexual men as increasingly organized around the phase-specific concerns with aging and mortality. Through relationships with men a generation younger than themselves, "the inexorable forward motion of time is slowed down—indeed, magically turned back" (p. 151). These chapters are fine contributions to the rapidly growing literature on homosexual development.

In the most thought-provoking chapter in the book, "Biological Considerations in the Middle Years," Steven Roose and Herbert Pardes explore a question raised in a developmental context by Robert Nemiroff and myself a decade ago: "what (if anything) of significance is happening to the structure of the brain during middle years?" (p. 179). Drawing on the extremely exciting biological brain research of the last ten to fifteen years, they conclude that while some areas of the brain stem are deteriorating in middle age, particularly those involved in the experiences of anxiety, arousal, and fear, others are changing: "This would imply that, contrary to

[1] Colarusso, C. A. (1990): The third individuation: the effect of biological parenthood on separation-individuation processes in adulthood. *Psychoanal. Study Child*, 45:179-194.

the popular conception that advancing age is equivalent to rigidity, the brain and presumably the mind remain open to change and learning in rather significant ways throughout the middle years" (p. 180). *It is this growing recognition of plasticity at the biological and intrapsychic level, when acted on by the enormous range of new experiences in adulthood, that makes the continued elaboration of a theory of adult development imperative for the advancement and relevance of psychoanalysis in the twenty-first century.*

Two clinical papers, by Otto Kernberg and Milton Viederman, and a debate on the relative usefulness of brief therapy versus psychoanalysis for older patients by Allen Frances and Charles Brenner constitute the loosely constructed "Clinical Papers" section of the book. The chapter by Kernberg is a beautiful illustration of how knowledge of the developmental tasks of midlife can be used by a skillful clinician in the diagnostic assessment of patients in this age group.

The book concludes with an interesting chapter by Milton Viederman entitled "Matisse's Nice Period, 1917-1928: A Confrontation with Middle Age." In it, Viederman uses the developmental pressures of middle age, which were organized around the aging of Matisse's wife, his own muted sexuality, and the death of his mother, to explain why "Matisse was unable to accept the safety and comfort that recognition and material success had brought him in middle life and was compelled to change the structure of his life and the form and content of his painting in a flight to the South" (pp. 260-261).

To summarize, *The Middle Years* is a valuable contribution to the psychoanalytic literature of adulthood. In addition to its usefulness for clinicians and theoreticians, it is an excellent source of new articles for teachers and students of adult development.

CALVIN A. COLARUSSO (LA JOLLA, CA)

SUPPORTIVE THERAPY. A PSYCHODYNAMIC APPROACH. By Lawrence H. Rockland. New York: Basic Books, Inc., 1989. 308 pp.

Lawrence H. Rockland has written an important work on an important subject, one significantly neglected in psychoanalytic literature. He addresses psychodynamically oriented supportive psychotherapy, a treatment approach appropriate and helpful to a

significant portion of the population currently seeking psychotherapeutic help. Central to his position is the belief that supportive therapy should not be considered a second class or second choice treatment. It can and should stand on its own merits, with clear indications, technical procedures, and theoretical underpinnings based upon psychoanalytic theory and a psychodynamic understanding of patients for whom it is appropriate. He argues throughout the text, insistently and persuasively, for establishing supportive therapy as separate but equal alongside of exploratory psychotherapy, psychoanalysis, and other treatment approaches.

Rockland leans heavily on research support for his advocacy of supportive therapy. He makes frequent reference to the research findings of Wallerstein and the Menninger Group, Luborsky and the Penn Studies, Stanton and the Boston Psychotherapy Study, and other familiar, empirically based investigations of psychotherapeutic efficacy. He argues that supportive therapy needs to be taught in a systematic manner to mental health professionals, that its techniques need to be studied and refined in a variety of clinical settings with different populations, and that it can and should be practiced with enthusiasm, confidence, and expertise alongside its sister treatment modalities.

Rockland's text is divided into three parts. Part One takes up what the author calls the supportive-exploratory continuum. He examines what constitutes a supportive intervention, particularly in relation to establishing general differences in the supportive therapist's handling of transference and resistance. In general, supportive therapy is aimed at strengthening the ego's adaptation to internal and external realities. The supportive therapist steers away from exploring unconscious material and avoids or at least discourages regression during the therapeutic process. The treatment emphasizes strengthening of the patient's reality orientation, particularly by undermining defensive operations that significantly distort reality. The therapist's stance is, in the author's words, more "real." There is less focus on transference and more focus on interpersonal interactions outside of the treatment situation. Resistances and defenses are evaluated according to their adaptive or maladaptive potential. Adaptive resistances or defenses are supported, encouraged, and strengthened, whereas maladaptive resistances are clarified, confronted, undermined, and otherwise actively discouraged.

The therapist systematically chooses which mental operations to explore and which to reinforce or ignore.

In general, patients for supportive therapy are more seriously ill than those who are best treated with more expressive treatment modalities. Most have significant and chronic ego defects, are more prone to impulsive acting out, are more likely to develop early, disruptive, negative transferences that threaten the therapeutic alliance, and are less able to tolerate the threat of regression inherent in exploratory treatments. Rockland also feels a supportive approach is appropriate in relatively healthier patients during periods of acute crisis. In the chapter, "Indications and Contraindications," Rockland takes up clinical decision-making about which psychotherapeutic treatments to recommend to patients. He explores the associated issues of concomitant pharmacologic treatment, environmental or "reality-based" limitations, substance abuse, and other familiar factors pertinent to clinical decision-making.

In the second section of the book, "Technical Aspects," the author addresses the familiar themes around which technique centers: transference, countertransference, the therapeutic alliance, resistance, working through, and termination. He discusses the difference between supportive and exploratory approaches around each of these clinical concepts. For example, in the handling of resistance in supportive therapy, the therapist makes a judgment about the role of the current resistance in relation to overall ego strength and adaptation to inner and outer realities. The supportive therapist, according to the author, may elect to encourage resistances, e.g., pseudo-insight or repetitive rationalization, in order to strengthen the vulnerable ego's ability to tolerate anxiety. He gives examples of how the supportive therapist might provide intellectual "pseudo-interpretations" in order to help the patient's ego defend against intolerable affects or perceived dangerous instinctual pressures. With regard to the handling of transference in supportive psychotherapy, Rockland favors early and aggressive exploration and amelioration of negative transferences that are likely to occur in the sicker patients treated with supportive psychotherapy. Termination may be carried out by attenuating rather than ending the therapeutic relationship.

Rockland provides four extended clinical vignettes illustrating supportive therapy in practice. One patient has paranoid schizo-

phrenia, the second a narcissistic personality disorder with paranoid trends, the third a schizotypal personality disorder with major depressive disorder (in remission), and the fourth a borderline personality disorder with self-mutilation. Clinical material is presented along with the author's running comments regarding the patient's associations and behavior and the therapist's interventions. In one of the vignettes, an example of a therapeutic misalliance is presented and explored. As with all printed clinical material, other interpretations of the data and different therapeutic interventions will suggest themselves to the reader. However, the clinical vignettes clearly illustrate the author's approach and thinking regarding technique.

The third section of the book, "Psychodynamically Oriented Supportive Therapy in Context," begins with an exploration of the mechanisms of therapeutic action of supportive psychotherapy. The author discusses the nonspecific effects of all psychotherapies, the roles of unanalyzed positive and negative transferences, identification with the therapist, and the corrective emotional experience viewed positively not as role playing within the therapeutic situation but rather as neutrality and objectivity in the face of intense transference demands. The author gives brief summaries of psychotherapies along the supportive-exploratory continuum to further emphasize clinical decision-making around how to handle material in an exploratory or in a supportive fashion. He discusses both macrodecisions in an overall clinical approach, and microdecisions regarding issues that emerge from moment to moment during sessions. He explores the usefulness of medications in relation to their dynamic and generally supportive meaning to the patient (both the prescribing and the taking of medications), as well as their specific pharmacotherapeutic effects in relation to supporting ego functions.

Rockland emphasizes that supportive psychotherapy must be carried out in a systematic manner. He leans heavily and consistently on an approach to clinical work and clinical theory advocated by Kernberg, to whom the author acknowledges his indebtedness in the text. To this reader, there is a tendency to present some material in a manner that seems more systematic, clear-cut, and organized than experience in the clinical situation dictates. This is consistent with Kernberg's way of presenting his ideas, and it makes

Rockland's text particularly appealing as a teaching text. More experienced clinicians may object to Rockland's style, one that downplays ambiguity, uncertainty, and the multiple possibilities inherent in any clinical situation. Rockland, an experienced analyst, is mindful of overstating his case, includes many cautionary remarks, and presents different ways of approaching clinical material. There is some tension between wishing to present his ideas in a clearly organized manner in order to underline the technical precision necessary and the internal logic and theoretical basis inherent in a supportive approach, while fairly representing the inevitable subtleties, confusions, and ambiguities surrounding clinical work, particularly with difficult patients.

Rockland frequently notes that considerable psychodynamic and psychoanalytic expertise is necessary in order to make the necessary decisions in carrying out supportive therapy. Implicit is that psychoanalysts will be able to make the kinds of interventions he suggests as appropriate for supportive psychotherapy without considerable internal conflict. It is here that I believe Rockland fails to do justice to important issues inherent in doing psychotherapeutic work. He speaks about technique as though the therapist has an armamentarium of interventions that are instrumentalities applied objectively and in a value-free manner as the situation warrants. It is my impression that most psychoanalysts cannot escape so easily from a value system that makes it difficult for them to assume an authoritarian, a sympathetic, a forbidding, a friendly, a gratifying, or a withholding stance at will as the situation appears to dictate. Particularly problematic to this reader would be providing pseudo-intellectual and essentially inaccurate and misleading interpretations about chemical imbalances and genetic vulnerabilities to patients in order to support faltering ego functions, as the author advocates.

Psychoanalysts are deeply committed to the search for truth in their work with patients. They are disinclined to purposely assume roles, purposely provide transference gratifications, or otherwise manipulate transference phenomenon, even for the patient's supposed good. There is an important difference between the inevitability of these phenomena occurring during treatment and their purposeful utilization to influence patients. These issues require further exploration in relation to supportive therapy. As Waller-

stein notes in the Foreword, Rockland's book is not "the last word in this still young domain of inquiry."

Rockland has made a significant contribution in the area of psychoanalytically based supportive psychotherapy. He has provided a valuable teaching text that is clearly written, well organized, and demonstrates a breadth of understanding of those phenomena that occur in the psychotherapeutic setting. His book is one that makes its case forcefully, compellingly, and in a manner that invites implementation, research, and debate. It is an important contribution to the psychodynamic literature and should develop a wide following. It extends familiar psychoanalytic discussion of the relationships among supportive psychotherapy, expressive psychotherapy, and psychoanalysis proper by outlining, in operational detail, how supportive psychotherapy might be carried out.

STEVEN T. LEVY (ATLANTA)

LEARNING AND EDUCATION: PSYCHOANALYTIC PERSPECTIVES. (EMOTIONS AND BEHAVIOR MONOGRAPH 6.) Edited by Kay Field, M.A., Bertram J. Cohler, Ph.D., and Glorye Wool, M.D. Madison, CT: International Universities Press, Inc., 1989. 1016 pp.

There is an inherent paradox in reviewing so comprehensive and far-ranging a volume as this one: to adequately illustrate its broad range of contributions exceeds the constraints of space, while narrowing the focus runs counter to the holistic, integrative intention of the editors. An overview of this ambitious work will follow, in which I shall attempt to avoid sacrificing detail to generality.

The 1982 conference, "The World of Learning: From Motive to Meaning," sponsored by the Teacher Education Program of the Institute for Psychoanalysis in Chicago, served as the impetus for this collection of original contributions by authorities in the fields of education, psychoanalysis, developmental psychology, sociology, linguistics, and mental health. It attempts to address the complicated question of how learning occurs, what affects its acquisition, and why some individuals learn with ease and pleasure, while others of adequate intelligence cannot learn, will not learn, or can only acquire knowledge selectively. This book positions itself in the thick of an often controversial field, where partisan factions emphasize

aspects of the problem from their own particular psychodynamic, sociological, educational, or neuropsychological vantage points.

The first two sections of the book examine the interdigitation of psychoanalysis, education, learning, and development. It is intriguing to review the evolution of psychoanalytic theory from the perspective of the mind as a learning apparatus that eventually sits in a classroom, yet acquires many types of learning long before formal schooling begins. The parallels and departures between psychoanalytic (metapsychological and dynamic) formulations and Piaget's cognitive epistemology serve as a reference point for many of the chapters. Bertram J. Cohler, whose chapter, "Psychoanalysis and Education: Motive, Meaning, and Self," could stand alone as a monograph, traces Freud's conception of the learning mind from the psychic topography of the *Project* and Chapter 7 of *The Interpretation of Dreams,* through the development of metapsychology, the genetic point of view, and drive theory, and into the contributions of ego psychology. The process by which ego functions involving attention, concentration, reality testing, judgment, and secondary process mental activity become increasingly autonomous from the immediate demands of the drives, yet are at times captured by conflict, constitutes the basis for a psychoanalytic theory of learning. E. James Anthony details the contributions of Rapaport (who was trained in cognitive psychology) and Hartmann. He observes that the development of ego psychology, child analysis, and psychoanalytically informed direct observation of early development gave impetus to a psychoanalytic learning theory. Against this backdrop, Ralph W. Tyler sketches the history of the American perspective on education from the vantage point of changes in the school system and curriculum. It would have been helpful to have correlated these classroom developments with the contemporaneous evolution of theory, and to have compared them to changes in the European school systems, where child analysis and child observation had their early roots.

Subsequent chapters describe the complex interactions among affect, cognition, attention, self-esteem, and motivation. Bonnie E. Litowitz discusses the vicissitudes of internalization as a type of learning, with special emphasis on the contributions of developmental linguistics. Frances M. Stott explores a special aspect of language development, the motivation for learning to write, using

detailed clinical material. Stanley I. Greenspan reviews the interaction between the drive-colored cognitive structures and impersonal cognitive structures. He posits a model of learning comprised of three, simultaneously occurring levels involving somatic learning, consequence learning, and representational-structural learning. Rita Sussman focuses on the intricate relationship between cognition and affect that constitutes the child's response to novel stimuli. Personal interest, curiosity, and the need to be effective are important expressions of the self-regulatory process of exploration and have enormous impact on the quality and ability to learn. Ann Fleck Henderson and Robert Kegan elucidate the constructive developmental view of learning and the significance of Piaget's approach. H. E. Bernstein addresses how the courage to try to learn involves active confrontation with the unknown and unfamiliar, and is directly affected by the vicissitudes of self-esteem. Benjamin Garber looks at the importance of the parent as teacher, examining how children learn to mourn from observation of the parents. Ernest Wolf considers learning from a self psychological point of view; he cites an analogy between teaching-learning and psychological structure formation, in that both involve the sequence of emergence-disruption-restoration. Rudolf Ekstein contends that learning, initially based on repetition, evolves into learning for teacher's love, and then learning to love that which is learned. In this model, motivation for reward becomes replaced by the inner motivation of love of learning, and for some, the love of teaching.

Martin Silverman examines male/female patterns of learning and differences in gender role identity. Formulations about social and cognitive gender differences tend to be attributed by various writers either to entirely biological factors (such as variations in male and female brain functioning) or to external, sociological power struggles between men and women. Silverman demonstrates how the evolution of gender identity, cognitive development, and successive attempts by boys and girls at resolving phase-appropriate intrapsychic conflict have an enormous impact on learning, and must be reckoned with in any formulation about gender differences. Irene P. Stiver specifies factors that contribute to work inhibitions in women, viewed from the unique perspective of the "self-in-relation" theory of J. Surrey. This theory emphasizes feminine self-differentiation and intellectual achievement as occurring

within a context of maintaining pivotal relational ties in a manner very different from that of a man. Stiver presents some of the fascinating research on gender differences in the subjective sense of academic achievement, occupational performance, and orientation toward maintaining relationships that characterize the asymmetrical experiences of men and women in the workplace.

Several chapters specifically examine the psychoanalytic process as learning. Psychoanalytic treatment is discussed by Gerhart Piers and Maria W. Piers as a complex learning activity wherein operate three postulated modes of learning (conditioning, insight learning, and learning through identification). Resistance to new learning in psychoanalysis is traced by Barbara Rocah, beginning with Freud's 1926 and 1937 formulations, through to a developmental review of the perceptual, cognitive, and affective factors as they impinge on the analytic process. The special learning-teaching situation of psychotherapy supervision is viewed by Hyman L. Muslin and Eduardo Val from the self psychological perspective of progressive internalization within the context of selfobject learning transference.

The third section focuses on the clinical applications of theory to teaching special subgroups of children. Sally Provence illustrates the confluence between education and psychotherapy in case vignettes of very young, developmentally delayed children. Donald D. Schwartz explores the cognitive and emotional shifts that occur as the child progresses through psychosexual development, with particular emphasis on the negotiation of the oedipus complex as it affects the capacity to learn. Clinical examples of how intrapsychic conflict and infantile neurosis can inhibit learning provide a compelling mandate for an integrated psychoeducational approach. Gil G. Noam writes of normal and pathological adolescent development, using case material from three borderline adolescent patients to illustrate the importance of progressive transformations of the self and the self in relation to others over the course of development. Richard Kaufman writes about the role of early developmental deficiencies in learning disabilities, contrasting case material from children with neurophysiological problems to a child with neurosogenic learning disorder. He demonstrates that the child with developmental damage experiences helplessness accompanied by rage, failure, and dread, despite what may otherwise be a "good enough" environment. The emotional inhibitions and reactions

against learning that follow these intrinsically biological deviations in maturation exert a profound impact on development. Benjamin Garber expands on the clinical and theoretical implications of deficits in empathy that occur in learning disabled children. Gaston Blom, Kerstin Ek and Madhav Kulkarni reject Freud's original view of physical disability as the "negative exception," with subsequent psychoanalytic perspectives positing that physical disability inevitably leads to psychopathology. They detail the adaptive aspects of exceptionality.

In the final section, chapters by Glorye Wool, Michael Basch, Miriam Elson, Linda A. Cozzarelli and Marilyn Silin, Ner Littner, and Kay Field who are all involved in the Teacher Education Program of the Institute for Psychoanalysis in Chicago, seek to foster and sensitize teachers' understanding of their interactions with children from a psychodynamic perspective. This section is a tour-de-force collection of essays that specifies the practical integration of the classroom interface between psychoanalytic theory, psychodynamics, and education.

This volume succeeds in its heroic task of integrating multidisciplinary contributions regarding the vicissitudes of learning at many different levels of experience. Psychoanalytic theory is primarily represented by self psychology, reflective of the project's inception at the Chicago Institute for Psychoanalysis. It would have been more in keeping with the comprehensive intention of the book to have broadened the scope to include other contemporary theoretical psychoanalytic formulations, which are now limited to brief mention in certain chapters, usually in the context of a historical overview. Otherwise, this is a scholarly, deftly edited, and highly readable contribution to the understanding of the multiplicity of factors that impinge on the learning mind and the human experience.

ANTOINETTE A. WYSZYNSKI (NEW YORK)

INFANTS IN MULTI-RISK FAMILIES. CASE STUDIES IN PREVENTIVE INTERVENTION. Edited by Stanley I. Greenspan, et al. Madison, CT: International Universities Press, Inc., 1987. 608 pp.

The introduction to this valuable book summarizes what the authors undertook in the study on which their report is based: "(1)

How psychopathology develops and in what patterns and configurations in infants from multi-risk families as well as other types of families; (2) What ideal combinations of clinical techniques and service delivery models would be needed to have even a chance of reversing maladaptive patterns; (3) Which clinical techniques and service system approaches were effective for specific problems, examined on a case by case basis; (4) A comparison between comprehensive and less intensive intervention approaches and treatment outcomes; and (5) The relationships among perinatal risk patterns, the formation of therapeutic relationships, and subsequent development in the children and their families" (p. 3).

Begun in 1977, the study adopted a team approach, assigning at least two staff members to each family as well as providing the services of an infant center staffed by well trained specialists. The interdisciplinary teams, with members of differing skills and professions, comprised the service staff of social workers, psychologists, nurse practitioners, early childhood educators, child therapists, a psychiatrist, and psychologists. A refreshing and clinically sound plan was put in place. It began with therapeutic approaches derived from previous knowledge of multi-risk families modified on the basis of new information. The time, energy, and resourcefulness required to sustain the families, the staff, and the study are noteworthy.

Much of the approach and detail of the work is presented via case studies involving four families. As the authors report, "We tried to work with mothers whose lives were full of difficulty and pain to help them create an opportunity to grow emotionally and to learn to care for their infants with tenderness and intimacy, even though they had never experienced such a relationship themselves" (p. 9). Their chief focus was on maternal functioning and the impact of multiple problems on the mothers' capacity to rear their children. These were families who generally distrusted service providers, did not seek psychiatric help short of hospitalization for their problems, and were not responsive to traditional mental health services.

When this reviewer asked the research group in the planning phase of the project why they wished to study these most difficult to reach families, they responded that if they could demonstrate ways to make a real difference in these lives, perhaps others, including funding sources, would see the value to the participant and

to society of such intensive efforts. Thus, preventive intervention to ward off later psychopathology was a goal.

Perhaps the most impressive aspect of the program, beyond the sophistication and energy of the staff, was the flexibility that allowed them to put in place whatever service a family needed. Changing needs of child and family were responded to with appropriate changes in the services provided.

The book addresses the first three of the five objectives cited above. Chapter headings such as "Reaching the Unreachable, Antecedent Psychosocial Factors in Mothers in Multi-risk Families (Life Histories)," "A Model for Comprehensive Preventive Intervention Services," and "Therapeutic Process" indicate the wide range of the material. The discussions are detailed, providing the reader with a basis for understanding the program and its conclusions. They avoid oversimplified approaches and illustrate the value of the clinical, descriptive, and dynamic tradition. They describe an integrated research approach to complex mental health problems and outline an agenda for infant/family research that comes in part from experience in the study of multi-risk families and in part from the previous work and sophistication of Greenspan and his colleagues.

In this book the combination of conceptual chapters with the description of therapeutic activity and detailed illustrative case studies makes the reading both challenging and satisfying. The group has persevered in their difficult work with multi-risk families and has demonstrated that such work can make a difference even to very dysfunctional, needy families, especially to the young children. Moreover, they have succeeded in an effective presentation that looks to the future in infancy research and preventive intervention.

SALLY PROVENCE (BRANFORD, CT)

INSTINCTUAL STIMULATION OF CHILDREN: FROM COMMON PRACTICE TO CHILD ABUSE. VOLUME 1: CLINICAL FINDINGS, VOLUME 2: CLINICAL CASES. By John Leopold Weil, M.D. Madison, CT: International Universities Press, Inc., 1989. 270 pp., 459 pp.

This is an ambitious work that attempts to demonstrate the traumatic impact of sexual and physical abuse on children from a psychoanalytic perspective. The author attributes a wide variety of

symptoms and dreams in abused children to certain types of sexual and physical overstimulation. For example, visual or tactile exposure to sexual stimulation by adults may produce enuresis, night terrors, and disturbances in sexual behavior, while exposure to punitive beatings and violent yelling results in symptoms and dreams pertaining to killing and destruction, learning problems, and delinquency. The first volume describes the typical symptoms and dream content associated with aberrant parental practices in the form of bedsharing, visual and tactile sexual contact, yelling and beatings, and anal stimulation.

The work is based on 100 clinical case studies of sexually and physically "overstimulated" children, many of whom meet the criteria for physical or sexual abuse. Of these 100 cases, 23 were obtained from the classical psychoanalytic literature, while the remaining 77 cases involved children who were treated at the Judge Baker Child Guidance Center in Boston and were known to the author. Brief vignettes of the 100 cases are presented in the first volume, along with a brief description of statistical findings. There are also chapters devoted to theoretical issues and treatment techniques. The entire second volume is devoted to more detailed histories of the 100 cases, with appendices containing an index of statistical findings and the results of a questionnaire sent to parents.

The author employs a research design that compares the percentage of physically or sexually overstimulated children exhibiting symptoms or pathological dream content with the percentage of children who manifest similar symptoms or dream content, but who were not exposed to this type of stimulation. The level of significance was determined by the chi-square test. This research is compromised by the lack of control groups and by the fact that each child was treated by a different therapist. Furthermore, the cases were not selected randomly, and there was no uniform data collection, nor were any efforts made to determine reliability. Some of these methodological weaknesses are acknowledged by the author, who nevertheless justifies the research because of the importance of expanding our knowledge in this area.

Weil's emphasis on the research paradigm adds a mechanistic, repetitive quality to the books which makes them difficult to read. The reader must proceed from the case histories to lists of overstimulating practices and lists of the symptoms and dreams allegedly produced by them, to the statistical analysis with chi-square

tables, to the more complete case history in volume two, and back to the next case history. The fascinating case material is unfortunately diminished by the awkward layout of the book. The research itself appears to be biased and at times designed to prove the hypothesis that certain kinds of physically and sexually abusive practices result in typical symptoms and dreams. The research data is often misinterpreted; i.e., retrospective association between stimulus and symptom is elevated to a causal relationship without clear justification. In many case histories, the instinctual stimulation, i.e., bedsharing, may be regarded as the result of a parent's accommodating to the regressive pull of a separation-anxious child rather than being the cause of it. In a similar vein, frightening dreams and phobias are not always caused by traumatic overstimulation but may be driven by guilt-inducing fantasies and intrapsychic conflict. The author also fails to differentiate the impact of acute traumatic stimulation (shock trauma) from the effect of chronic, long-standing aberrant parenting (cumulative trauma). He explains the causal relationships between instinctual stimulation and symptoms/dream content by a cognitive trigger theory based on matching somatovisceral reactions. However, no mention is made of acute or delayed post-traumatic stress disorder models which might seem relevant here.

The positive and valuable aspects of these volumes are the author's consolidation and expansion of the existing psychoanalytic literature pertaining to child abuse and his willingness to explore, from a psychoanalytic point of view, the devastating and long-lasting impact of traumatic stimulation on the child. Despite the problematic aspects, I would recommend these volumes to those interested in the area of child abuse and psychic trauma in general. The case histories and psychodynamic formulations, in themselves, provide fertile ground for those who would try to understand the elusive relationship between trauma and symptom formation, which intrigued Freud and his disciples almost a century ago.

ARTHUR H. GREEN (NEW YORK)

AUTISTIC BARRIERS IN NEUROTIC PATIENTS. By Frances Tustin. New Haven/London: Yale University Press, 1986. 326 pp.

Autism as a diagnostic category has the connotation of incurability, like cancer. The conviction exists even among psychoanalysts that

psychoanalytically oriented treatment of autistic children is not useful or possible. What this does not take into account is that the descriptive autistic picture can reflect different degrees of severity and that autism does not as yet have an identifiable organic cause.

Frances Tustin, originally trained as a Kleinian, has developed her own theory and treatment methods for autistic children. She agrees that some autistic children are clearly brain damaged and that it would be wrong to raise false hopes in the parents of such children. In all cases she feels that it is important not to blame the mothers for their children's disability. I would like to add something from my own experience, namely, that I have found it difficult at times to predict how a given autistic child will respond to treatment. In one case I treated a child who did not develop language until she was eight years old, a fact known to be a negative indicator for psychoanalytic treatment. Nevertheless, circumstances made treatment seem possible. Even though this child did not speak, it was clear that she was highly intelligent and artistically gifted, and she had extremely devoted parents. Treatment eventually proved to be quite successful. Another child, who also had very devoted parents and two older healthy siblings, had developed some communicative language by the time she came to treatment at around four years of age, making her case seem hopeful. However, with her, psychoanalytic treatment was not successful, and she had to be placed in a residential treatment program. In every case of an autistic child, parents and therapists together have to be ready to embark on an adventure, the result of which cannot be guaranteed or predicted. Tustin captures this spirit of adventure in her case discussions.

The book is divided into two parts, the first (Chapters 1-10) on psychogenic autism and the second (Chapters 11-16) on certain neurotic patients in whom she finds an encapsulated autistic core. Tustin defines psychogenic autism as a reaction to a catastrophic situation in early infancy. The catastrophic situation is conceptualized as a traumatic awareness of bodily separateness from the mother which occurs before the suckling mother has become established as an inner psychic experience—before a secure sense of continuing to exist has developed. In Stern's terminology,[1] it occurs

[1] Stern, D. N. (1985): *The Interpersonal World of the Infant. A View from Psychoanalysis and Developmental Psychology.* New York: Basic Books.

during the period of the emergent self before the formation of the core self. Because of such early trauma, these patients are overwhelmed by elemental terrors of falling apart, spilling away, losing the thread of continuity of their self experience: thus they are unable to develop satisfactorily, either emotionally or cognitively. Because the mother has been unavailable as a predictable soothing presence, these infants turn first to their own predictable, autosensuously produced sensations and later to autistic objects and autistic shapes.[2] Tustin finds that this catastrophe can occur if separation from the mother has been premature or if it has been delayed.

Children who have experienced such early catastrophic loss of the self, because they have become aware of separateness before they have had the chance to experience the symbiotic state (i.e., before the beginning of a core self), are different from children who have had too long a period of closeness with the mother and are therefore unprepared to function separately. This second type of child would have to be on a higher developmental level than the first. I believe that these two types of disorders correspond, in Margaret Mahler's terminology, to primarily autistic or primarily symbiotic defensive structures, i.e., autistic or symbiotic psychotic children with secondary autism. We must assume that in psychogenically determined autism early processes of regulation must have been massively, yet possibly subtly, disturbed. What we see when such children come to treatment is profound rejection of all human contact, leading those who try to care for them to a state of helpless despair.

Tustin agrees with Mahler's view that autistic children have not been able to attain a sense of separate entity and identity. She goes one step further in stating that autistic children lack empathy and imagination and that it is largely incorrect to ascribe fantasy to them. To the extent that autistic children lack a sense of self this would seem to be correct. Yet Tustin finds it important for the therapist to join with the patient's inner life and fantasy no matter how stunted and primitive it may be. I believe that understanding their elemental terrors is a way of acknowledging the inner life that is hidden behind their autistic preoccupations.

[2] Tustin has substituted the concept of an autosensual phase to take the place of what was considered by Margaret Mahler a normal autistic phase.

The most important new step in this volume is the application of the theory of too early separation as the cause for psychogenic autism to a theory of autistic barriers in adult neurotic patients. According to Tustin, patients in this category can function on a neurotic level while simultaneously maintaining an encapsulated autistic core. The question is whether "autistic" barriers in neurotic patients are in fact comparable to childhood autism. Autistic children who are not treated develop into autistic adults rather than into neurotic patients with autistic barriers.

Tustin argues that there are severely neurotic adult patients who have an autistic core because they have avoided and therefore have not developed true human relationships. She feels that it is wrong to classify these patients as having a false self or as being narcissistic because they *lack* a sense of self. They have a "puffed-up ego, not a true ego. . . . It is both a deceit and a conceit. . . . The psychogenic autistic patient can best be described as having an ego which is an 'empty fake' or a 'hollow sham'. He does not have a self to be false" (p. 45). I see a contradiction in Tustin's theory. It is difficult to conceptualize such individuals as being able to function on a neurotic level. If they did, they at least would have to have a social self (which I would think of as their false self) on top of an encapsulated, autistic core as their undeveloped true self, undeveloped because the connection with the mother in the sense of still feeling part of her has not been relinquished, which makes them seem to be functioning on a neurotic level. Maybe our existing diagnostic categories are inadequate to characterize them.

Tustin states that certain neurotic patients feel immobilized and at the point of death in a hidden area of their personality. Sometimes they counteract this by having unlimited expectation of themselves and other people. Tustin feels that such patients can only describe this hidden area in dreams which contain out-of-body images of falling, encasement, frozenness, and boundlessness. Tustin feels they divert attention away from the mother, who is rejected in favor of self-generated sensations which are always available and predictable but which bring about a state of diminished perception, thinking, and feeling. Therapy attempts to modify this by exposing the patient to interaction with life. The emphasis in the therapy is on helping the patient go through the primitive processes of mourning which will heal the wound of the early loss. This occurs

through the medium of the infantile transference in which tragic disillusionment is re-experienced.

There is one detailed case history. Tustin first saw the patient, Ariadne, at the age of ten, for learning difficulties. She improved, but Tustin felt that she had never been in touch with her in a fundamental way. At the age of twenty-five, Ariadne returned, following a very frightening panic attack in which she had gone cold and frozen like a corpse. She was seen on a twice-a-week basis. After three years of treatment, Ariadne had a dream which started off a train of thoughts, on the basis of which treatment could finally be terminated. Ariadne's dream occurred after a five-week vacation. In the dream

> Ariadne was going happily towards an interesting, characterful house in which she knew that both her grandparents and great-grandparents lived, and where her parents lived now. However, before she could reach the house, she found herself in the chasm of a huge black wave which was arching over her. The arch of the wave had glistening black ribs of water, in which there struggled drowning people rather like the people in a Hieronymus Bosch painting. The wave was so high that Ariadne could barely see the white crest on the top. She was terrified that it was going to engulf her (p. 269).

Before the five-week vacation Ariadne had expressed concern that a break in continuity would occur. Tustin connects this concern with the fact that as an infant Ariadne had had an overly caring mother who had been grief-stricken as a result of the death of an earlier boy child. This caused an unduly close relationship between mother and baby, from which the father was virtually excluded.

I would question that the closeness was responsible for the "autistic core." Wouldn't the clinging of the mother to the child, to ease her own anxiety and to use her child as a replacement for the lost one, have made it very difficult for the mother to be empathically attuned to the needs of her living child? The child, deprived of empathic attunement, would have had difficulty attaining independence from a mother from whom she forever longed for the missing emotional bond.

This extreme dependence on the mother had been transferred to the therapist. Tustin interpretively informed the patient that her undue, utterly dependent closeness to her mother as an infant and small child had engendered the illusion that her body was contin-

uous with the body of her (ever-present) mother and that their union could never come to an end. When she could no longer avoid awareness of their bodily separateness, she could finally realize that her therapist was not an immortal being who went on forever and upon whom her whole existence depended.

As a Kleinian, Tustin believes in the crucial significance of the first six months and has no difficulty in viewing the earliest events as the root cause of basic, later psychopathology. In the Kleinian model of the mind, great emphasis is placed on the struggle to relinquish a belief in omnipotence that, when not given up, can profoundly affect thought processes throughout life. As Hanna Segal puts it, "the nascent thought conflicts with the illusion that the infant is merged with, or in possession of, an ideal breast. And disillusion must be tolerated for thought to develop."[3]

Beginning to feel separate had led to a flood of overwhelming terror about her personal survival. Through another dream and the patient's saying "that she had found a rhythm of safety," Tustin concluded that, by facing her fears, Ariadne had been enabled to become aware of resources within herself and had developed an interactive, reciprocal relationship with her which she compares to Brazelton's descriptions of mother and baby interacting with each other to create a reciprocity envelope. Tustin feels that such an infantile, interactive situation can be created later in life in an analytic situation in which the infantile transference is understood.

Tustin asked her patient to stop biting the inside of her cheek, through which she was treating that part of her body as an autistic object. Even though she had never seen the patient do it, she had guessed that she was using hidden autistic maneuvers to delude herself into believing that she could feel her body to be continuous with that of an everlasting mother who insured her safety and existence. According to Tustin, such autistic activities create the illusion that partings and endings can forever be avoided. They take the place of mental activities which truly bridge the gap of separateness, such as fantasies, thoughts, memories, and metaphors. In the treatment process, these are slowly built. I believe that

[3] Segal, H. (1981): Psychoanalysis and freedom of thought. In *The Work of Hanna Segal.* New York: Aronson, p. 223.

Tustin has an unusual ability to use metaphor, imagery, and poetry to convey her ideas, which probably is instrumental in helping her patients build psychic structure.

In the final chapter we are told about three overlapping phases in the treatment of psychogenic autism: (1) modifying the autistic barriers so that relationships with people can be set in train; (2) healing the damaged psyche (psychotherapy can begin); and (3) psychoanalysis as it is ordinarily practiced. Tustin says that during the first phase it is important that the therapist be more firm and active than in other psychoanalytically based psychotherapy. Such patients have gone along in futile self-destructive ways of nonrelating, and therefore they must be asked incisively to give up their idiosyncratic autistic behaviors to release the feelings locked away behind them. It is important that the analyst's authority not be undermined, as such patients have often had a mother whose confidence was undermined and a father whose authority and presence was insufficiently felt. The children have had to feel strong and invulnerable and have been left too much to their own devices, so that they have had to make up the world in their own terms. They have never experienced being an ordinary member of an ordinary family. Eventually these patients have to become able to mourn for the object which was felt to be a part of their body and which had been lost. They have to bear the disillusionment that comes with realization that things come to an end and that they are ordinary human beings who will come to an end. They eventually have to become ready to bear the pressure of active intervention that helps them face reality. Tustin feels that their potential for cruelty is often overlooked and that in therapy it is important not to collude with their cover-up of this part of their personality. Their atavistic savagery has not been modified by loving interactions with the suckling mother. By way of the infantile transference, patients respond to the therapist as the breast of infancy and are able to work over their feelings of sulky umbrage. As no therapist, however good, can possibly fulfill their demands, however, they have to meet their disillusionment over human inadequacies and come to terms with it.

During phase two, the healing process consists of letting patients feel wrapped up inside the body of the therapist but also directing them to be able to do this for themselves through the development

of healing psychic images. Patients' developing sense of identity at first seems dependent on the therapist, seeming to live inside the therapist's skin. The therapist's aim is to help patients develop the sense of having an intact skin of their own. It is a confusing period, because there is slipping back from the state of feeling human and alive to the inanimate, empty, "fake" autistic state. One by-product of leaving their autistic protection is that patients become much more vulnerable to physical ailments. Here Tustin describes work that is extremely difficult and at times feels extremely dangerous.

Leading patients out of their protected quasi-autistic states takes a great deal of courage, steadfastness, and imagination. Frances Tustin has shown her courage and imagination in dealing with psychotic children and now has extended her approach to adults. In both cases, she believes that empathy with the patients' catastrophic anxieties is not enough, but that it takes incisive and firm guidance to help them with the necessary painful mourning process. When we begin work with a patient, we often do not know what awaits us at the deeper levels where we meet up with infantile transferences. Tustin shows us one way to approach the autistic or psychotic parts of adult patients who manage to function in the world but have deeper, ominous underlying pathology. One hopes that in the future she will write more about her work with adult patients, inspired by her lifelong work with autistic children.

ANNI BERGMAN (NEW YORK)

FAIRBAIRN'S JOURNEY INTO THE INTERIOR. By J. D. Sutherland. London: Free Association Books, 1989. 191 pp.

John Sutherland, pupil, analysand, colleague, and friend, here traces Fairbairn's journey. Drawing on his own personal relationship of thirty-six years, recollections of Fairbairn's family and friends, diaries from his youth, self-analytical notes, and Fairbairn's published work, Sutherland portrays the effects of analytic work on the life and thought of a preeminently kind, courteous, humble man. It is an engaging read.

I have the impression that, like Sullivan, Fairbairn often worked with rather severely distraught patients. Neither Fairbairn nor Sullivan were aware of the other's closely related work. I think of

Sullivan not only because of similarities in their thought but also because I first studied Fairbairn's *Psychoanalytic Studies of the Personality* under the tutelage of Lewis Hill at Sheppard-Pratt Hospital where, in 1953, Sullivan's spirit was omnipresent. It was, indeed, Sullivan's and Fromm-Reichmann's work with the severely ill that determined my choice of Sheppard-Pratt and later Chestnut Lodge for training.

After id psychology (in which economic pseudo-explanation was the rule and wherein reification of the concepts of libido and aggression was exemplified in the idea of their fusion and defusion), Freud suggested that further knowledge of the ego would likely come from work with the narcissistic disorders; from work, I would say, like that of Klein, Fairbairn, Sullivan, and Winnicott with schizophrenic, schizoid, and depressive patients and with children, and like that of Kernberg and Kohut with narcissistic and borderline personality disorders. But there proved also to be another more general source of knowledge about ego functioning and of the growing emphasis on object relations. The gradually increasing duration and depth of analysis from the time of Freud's early work led to encountering the significance of primitive levels of splitting and of early modes of object relations as these came to the fore in the transference/countertransference recapitulation of traumatic preoedipal events. Perhaps it could be said that amidst all the fighting about orthodoxy or deviation, the published and verbally reported work in the community of psychoanalysts sustained the courage for individual practitioners to proceed to deeper strata of dividedness and conflict—in their patients and in themselves. Fairbairn's courage to do so is the theme of Sutherland's biography.

In preliminary or short-term work with neurotic patients the object as a defining characteristic of instinctual drive ("the outstanding conceptual invention in Freud's theory of the instinctual drive," Rapaport wrote[1]) can be taken for granted. Regardless of repressed narratives, subselves and their objects (or in whatever other ways such phenomena may be conceptualized), differentiation from the primary narcissistic union with the mother has been

[1] Rapaport, D. (1960): On the psychoanalytic theory of motivation. In *The Collected Papers of David Rapaport*, ed. M. M. Gill. New York: Basic Books, 1967, p. 877.

achieved. The person is, by and large, capable of relating to an object as a separate being. However, in work with schizophrenic, schizoid, severely depressed, borderline, or narcissistic personality disorders, and in work with young children, one is faced with more primitive modes of relating. The status of the self and its object, the subject and its other, is immediately thrown into question. The same is true upon reaching these repressed levels of relating in intensive and prolonged work with the neurotic.

If transference (and countertransference) can be taken as entering and interpreting a new relationship in the light of prior relationships, the schizophrenic is not, as Freud thought, incapable of transference but instead is capable of a more massively primitive transference. By now, with the work of Fairbairn, Klein, Sullivan, Winnicott, Hill, Fromm-Reichmann, Loewald, Will, Searles, Kohut, Kernberg, and many others before us, this recognition of primitive modes of transference and the importance of different levels of object relatedness is old hat. Fairbairn, relatively isolated by reasons of antecedence, geography, and personal history, learned it on his own. Sutherland's story is a compelling account of the toils of that learning.

I shall confine this review to one note pertaining to Fairbairn's work and personal history (that, of course, can be only speculative), and one brief judgment and estimate about the fit of his theory in the current and future psychoanalytic scene. Sutherland's account tells us that, like most persons who enter such fields as art, religion, philosophy, literature, or psychoanalysis, Fairbairn did not experience an unhampered transition from the narcissistic to an object mode of relatedness. His mother was loving but also domineering and demanding. She was ambitious for Ronald, her only child, but evidently severely repressed and repressive sexually. The father, a staunch and somewhat stingy Scotch Presbyterian, was also caring and almost embarrassingly proud of his son's accomplishments. He did, though, veto the desire of the mother and son that Ronald attend Oxford, a place of dubious morals, in the father's view, and a hotbed of episcopacy. Ronald prized, but not without guilt and inhibition, what he felt in adolescence to be an alliance against the father with his English and originally Episcopalian mother.

Freud called identification with "the father in [one's] own per-

sonal prehistory" "the origin of the ego ideal; . . . an individual's first and most important identification."[2] The concept refers to the internalization of aspects of the relationship with the mother *and* father that promote movement out of the narcissistic enclosure with the mother and toward being in the world as a separate being. Such identification facilitates the capacity for object relatedness and prepares the way for entering the oedipal crisis. In that crisis lies the first and main chance for both the boy and the girl to suffer symbolic castration, to renounce the role of being an extension of the mother, to claim and *have* their genitalia rather than continuing to *be* the phallus of the mother.[3]

In a footnote to the passage cited on identification with the father in one's individual prehistory, Freud stated that the process involves *both* parents. It is the mother who is first in the place of what Lacan calls "the Other," meaning language and the law-like effects of language that allow a human world to be. The mother is at first the mediator of language and of the world. However, the transition from the mother/child dyad depends on the mother's mediating, in due course, the place of the Other to the father. For this an actual father need not be present. It is enough that the mother's non-narcissistic mode of being in the world foster a love and respect for (and the capacity to grieve) the necessity of the child's move toward separateness from her. To the extent that the mother is attuned to the culturally established necessity for triadic oedipal resolution, she relinquishes the child in the name of the father, meaning the paternal function experienced in the mother's own oedipal transition as mediated by her mother, her father, and her foremothers and forefathers. As I have indicated, Sutherland here details the reasons for believing that that transition in Fairbairn's history was hampered.

At age forty-five, Fairbairn became the victim, and remained so for the rest of his life, of the identical symptom that had plagued his father—a difficulty in urinating in the proximity of others. As a child, watching his father in pain had been a great trauma, and acquiring the symptom himself was the cause of much suffering

[2] Freud, S. (1923): The ego and the id. *S.E.*, 19:31.

[3] See Smith, J. H. (1991): *Arguing with Lacan: Ego Psychology and Language.* New Haven/London: Yale Univ. Press.

and restriction from mid-life on. The phobia was given as the reason for not accepting invitations for trips to America, although it is not readily apparent why such trips would have been any more difficult than the periodic trips he made to London. In America he certainly would have been warmly welcomed by Hill, Fromm-Reichmann, the Menningers, and many others.

The symptom began in 1934 and became entrenched in early 1935 following an attack of acute renal colic. Among the several possible precipitating factors for the phobia, Sutherland notes "the expanding effect upon him of Melanie Klein's work" (p. 37). "Whether or not Fairbairn had any foreknowledge of the content of her current thinking, his illness [the attack of renal colic] prevented him attending the meeting of the Psycho-Analytic Society to hear Melanie Klein read her paper 'A contribution to the psychogenesis of manic-depressive states' " (p. 37). This was the paper that led to the split between the British and Viennese analysts. Although Fairbairn was among the group (others were Jones, Rickman, Sharpe, Strachey, and Winnicott) who refused stringent taking of sides, Sutherland believes that for five ensuing years Fairbairn "seemed to be struggling internally" (p. 41) with the reverberations of Klein's formulation of the developmental significance of the depressive position.

Fairbairn chose a wife who was a "close fit" (p. 36) with his mother. Was Klein another mother beckoning him toward another alliance against Freud the father, notwithstanding Klein's overt disavowal that her thought was anything other than a development "of Freud's work" (p. 37)? If so, it was to become a guilt-prone and less than wholehearted alliance. Probably Klein more than Freud reified the concept of instinct, a reification that Fairbairn resisted. No doubt, like the rest of us, he was a double agent, on the side of both his mother *and* his father.

But the hampered transition from primary narcissism meant that the risk of wholehearted alliance with the mother was that of dissolution and remerger. The burning urethral ambition he unconsciously resisted was probably in large part his mother's and, in their alliance, an attack on the father. To give it free rein would be to function as the mother's phallus. In that case, killing the father would not win freedom. The symptom, the identification with the father, was the guilty torment for exceeding him but also emblem-

atic of a secret alliance with the father, of sustaining the father-protector against the danger of remerger with the mother and the even more catastrophic defenses that nearness to remerger would evoke.

Klein understated her differences from Freud; Fairbairn overstated his. Perhaps both positions were ruses—to hide Klein's opposition on the one hand, and Fairbairn's secret alliance on the other. Fairbairn, though, had to find a way of living and working at least somewhat apart from all his inner torment. No doubt what he achieved was still derived from those conflicts but that in no way detracts from their value. To the contrary, the person with the greatest trouble has at least a chance for the deepest insight.

Finally, regarding overstatement of differences, contradictory passages can be cited, but a reading of Freud with an eye for internal consistency will reveal that instinct has never been a biological concept and that the libido has always been presented as object seeking. This is the meaning of the object as a defining characteristic of instinctual drive. The original image is an image *of* the object, even though it be the "not-yet-object." Similarly, to take pleasure as the goal is to misunderstand the pleasure principle as a principle of pleasure-seeking.[4] I have in other places repeatedly cited Rapaport's claim that the pleasure principle is the most misunderstood of psychoanalytic concepts and his statement that the pleasure principle "has not *per se* anything to do with pleasure or pain."[5] It is simply a statement that behavior is directional or intentional; it moves from high potential to low, from an area of imbalance toward an object promising restoration of balance. To be sure, it can be taken on that basis as equivalent to the death instinct. However, that assumption could overlook the fact that no energy or force is operative outside structural conditions and, in humans, the ongoing creation of structure. This is to say that while pleasure principle regulation goes toward tension reduction, the effect of the playing out of forces is to incite delay, structure formation, and thus tension maintenance.

No doubt other concepts will supersede those of instinct, psychic

[4] Smith, J. H. (1977): The pleasure principle. *Int. J. Psychoanal.*, 58:1-10.

[5] Rapaport, D. (1957-1959): Seminars on elementary metapsychology, ed. S. Miller. Bound mimeographed copies of seminars, Austin Riggs Center, Vol. 1, p. 74.

energy, libido, the death instinct, and the pleasure principle, but while they are around, let us not trivialize them as being the polar opposites of all that we have learned regarding the significance of object relations.

I would guess that fifty years from now, after all these matters no longer incite warfare, Klein, Fairbairn, Sullivan, Winnicott, and Kohut will still be listed as the main thinkers who explicitly formulated the importance of object relations. However, I think that will not be seen as "a paradigm shift," nor a move from one-person to two-person psychology, nor primarily as the vanquishing of instinctual drive theory. I believe its importance will be seen as having been a turning point occasioned by a new insight into modes and degrees of differentiation from primary narcissism, the paranoid and depressive trauma involved therein, together with the knowledge of defenses thus evoked. The corollary of that turn is the new emphasis on clarifying the transference/countertransference recapitulation of such early developmental processes—all in all, changes of no small significance.

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SHAME. THE UNDERSIDE OF NARCISSISM. Andrew P. Morrison. Hillsdale, NJ/London: The Analytic Press, 1989. 226 pp.

The last few years have seen an upsurge of interest in the topic of shame, albeit more outside than within the analytic community. Even today there seems to be a marked reluctance to explore the fascinating theoretical and technical implications of attributing an independent role to the affect of shame, to shame as defense and the defenses against shame, to the forms of anxiety and depression specifically connected to shame, and questions like: What is the distinction between shame and guilt? How does analytic theory have to be modified to accommodate the complex issues involving shame in a way that does not simply treat them as a subset of those articulated about guilt? What is the relevance of the studies on shame for psychoanalytic technique? And particularly: What are the roles of intrasystemic superego conflicts, the *opposition between shame and guilt*, the dialectic between "shame values" and "guilt values" (and their corresponding ethical categories), both for the

psychoanalytic model of the human being and for the understanding of value conflicts in culture and society?

For a number of years Andrew Morrison has dealt with the twin issues of shame and narcissism. He rightly states that "shame is a crucial dysphoric affect in narcissistic phenomena" (p. 8)—the essence of narcissism being seen in the "yearning for absolute uniqueness and sole importance to someone else, a 'significant other' " (p. 48). Assuming that "shame strains the boundaries of structural psychology" (p. 46), he tries to undertake an analysis of the shame phenomena and their explanation with the help of Kohut's theoretical system, modifying it somewhat wherever necessary.

A first part of the book gives a very good overview of the psychoanalytic literature on shame, although the account is understandably slanted by the theoretical predilection. The second, somewhat larger part provides a number of case excerpts illustrating the relationship of shame to other affects (rage, contempt, envy, depression), to narcissistic pathology, neurosis, and manic-depressive psychosis, and the reciprocal relation of shame as defense and of the defenses against shame.

The book builds on the descriptive statement that "shame is the central response to *failure* with respect to the ideal, to flaws in the experience of self," and on the developmental, interpersonal explanation that "failures in early object relationships—either because of active, humiliating attacks or as a result of disruptions in empathic attunement by the significant selfobject—lead to shame sensitivity in the later construction of the self" (p. 20). ". . . structural, drive-defense theory alone cannot fully encompass the importance of the affective experience of shame, particularly for the narcissistic patient. . . . Unlike guilt, which can be well explained in terms of the conflicting vectors of traditional theory, shame as an affective experience can best be appreciated as a reflection of passive failure, defect, or depletion" (p. 82). Instead of resorting to conflict as the central explanatory tool for intrapsychic dynamics, Morrison employs the related concept of "dialectics," e.g., "between feelings of inferiority and (defensive) grandiosity, between the ideal of autonomy and self-sufficiency and merger with the fantasied, omnipotent 'other' " (pp. 20, 65).

Morrison substantially adds to Kohut's view that "shame reflects only the breakthrough of unneutralized grandiosity" by suggesting

"that shame can also be experienced because of failure in relationship to the idealized parental imago. . . . In fact, failure of the parental selfobject to respond to the self's idealizing needs and quest for merger is a prominent source of shame vulnerability and a model for subsequent shame over the self's experience of its needs" (pp. 78-79). Interestingly, he also sees, in another expansion of Kohut's schema, a "developmental sequence from grandiosity to idealization" (p. 70); hence "shame experienced in relation to the idealized parental imago tends to be less archaic and more differentiated than that experienced as a result of overwhelming grandiosity" (p. 79). Correspondingly, and again in a modification of Kohut's views, fragmentation anxiety would relate to the earlier level, depletion anxiety to the later (p. 76). In short, according to Morrison, "shame reflects primarily the *depleted* self, having failed to receive responsiveness from the *idealized* selfobject" (p. 83).

In regard to the implications for therapeutic technique, Morrison proffers the view that "whereas guilt motivates the patient to confess, shame motivates one to conceal" (p. 82). He stresses the importance of "*secrets* as a manifestation of shame" (p. 163) and agrees with Helen Block Lewis that "the continued bypassing of shame represents one of the major sources of the negative therapeutic reaction" (p. 180). "For guilt the antidote is *forgiveness*; for shame, it is the healing response of *acceptance* of the self, despite its weakness, defects, and failures. The selfobject/therapist must strive to facilitate self-acceptance through his own protracted empathic immersion in the patient's psychological depths. Modification of grandiose ambitions and the ideal of perfection may then eventuate through understanding, and through identification with the accepting, empathic therapist" (pp. 82-83). In a concrete case, "the immediate focus of therapy became empathic appreciation and the *mirroring* of her pervasive sense of unworthiness and shame as a reflection of unresponsive parental selfobjects, the resultant paucity of selfobject availability for providing understanding and empathic resonance, and interpretations of these experienced parental failures as sources of shame and fragmentation. Interpretations of intrapsychic, oedipal conflicts are indeed important, but they require patience and sensitive timing before they can be therapeutically useful; otherwise, they may seem like yet further accusations or irrelevancies" (pp. 142-143).

I would like to turn to some fundamental questions raised by Morrison's self psychological approach. As held by many of us, the central concern for us as psychoanalysts is the consistent, systematic exploration of inner conflict, especially of unconscious inner conflict. No matter how we try to define our work, it always comes down to the fact that the focus, the center of our interest during our analytic work at its best, lies on inner conflict. Everything else moves to the periphery: it is not irrelevant, but we notice it as part of the surrounding field, not as the beacon that guides us.

Self-regulation and personality deficiencies immediately evoke memories of deep-seated developmental defects that somehow need to be filled or bridged, defects that definitely are *outside the purview of conflict theory*, as Morrison emphatically states. In particular, the affect of shame precisely refers to the *experience of being defective*, as Morrison also repeatedly stresses. Yet that is not the same as *explaining psychopathology as derived from defect.* To look at any severe psychopathology in terms of deep defects—of some fundamental deficiency, as a structural fault or lack of structure—has been a leading theme of scientific discourse at least since the late nineteenth century. Dependent upon practical approach and theoretical model, both the center of conceptualization and its periphery and boundary radically shift. Thus the clinical phenomena of the range of shame affects presented by Morrison can be formulated within either model. In my experience the one centered on conflict is by far the more useful with these severe forms of neuroses, provided we do not fall into the trap of equating "conflict" and "structural model" with "oedipal," and of setting up, as straw men, narcissism as being beyond conflict, self concepts as being *opposed* to structural theory, and "fragmentation" as being a separate form of anxiety rather than as inherent in all experiences of deep anxiety (as Rangell has convincingly stated[1]).

Philosophically, it is, however, important to recognize that the analytic, conflict-centered understanding of the human being represents one fundamental theoretical paradigm. It is antithetical to a holistic, synthetic, teleological paradigm. There is not more or less truth to the one or the other—to the model of conflicting inner parts versus that of perfection and deficit. The synthetic holistic

[1] Rangell, L. (1982): The self in psychoanalytic theory. *J. Amer. Psychoanal. Assn.*, 30:863-891.

model, with its orientation toward harmonious and self-fulfilling growth, is the philosophical view of the human being underlying both Jung's "analytic psychology" and Kohut's self psychology; with its focus on deficits and restoration, it is more Aristotelian. The analytic model, with its focus on parts and conflict, the model held by Freud and the classical psychoanalytic tradition, is more Platonic. The question is not "which is more correct?" but "which is more useful in a given context?" And that means "which is more causally relevant in regard to the tasks posed?" To conceptualize some aspects of development, especially early development, the holistic-teleological model, which is really one of learning and adaptation, may at times be more useful. Also, to conceptualize severe developmental disturbances, the deficit model may be more appropriate as central focus, with the conflict model as peripheral. The *phenomena* of shame, their development from their very earliest appearance, can very aptly be studied within this model; and Morrison has, together with others such as Brouček, done an excellent job with this approach.

The problem becomes very different, however, when we work with neuroses and the more severe forms of psychopathology being treated in intensive psychotherapy and especially in analysis. There, conflict becomes the central focus; deficit and the imagery and configurations of the whole self move to the periphery; they are not untrue, but become ever less useful for the task at hand.

Morrison consistently tries to apply this basically different philosophical model to the clinical, mostly *psychotherapeutic* understanding of shame pathology. I, too, find this approach and model to a considerable extent useful, but it reaches its limitations when I try to get to the *deeper* layers of inner causality and analytic effectiveness—in psychoanalytic work proper even with the severe forms of pathology ("borderline" and "narcissistic").

The two models or basic views of human nature are complementary to each other. If our focus is on the one, the other has to move to the periphery. Only very long, very intense study of individual cases with pure or modified psychoanalysis can show whether and where the conflict model reaches its limit. More often than not, the failure to understand conflict lies in faulty technique (e.g., in instances that correlate with Morrison's repeated statements about interpretation of defenses being experienced as "accusatory"), in an insufficient insight into archaic conflicts (into "narcissistic

conflicts," "shame conflicts," "intrasystemic superego conflicts between guilt and shame"), in short cuts attempted out of impatience when pathology eludes rapid understanding.

In contrast, we may look at the same phenomena as results of derailed lines of development, hence as more or less severe defects which might be repaired by emotional nurturing, exhortation, supportive-empathetic holding, and, most of all, by some form of education rather than by analytic, conflict-centered therapy, as Morrison shows with the greatest diligence. The drawbacks of this approach lie not only in severe curtailment of the understanding of inner, especially unconscious conflict, but in a disregard of the centrality for any theory of shame of the processes of *looking* and *being seen*, more generally, of perception and expression, and the conflicts relevant to these processes. The relationships to ego ideal, or "ideal self," stressed by Morrison, cannot do justice to the central importance of the "eye" in shame.

The *learning model* and the *conflict model* are *complementary* in the sense that each by itself attempts to explain much of psychology and psychopathology without being able alone to explain everything (or at least to explain everything equally well). They are complementary also insofar as each model shows its full value only when it is used to the very limit of applicability and thus reaches the other model's explanation only as a boundary phenomenon, as a *limiting concept*.

We should not be seduced by the surface phenomena, by the phenomenology. All neurotic patients have the experience of being deficient, or lacking something essential, and of feeling shame about this.

In conclusion, Morrison has given us a very conscientious, thoughtfully presented study of the clinical theory of shame. It is very useful, but limited by the compass of its presuppositions.

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ORIGINS OF HUMAN AGGRESSION. DYNAMICS AND ETIOLOGY. Edited by Gerard G. Neuman, Ph.D. New York: Human Sciences Press, Inc., 1987. 200 pp.

Theodore Roethke's attention was caught by an article in which mammals were characterized as preferring to receive loving atten-

tion while reptiles were described as more inclined to give it. He was inspired to write a playful poem, "For an Amorous Lady," about the giving and receiving of love in his own relationship with a woman, presumably Louise Bogan. The poem ends, somewhat ambiguously, or perhaps ambivalently, as follows:

> You are, in truth, one in a million,
> At once mammalian and reptilian.

Paul MacLean, the celebrated neurosurgical investigator who has contributed so much to our understanding of human brain structure and functioning, would say that this applies not only to Roethke's lover but to all of us. We *all* are "at once mammalian and reptilian." In two brief, overlapping chapters, MacLean presents his concept of human triune brain hierarchy, with its three successive drivers of the basic aggressive and appetitive behaviors that mediate preservation both of the individual and of the species.

The first and most primitive is the reptilian complex or R-complex that induces and regulates the aggressive attack behaviors and the courtship patterns that unite in violent combat behavior with reproductive rivals. It also mediates the specific imitative, preservative, re-enactment, tropistic, and deceptive behavior patterns that identify individuals as belonging to a particular species. He links these various behavior patterns with the basic human drives postulated in psychoanalytic theory.

The second is the paleomammalian complex, or limbic system, surrounding the reptilian-derived brain stem structures of lower animals. It ties basic "reptilian" response patterns to emotional feelings, which are closely connected with olfactory and oral functions, and to genital and procreative functions. These mediate feeding, fighting, and self-protection, on the one hand, and attention to and protective care of the young (including protection of them from the parent's own eating and fighting inclinations), on the other. The third subdivision of the limbic system, which reaches its highest development, according to MacLean, in the human brain, subserves neurologically programmed "maternal behavior, play, and emotional vocalization, including the isolation call [from newborns to their mothers]" (p. 45). There are important links with the visual system, through the cingulate gyrus of the limbic system.

Finally, there is the neomammalian brain, with its greatly expanded prefrontal cortex that mediates between the outwardly di-

rected receptors of sight, hearing, and touch, and the inwardly directed connection with the third limbic subdivision. This provides the capacity for the empathic identification with and concern for another individual that is the hallmark of higher mammalian functioning.

The significance of MacLean's observations is presaged in Gerard G. Neuman's Introductory Overview. In it, he surveys various ideas about human aggression, mainly the social scientist's view of it as a response to external frustration and the contrasting psychoanalytic view of aggression as arising from within each individual as a preprogrammed impetus toward acting upon the animate and inanimate world. He stresses Devereux's view of culture as an extension of parents' ambivalently cannibalistic and incestuous love for their children (p. 22). He also stresses the struggles Freud had to go through to recognize the existence of innate aggressive drive pressures (which Adler saw but retreated from, which Jung could not for personal reasons ever admit into his conceptualizations, and which Melanie Klein uncompromisingly accorded a central place in her own psychological constructions).

The book emerged out of a symposium on human aggression which was held in New York City, in December 1984. The various chapters, as is usual with a compendium of invited contributions, are very uneven, and they do not always integrate well with one another, but most of them are interesting and thought-provoking.

Kent Bailey's "Human Paleopsychology" picks up MacLean's concept of three-brains-in-one. Bailey addresses the phenomenon of to-and-fro shifts, especially in males, between civilized self-control and periodic eruption of violent outbursts, which frequently are enjoyable, via a phylogenetic regression-progression model that posits "primitivization, dissolution, and hierarchic disintegration" (p. 51) within the triune system of organization. He attributes central significance to the pleasurable aspect of phylogenetic regression, against which inhibitions cannot always prevail. To his credit, he adduces meaningful clinical observations to justify his ideas.

This is not so in Lloyd de Mause's entirely speculative linking of destructive rage with "an imprint or mind set or memory, or whatever you want to call it, of a *poisonous placenta* and a *nurturant placenta*" (p. 67), which he traces back to experiences of placental

failure even before the fateful placental abandonment that occurs during the baby's birth: "It depends on the placenta for the nutrition and constant cleansing of the blood, and it responds to every decrease in placental functioning with visible anger, as shown by its thrashing movements and elevated heart rate" (p. 67). "It is my contention," he states, "that when you are born and cut off from the umbilicus you lose your first object, and from then on you are searching for the *nurturant placenta* and fighting the *poisonous placenta* for the rest of your life" (p. 70). I find this a reifying, reductionistic view, which is open to very serious question on multiple grounds. Nevertheless, I have recently come across a very interesting paper, part of a book in progress, by Domenico Nesci of Rome, in which he interprets the willingness of the members of the Peoples Temple in Guyana not only to submit themselves unquestioningly to the mesmerizing domination of Jim Jones but even to participate in collective suicide when the community appeared faced with extinction in terms of "the fantasy of placental leadership." As a *derivative of unconscious fantasy*, the concept of yearning for the lost placental, all-providing Garden of Eden is much more plausible as a fundamental wish than is de Mause's Rankian idea.

Another speculative, neo-Lamarckian chapter is provided by Gerard G. Neuman. He hypothesizes that the relative security of arboreal life, with its ample food supply, bred aggressiveness out of our prehistoric ancestors, only to have it return when an assumed defoliation forced a shift out of the trees. On the ground, an aggressive push was necessary to keep our forebears moving and to enable them to become predatory hunters. In this chapter and in Neuman's valiant effort at synthesis at the end of the book, he traces out a hypothetical line of development from aggressive hunting with increasingly efficient weapons and tools, to cannibalistic "oral aggression," to "anal-sadistic" urges and defenses during cave-dwelling times, to a host of destructive and homicidal patterns as our over-aggressiveness and destructive efficiency outpaced our capacity to evolve reliable inhibitory mechanisms to maintain self-control. Neuman supports this hypothesis to a certain extent by examination of the record provided by paleontological findings and anthropological observations. He also briefly examines paleolithic efforts to create order via establishment of a matriarchal religion

centered about worship of the Great Mother Goddess who would ensure fertility of the land and of the tribe.

Robert S. McCully explores this in greater detail in a chapter in which he focuses on the ambivalent nature of the Great Mother and then Moon Mother Goddess worship, with its reliance on the maternal generative-nurturing-guardianship imago, on the one hand, and terror of the destructive, violently aggressive Terrible Devouring Mother on the other hand. Fear and envy of the all-powerful, primal mother appear to have continued into relatively recent times, if not into the present, despite the ascendancy of (at least partly reactive?) masculine power beginning in the neolithic period.

Robert Rousselle contributes a chapter in which he telescopically reviews the progression from ancient Greek myths, fantasies, and intermittent, symbolic animal orgies, derived from the need to sublimate parental murderous and cannibalistic urges toward their children, to Roman and early Christian myths and practices. That he need not have stopped there is illustrated by the reaction formations evident in the intense anti-abortion movement we are experiencing in our own time. In a companion offering, Judith and Milton Kestenberg trace child-killing practices from ancient Greek and Roman times on up to the twentieth century, when the Nazis in Europe exploded in bestial violence and murder not only of scapegoat Jewish children (and mothers) but of their own children as well, whom they hurled into battle to be maimed and killed. (One need only read the accounts of concentration camp survivors to appreciate the *especial* virulence with which pregnant women and children were brutalized.)

Howard F. Stein, in an examination of the cold war between the United States and the Soviet Union, comments on "the group psychodynamics of the *boundary* between one's own group and that of the enemy" (p. 155). His thesis is that as nations we need enemies in order to direct our potentially self-destructive overaggression toward an external group onto which we can project the attributes in our own selves that we despise and wish to extrude.

In a pair of concluding chapters, the editor, Gerard G. Neuman, attempts to effect an integration of the various contributions contained within this volume and to find reason to hope that rational good sense will ultimately prevail over the destructive and self-

destructive inclinations within us. He does not, however, find reason to be optimistic.

> This may be one of the saddest chapters in this book. The message of the book is that the human species went through experiences in the beginning which made it necessary to develop special aggressive capacities to survive. In the specific evolution of the human species there was insufficient preparation to carry this necessary aggression, which was later experienced as overaggression. All culture, civilization, and changing human development are mankind's attempt to convert, or at least, control this overaggression, which threatens to destroy the world and ourselves. So far, we have not been successful in accomplishing this. From early victims, we developed into killers and destroyers. We have not made much headway in healing the basic split between restitution in creativity, scientific rationality and beauty, and the lurking violence underneath (p. 165).

The problem of human aggression, Neuman points out, is one about which we have gained little understanding. With all of Freud's courage and candor, he was able to look into it only late in life and to a limited extent. And we have not yet gotten significantly further than Freud was able to do. "Freud," Neuman states, "just as Sophocles before him, finds the sexual construction a useful defense against the less acceptable aggressive understructure. As unacceptable as wanting to sleep with the mother is, wanting to kill her is even less acceptable" (p. 178).

I heartily recommend this volume to anyone interested in the role of aggression in human psychology. It will be of interest to anyone, in fact, who is concerned about the future of humanity.

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CULTURE AND HUMAN NATURE. THEORETICAL PAPERS OF MELFORD E. SPIRO. Edited by Benjamin Kilborne and L. L. Langness. Chicago/London: University of Chicago Press, 1987. 309 pp.

Melford E. Spiro is a major contemporary figure in the field of anthropology who has kept alive the link between psychoanalysis and anthropology through its vicissitudes over the decades. More broadly, he has stalwartly maintained a commitment to investigating the universals of human nature in the face of what he regards as a blind acceptance of cultural relativism on the part of anthropology as a discipline. His debates with Clifford Geertz over this

issue—whether the anthropological project should be essentially hermeneutic and interpretive, as many anthropologists have argued in increasingly radical ways, or whether anthropology can be a "science" that relies on hypothetico-deductive research strategies, as Spiro maintains—have resounded throughout the discipline. The present volume is a collection of twelve of Spiro's previously published theoretical papers, written between 1961 and 1984, which demonstrate this ongoing concern with the relationship between human universals rooted in individual, precultural needs and the influence of specific cultural processes on human development. It is the first time that Spiro's theoretical papers have been brought together, although several major papers are, unfortunately, missing. Nevertheless, the papers included demonstrate the impressive scope and brilliance of Spiro's thinking.

The book has been organized topically into three sections. The first section, "Culture and Human Nature," includes four of his more recent papers. All of the papers in this section demonstrate, from various angles, the pitfalls of cultural relativism and cultural determinism and the importance of continuing to investigate cross-cultural regularities and human universals. The universals he identifies, such as the oedipus complex and gender identity, are psychoanalytically inspired formulations which he attempts to confirm by showing that even for cultures that would seem least conducive to the expression of these universal dispositions, their existence can be demonstrated.

The volume's second section, "Functional Analysis," includes two chapters from the early 1960's, when functionalism was still in its heyday, and one written in 1982. The former are important statements that carefully articulate the relationship of culture, personality, and social structure without reductionism, belying the misconceptions about culture and personality studies that have developed among cultural anthropologists in recent years. The 1982 paper, "Collective Representations and Mental Representations in Religious Symbol Systems," updates the functionalist mode of explanation as Spiro asks why people believe in the religious doctrines of their cultures. The title of section three, "Religion and Myth," was, in my opinion, poorly chosen, since it does not accurately differentiate the papers of this section from those of the previous sections. As the editors indicate in the introduction, these papers

illustrate Spiro's use of early family experience in his arguments about how culture is internalized and how, in turn, adults experience their cultural worlds through the lenses of their own family circumstances.

The first paper of the volume, "Culture and Human Nature," is also one of the most illuminating, particularly for a younger generation which has inherited an array of established opinions and well-worn arguments but is unaware of how these opinions developed. It is an autobiographical essay which traces the rationale that led Spiro to conduct field research in a remarkably wide range of cultures (Micronesia, Israel, Burma). The paper clearly articulates the limitations of cultural relativism and powerfully demonstrates why personality must be investigated independently of behavior and culture.

The paper "Preculture and Gender" is more problematic, its weakness demonstrating the difficulties of attempting to approximate controlled experimental research in anthropological field research. In an effort to test (and disprove) the hypothesis that gender orientations are cultural artifacts, Spiro studied the development of children on an Israeli kibbutz. Though acutely sensitive to unconscious motivations in most situations, Spiro seemed to assume in this study that the kibbutz's conscious ideology of sexual equality and gender blindness was all that these children were exposed to. He thus concluded that the acute sexual consciousness and desire for sexual segregation displayed by adolescents, despite their communal experiences from infancy, were "precultural" needs. He would have perhaps more accurately assessed the situation by investigating how the caretakers, themselves raised in traditional households, communicated their culturally shaped but disavowed assumptions of gender identity to the children under their care.

"Religion: Problems of Definition and Explanation" demonstrates, as do his other essays, clear thinking and a careful use of logic in articulating his position with respect to prevailing opinions in the field of anthropology. His cross-cultural orientation to the study of religion is in sharp contrast to Geertz's hermeneutic approach (this article was originally published in a volume with an influential article by Geertz on the same topic). His more or less explicit positivist attitude, that religions are false and become less

important as cultures adopt more "realistic" stances (p. 215), places him well outside any hermeneutic interpretive circle. (Hermeneuticists argue that since all thought is symbolically constituted, there is no "reality" apart from any particular belief system.) From this stance of claimed objectivity he then asks what causes people to believe in religious ideas (which he defines as belief in supernatural beings) that are irrational.

Spiro convincingly demonstrates that certain aspects of religious belief do serve psychological functions. He finds the motivational source of religious behavior in psychologically primitive fears such as fears of destruction and dissolution and impulses that are culturally forbidden and are, hence, unconscious. In this and other articles he demonstrates that, though these fears and impulses are universals of human nature, their particular form is shaped by early experiences in the family. One would, consequently, expect to find correlations within a culture between family structure and religious beliefs and practices. Spiro demonstrates these correlations ethnographically in the chapter, "Some Reflections on Family and Religion in East Asia."

The difficulty I have with Spiro's way of defining religion and his way of framing his question about religious belief is that he unnecessarily exacerbates the dichotomy between his project and an interpretivist stance. Interpretivists are offended by essentialist definitions of phenomena, which ignore the complexity of religious experience in favor of a lowest common denominator. The consequence has been a persistent dismissal within anthropological circles of anything psychoanalytic as "outmoded positivism." But I would argue that there are other ways of identifying cross-cultural regularities in symbolic processes and their psychological significance that do not involve beginning with an essentialist definition removed from indigenous experience. Nevertheless, it was Spiro who clearly articulated the theoretical problem that a younger generation of scholars has been struggling to resolve.

Spiro has served as a champion of psychoanalysis within the discipline of anthropology for many years. These selected papers are a preliminary tribute to his accomplishments. They are essential reading for anyone concerned with the cross-cultural applicability of psychoanalytic theory. They vividly demonstrate why Spiro has been a major force in the development of psychological anthropol-

ogy and a source of inspiration for his students and younger colleagues.

KATHERINE P. EWING (DURHAM, NC)

ON DEFINING FREUD'S DISCOURSE. By Patrick J. Mahony. New Haven/London: Yale University Press, 1989. 104 pp.

Patrick Mahony, professor of literature, practicing psychoanalyst, skilled reader and critic, continues to guide us toward more intense, psychoanalytically shaped experiences of reading Freud. He shows us how (and encourages us to join him) he allows himself to resonate creatively as reader/re-reader/interpreter of Freud as creative writer/mentor/psychoanalytic explorer. Writing and reading *both* become exciting, creative acts when one allows oneself to discover where one is going, while immersed in writing or reading. Mahony encourages us to follow Freud's example ("Itzig, the Sunday rider") of writing as creative organization of as yet barely formulated inner experience. Writing becomes a creative act of self-discovery.

I am reminded of Joyce McDougall's description of sitting down to write an article when she is troubled about a psychoanalytic case. A patient who came to me after having read a paper of mine left angrily, taunting me, "At least you'll probably get a paper out of this!" Actually, Mahony takes us back earlier, to St. Augustine: "I try to be among the number of those who write as they progress and who progress as they write" (p. vi). Mahony is inspired/energized by this model of creative writing/exploring, which he does so well. He invites us to join him.

Mahony's combined reading approach as a literary critic and as a practicing psychoanalyst leads to a rich reading of Freud, with psychoanalytic emphasis on process, the writer's and the reader's. Mahony writes:

> My own approach presumes that Freud's texts, like crystals, have fault lines, and I wonder where they are and how wittingly as well as unwittingly they are covered up. I muse about whether Freud's self-irony fully accounts for the gaps and contradictions in his report. Given the foiling nature of the unconscious, these questions are where I begin, not end, my enquiry. In addition, by splitting my ego into participant and observer roles, I aim to respond antiphonally to the dual activity that characterized Freud's own compositional creativity (p. 94).

He tells us that he is working within a writing space and a reading space, akin to the analytic space. Earlier work in applied psychoanalysis, as by Green and Gorney, drew on Winnicott's idea of transitional play space to describe creative interaction between writer and reader. But these focused primarily on issues of separation, aloneness, and search for another in writing.

Mahony succeeds in his creative attempts to take apart Freud's texts. He emulates with his reader, and with Freud-as-writer, Freud's interactive engagement with his reader and his work. This leads to a creative enactment in reading Mahony reading Freud. Writing and reading thus become creative, psychoanalytic experiences of working out and working through. Freud has contributed to what Mahony calls a "hermeneutics of suspicion" (p. 94) in reading; reading can never be complete and closed but must, on the contrary, aim to open and question.

Mahony presents well the complexity of Freud's efforts as a writer. He is persuasive about Freud's conscious, preconscious, and unconscious efforts to deal with the reader's resistance so as to influence him or her. Mahony shows us a passionate Freud, writing under the sway of intense feeling, which infiltrates his prose. He demonstrates persuasively, from the German, the erotized tone of Freud's writing about Katharina. Mahony arouses us, too, with images of the mountain setting in which Freud and Katharina met, with references to climbing, falling, looking, penetrating, abstaining, and desiring. He convinces us that Freud's creativity involves expressing and managing his desire.

Mahony introduces us to Helmut Junker, who opens up the logical contradiction in the title of Freud's "Analysis Terminable and Interminable." The emphasis shifts to flow, movement, interweaving of this contradiction between "ending" and "non-ending." Mahony shows us Freud's tendency to find "similarity-in-difference" (p. 85) within the psyche. He will not just accept Freud's well-known tendency to think in binary terms. Freud's writing becomes richer as Mahony twists and turns these polarities back on themselves and on each other. Whatever these seeming opposites may be, ending and non-ending, ego and id, eros and thanatos, etc., they cannot be separated so easily. Freud's story of life and psychic conflict becomes a struggle among division, intermixing, synthesis, and integration, which can never be clearly and forever won. Ma-

hony, the classicist, heightens Freud's tragic view of life. He returns Freud to the Scholastics (p. 87): " '*Distinguo ut uniam*' (I distinguish in order to unite)."

What I find most important about Mahony's work is his attempt to elaborate a psychology of writing and reading that is both literary and psychoanalytic. Both author and reader struggle to work through conflicts in the acts of writing and reading, seeking creative expression and integration. In reading Freud, Mahony would have us be attentive to Freud's creative and conflictual needs, within his text and toward his readers. And he would have us attend to our own attempts to seek creative solutions to our conflicts as we read Freud, conflicts within ourselves and toward our progenitor, Freud. Writing and reading become "ending" and "non-ending." Our struggles and our creative efforts are never done. Eschewing such closure makes both writing and reading more exciting, more creative, worth turning to again and again. Mahony shows us this by his own creative re-readings of Freud (and himself), as he leads us to read, write, and create with and through him.

STANLEY J. COEN (NEW YORK)

REPETITION AND TRAUMA. TOWARD A TELEONOMIC THEORY OF PSYCHOANALYSIS. By Max M. Stern. Edited by Liselotte Bendix Stern. Hillsdale, NJ/London: The Analytic Press, 1988. 169 pp.

This book is a laudable attempt to integrate psychoanalytic metapsychology with modern neurobiological research. Stern was a member of a small group of clinicians attempting to actualize Freud's wishes for a solid neurobiological foundation for psychoanalysis. I applaud his efforts and see this document as a tentative initial statement indicating areas for much research. His work suggests that the psychoanalytic community should engage in more integrative theorizing of this kind rather than sit in their inbred ivory towers continuing to damage the general credibility of psychoanalysis in the eyes of other medical professionals.

The book suffers from posthumous publication and would have benefited from some more work by the author himself, although we can be grateful for the creditable effort exerted by his wife. Many of the ideas are not fully developed, and most of them are

stated in general terms without sufficient clinical examples so that they are difficult to understand or apply.

The book is divided into five chapters. It attempts to examine particular special instances of post-traumatic dreams and pavor nocturnus. In four chapters, Stern evolves a theory that further develops Freud's idea of the death instinct; and he integrates his material with some of Hans Selye's concept of countershock. There is a relatively weak final chapter in which he attempts to provide a broad philosophical foundation for his ideas on the basis of a non-dualistic theory of human "instinct" using the geneticist Monod's teleonomic ideas. There is also an extraordinarily lengthy introduction by psychoanalyst Fred Levine that attempts to update Stern's work by connecting it with developments in sleep and dream research since 1982.

Stern considers pavor nocturnus to be a physiological defense against stress resulting from a preceding nightmare. He makes his case in a detailed, even at times repetitive fashion, citing primarily the early research on sleep and dreams conducted by Fisher and others in the 1960's. Fisher's view was that night terrors are pathological symptoms rather than being either wish fulfilling or illustrative of the death instinct. He also believed that the thought content derives from the physiological reaction rather than the other way around. Stern's view is directly opposed. He develops his ideas, using the research of others to speculate that a more cognitive, less symbolic dream precedes the nightmare, along with an unusual low level of autonomic arousal. According to Stern, the dramatic, morbid fear of night terrors resembles a shock state, first described by Selye and called by Stern "catatonoid," in which the brain is at first aroused and then suppressed by the trauma itself. In Stern's view, the function of the night terror, whether caused by subtle childhood conflicts or direct post-traumatic stress responses (e.g., to an accident) is an attempt to correct by compulsive repetition a "developmental failure to attribute meaning to a state of tension" (p. 8). Thus, pavor nocturnus is not seen as a regressive phenomenon, i.e., an ego regression to a fixation point, as Fisher described, but as a developmental failure of the ego to attribute meaning to a state of tension. In this instance, the response is a shock response whose purpose is to cope with fright in Freud's sense.

Stern also acknowledges, however, that night terrors arising dur-

ing childhood will contain more distortion of material influenced by pre-existing psychic conflict and by transference factors than night terrors resulting from concrete traumatic experiences, such as accidents, war, etc. The paralyzed, shock-like state of pavor nocturnus is seen as a temporary maladaptive response of the brain to fright. Stern points out that the brain and its mechanisms of defense, according to Freud, have several ways of anticipating danger. "Signal anxiety" leads to a much more adaptive response to such threats than does the fright response. It might be added here that modern genetic research, particularly the studies reported by Neubauer and Neubauer,[1] on vulnerable and invulnerable children (the genetic traits of susceptibility and resilience) might amplify and make clearer some of Stern's ideas. Probably, highly resilient children who survive severe psychic trauma do not have the same catastrophic post-traumatic stress responses as the genetically more vulnerable children.

For the psychoanalyst, the key chapter is Chapter Three, in which trauma and repetition compulsion are examined in some detail, including the contributions of Freud and Schur. There is a review of Freud's ideas, highlighting the difference between signal anxiety that leads to active mastery of danger when anticipation is possible and fright as a passive, unprepared state in which submission occurs. The traumatic dreams of Freud's patients were attempts to master fright by repetition, somewhat similar to child's play. Stern concludes, as did Freud, that traumatic dreams are not produced by intrapsychic conflict, but that, in general, "dreams (traumatic) . . . persist until adaptation to the consequences of the trauma has occurred, until signal anxiety can be brought to bear on the memory of the traumatic situation. In this sense, repression by means of signal anxiety is the necessary pre-condition for further adaptation to the trauma by means of the development of an intellectual understanding of the situation that led up to it" (p. 113). Here, the role of the psychoanalyst, therapist, friend, or whoever assists the individual to deal with the repetitive dreams is clear. With therapy, "meaning is assigned to the subject's own state of tension." Once meaning is assigned, the symptom is ameliorated.

[1] Neubauer, P. B. & Neubauer, A. (1990): *Nature's Thumbprint. The New Genetics of Personality.* Reading, MA: Addison Wesley Publ. Co.

Repetition thus becomes less necessary. Some sketchy clinical material is provided to illustrate these hypotheses.

The final chapter, concerning the application of Monod's ideas, is the weakest in the book. It is in need of a lot more elaboration. Although I am not familiar with Monod's writings, some of the statements made do not seem in line with modern genetic theory. For example, there is a statement that seems to imply a Lamarckian view of genetics: is it reasonable to say, Stern asks, that "the inevitable experience of trauma was absolutely necessary to the development of an innate program capable of generating anticipation?" (p. 146). Teleonomic here means goal-directed. Monod's idea centers highly on the intrapsychic by implying that human development is only a form of autonomous determinism (mainly genetic) whereby the external world shapes, but does not largely determine, how a human being is.

This book will not be of great value to clinicians, but it will be of interest to psychoanalysts who have a philosophical or metapsychological bent. It might be of some interest also to research workers who are concerned with the integration of biological and psychoanalytic research.

STUART W. TWEMLOW (TOPEKA)

MALE HOMOSEXUALITY. A CONTEMPORARY PSYCHOANALYTIC PERSPECTIVE. By Richard C. Friedman. New Haven/London: Yale University Press, 1988. 296 pp.

Since 1976, Friedman has been a proponent of viewing exclusive homosexuality as one type of sexual object choice. In a 1976 paper,[1] he gave the impression that he questioned the role of psychodynamics in determining sexual object choice. His views were in keeping with the position held by those who eliminated homosexuality from the psychiatric nomenclature.

The 1976 paper contained the seeds of the ideas expressed in the current volume. In this book, Friedman devotes himself to an exegesis of biological considerations—plasma hormone levels, neuro-

[1] Friedman, R. C. (1976): Psychodynamics and sexual object choice. *Contemp. Psychoanal.*, 12:94-108.

endocrine influences, effects of prenatal stress, and the role of genetics. He only briefly describes psychoanalytic clinical research, and in this he concentrates on what he considers the major works of psychoanalysts on the topic, especially a 1962 study by Bieber, et al.[2] He gives a great deal of space to the work of nonpsychoanalytic investigators such as Kinsey and his co-workers, Saghir and Robins (1973),[3] and Bell, Weinberg, and Hammerschmith (1981),[4] who have arrived at the conclusion that homosexuals of the obligatory type have a "gender nonconformity" (p. 38). Friedman does not appear to agree with those psychoanalysts engaged in clinical research into the genesis of homosexuality who have concluded that disturbance in gender-defined self-identity is the core disturbance in homosexual patients. He views homosexual object choice as an expression of a "biological predisposition" (p. 25).

Friedman indicates that he is "atheoretical with regard to homosexuality. No assumption is made concerning the relation between homosexuality-heterosexuality and preoedipal and oedipal development and motivational concepts. No assumption is made concerning the relationship between homosexuality and psychopathology" (p. 95).

Friedman holds the view that the "homosexual identity" of a patient should be "preserved." This is very different from the view held by analysts whose treatment of homosexuals aims at removal of symptomatology. This position has various sources: sociopolitical activism in an era of sexual permissiveness and liberation, which offers genuine concern but misguided efforts to remedy the plight of the homosexual, who has suffered social disapproval for centuries for something over which he or she has no control; the ego-syntonic nature of homosexuality; and undue pessimism as to the value of psychoanalytic therapy for this disorder. Psychoanalytic clinicians versed in the treatment of sexual deviations are now being accused of suffering from a countertransference to their ho-

[2] Bieber, I., et al. (1962): *Homosexuality. A Psychoanalytic Study.* New York: Basic Books.

[3] Saghir, M. T. & Robins, E. (1973): *Male and Female Homosexuality. A Comprehensive Investigation.* Baltimore: Williams & Wilkins.

[4] Bell, A. P., Weinberg, M. S. & Hammerschmith, S. K. (1981): *Sexual Preference: Its Development in Men and Women.* Bloomington: Indiana Univ. Press.

mosexual patients due to societal pressures and prejudice. Those who take these positions often rationalize them by saying that homosexuals are thereby spared the pain of treatment and what is assumed to be its inevitable failure.

There are numerous misconceptions in Friedman's book, but I prefer to mention only one, which I can directly refute, citing the same source he claims in his chapter, "Conclusions, Psychoanalysis, Science and Homosexuality," in which he states that "subsequent advances in descriptive psychiatry, the neurosciences, psychology, psychopharmacology, clinical, development and neuropsychology have *invalidated* some of these hypotheses and have posed serious problems for them. . . . Much material in this area is reviewed by Bayer [1981],[5] who paid particular attention to the disagreements among psychoanalysts, psychiatrists, and gay activists over the American Psychiatric Association's decision to drop homosexuality [per se] from the diagnostic nomenclature" (p. 268, italics added). In fact, there was no opportunity for disagreement among any of these professionals, as the "normalization" of homosexuality was done *ex cathedra* by the political powers within the APA, and without any opportunity for scientific discussion.

Friedman engages in a wholesale rejection of new scientific insights gained by psychoanalytic clinical researchers who actually treat homosexual patients. These insights are built upon a solid foundation of hundreds of psychoanalytic clinical research reports in the literature of the last eighty-five years (see Socarides[6] for an extended bibliography). Refusal to accept the scientific findings of psychoanalysis is not a new phenomenon. In fact, as Freud observed:

> Now it is inherent in human nature to have an inclination to consider a thing untrue if one does not like it. . . . Thus society makes what is disagreeable into what is untrue. It disputes the truths of psycho-analysis with logical and factual arguments; but these arise from emotional sources and it maintains these objections as prejudices, against every attempt to counter them.[7]

CHARLES W. SOCARIDES (NEW YORK)

[5] Bayer, R. V. (1981): *Homosexuality and American Psychiatry. The Politics of Diagnosis.* New York: Basic Books.

[6] Socarides, C. W. (1978): *Homosexuality.* New York: Jason Aronson.

[7] Freud, S. (1916-1917): Introductory lectures on psycho-analysis. *S.E.*, 15:23.

THE WISH FOR POWER AND THE FEAR OF HAVING IT. By Althea J. Horner, M.D. Northvale NJ/London: Jason Aronson, Inc., 1989. 199 pp.

This is Althea Horner's third volume on topics of interest to psychotherapists, patients in psychotherapy, and members of the general public who wish to be enlightened about dimensions of human motivation.

The volume is divided into sections which are united by a developmental-object relations perspective. The first section describes the range of the power-powerless continuum. Horner distinguishes between an individual's subjective perception and experience of power in an interaction that is internalized as part of the self- and object representations, and intrinsic power, which refers to effecting, assertive, and mastery motivations of the developing self or ego. These intrinsic motives are in the area of primary autonomy but can secondarily become involved in conflict.

In the second section, a developmental perspective based on the formulations of Mahler, et al.,[1] is presented. She uses the term "power pivot" to describe the separation-individuation process that culminates in the rapprochement phase, in which a child loses its illusions of omnipotent power and comes face to face with the reality of its dependency upon powerful parental figures. Within the dyad there exists a potential for power sharing between interactive partners that enhances and supports the child's evolving intrinsic capacities for competence, mastery, and initiative. Alternatively, there may be power plays in which dominant parents force submission from intimidated, angry children. These internalized power plays are eventually transformed into envy, sadomasochistic enactments, persistent aversive behaviors, and defensive inhibitions of assertiveness and potency, as the vicissitudes of competitiveness and envy enter human relationships in the context of oedipal conflicts.

Although childhood and adolescence offer new opportunities for renegotiation of these internalized patterns, psychopathology results when negotiations fail. Horner examines subtle, sometimes contradictory messages concerning power values in the section on psychopathology of power. Addiction, the erotization of power,

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

suicide, and eating disorders are outcomes of the wish for and fear of acquiring power. In these disorders a pseudo-self-sufficiency is claimed as a flight from anxiety-provoking human relationships. The final section discusses power tactics as part of everyday life. The book closes with a questionnaire in which the reader is invited to construct an autobiographic introspective profile on the use of power in love, play, and creativity.

Horner's thesis demonstrates that power is not a unitary, irreducible concept. Much can be learned from an introspective approach to illusions of grandiosity and omnipotence and defensive positions concerning one's power to exert control over one's life and to affect others. She demonstrates that each person, from his or her own developmental experience, has a subjective perspective on what power is, where it lies, who possesses it, and what forms count. The limitations of this book are not in its intention to explore these factors. They reside rather in the superficial, anecdotal treatment that Horner gives to the broad range of topics she addresses. Her approach offers little that might appeal to a research-oriented or a clinically oriented psychoanalyst.

Her theoretical formulations are derivative of multiple psychoanalytic authors. She is greatly influenced by Mahler's developmental formulations. She differs from Parens[2] insofar as she regards power as a motivational force in its own right, rather than derived from the aggressive drive in either its pleasure-seeking destructive form or its aim-inhibited form. She conceptualizes power conflicts as compensatory for deficiency states that are either biologically determined[3] or due to environmental failures to provide suitable contexts for healthy development of intrinsic power, as proposed in the works of Hartmann,[4] Kohut,[5] Winnicott,[6] and White.[7] Many of

[2] Parens, H. (1979): *The Development of Aggression in Early Childhood.* New York: Aronson.

[3] See Adler, A. (1930): *Individual Psychology in Psychologies of 1930*, ed. C. Murchison. Worcester, MA: Clark Univ. Press.

[4] Hartmann, H. (1939): *Ego Psychology and the Problem of Adaptation.* New York: Int. Univ. Press, 1958.

[5] Kohut, H. (1977): *The Restoration of the Self.* New York: Int. Univ. Press.

[6] Winnicott, D. W. (1965): *The Maturational Process and the Facilitating Environment. Studies in the Theory of Emotional Development.* New York: Int. Univ. Press.

[7] White, R. W. (1959): Motivation reconsidered: the concept of competence. *Psychol. Rev.*, 66:297-333.

her formulations touch on current psychoanalytic debates concerning motivation, development, and intrapsychic versus interpersonal foci of interest in the clinical situation. In my view, she neither clarifies nor adds to these discussions. Although she depends upon an object relationship perspective that focuses attention on inner schemata of self and other, the bulk of what she describes excludes the unconscious and emphasizes real transactions in the world and the individual's subjective assessment of his or her own or other's power or lack of it.

With these criticisms in mind, the book does have limited value in alerting the lay public to the significance of power as a motivational force in human behavior. However, the book falls short of the author's stated purpose:

> To provide the reader with insights and power to resolve the kinds of power issues and anxieties associated with powerlessness that may be standing in the way of his or her ability to achieve life goals both in the arena of personal relationships and in that of work and career (pp. xii-xiii).

BARBARA S. ROCAH (CHICAGO)

BERTOLUCCI'S DREAM LOOM. A PSYCHOANALYTIC STUDY OF CINEMA. By T. Jefferson Kline. Amherst, MA: University of Massachusetts Press, 1987. 206 pp.

Bernardo Bertolucci's cinema visualizes the forbidden. It portrays sadomasochism, seduction, homosexuality, and oedipal struggles in a style that is dreamlike and provocative without exploitation of his audience. Bertolucci roots these manifest themes to their unconscious derivatives and pervasively uses aesthetics, literature, and political ideas like day residues. In homage to psychoanalysis, this image-maker speaks of it as another lens on his camera, of his films having been constructed in the framework of analysis and dreams. He says, "Cinema is made from raw material woven on a dream-loom" (p. 10). He speaks of the unconscious as the modern word for the Greek concept of fate and of his own unconscious as the fate of his movies. (Because his work so richly evokes psychoanalytic discussion, the Forum for the Psychoanalytic Study of Film twice conducted weekend retrospectives of his work, with Bertolucci's participation.)

Despite the popularity of *Last Tango in Paris* and *The Last Em-*

peror, Bertolucci's cinema can be dense and difficult to absorb because of the intricate cinematic architecture he constructs from dreamlike images, flashbacks, doubling, literature, painting, opera, and myth, as well as from his lengthy psychoanalysis. Three of his most acclaimed films were created in the early years (1970-1972) of his analysis that began in 1969 when he was twenty-eight.

T. Jefferson Kline is a Professor of Modern and Romance Languages and Literatures at Boston University. His background in analysis originated in a Norman Holland study group on applied psychoanalysis. Through self-education he keenly uses the insights of psychoanalysis—classical through contemporary—to engage the reader in an intense exploration of Bertolucci's dream loom. In contrast to many "psychoanalytic" film scholars, he is neither a Lacanian nor does he employ early Freud out of historical context.

Like the dream interpreter, Kline unravels the threads and "colors" of Bertolucci's complex dream material and reweaves them on his own loom—his knowledge of psychoanalysis, film, literature, language, aesthetics, and political theory. This panoply of scholarship leads the reader to unexpected, compelling views of the signs, metaphors, and "sights" in Bertolucci's cinema and the language of cinema itself.

Kline traces the evolution of Bertolucci's work to his personal history, directly quoting passages from Bertolucci. Bertolucci's father, Atilio, is a major Italian poet and film critic. The son, after winning a national poetry prize at age nineteen for *In Search of Mystery*, ended his career as a poet to apprentice with film-maker and poet Pier Paolo Pasolini, his father's friend. Kline sees "Bertolucci's entire *oeuvre* as a long and intensely ambivalent battle of liberation from two paternal figures" (p. 7) and a transformation of poetic language into cinematic language.

Kline clarifies Bertolucci's auto-referentiality, complex use of the primal scene, doubling, mirroring, dream screen (Lewin) and film screen, voyeurism, father-son oedipal struggles, identification, and the repetition compulsion. Kline's thesis that dream work so parallels the creation of film suggests the term "filmwork." His splendidly resourceful opening chapter asserts that, as with dreams, our desire to see film is based on "perverse" desires, and that cinema might be called a "normal perverse fantasy" in which viewer and film-maker collude in an attempt to recreate the primal scene. (Ar-

low attributes one's capacity to enjoy the forbidden in art to a mutual exculpation of guilt between audience and artist that lessens superego condemnation.) Kline also discusses projection onto the "dream screen," Winnicott's transitional space, and how censorship masks, yet reveals.

He explicates the dialectics between the literature of Stendhal, Dostoevsky, Borges, and Moravia and the respective films: *Before the Revolution* (1964), *Partner* (1968), *The Spider's Stratagem* (1970), and *The Conformist* (1970). In contrast, the *Grim Reaper* (1962), *Last Tango in Paris* (1972), *1900* (1976), *Luna* (1979), *Tragedy of a Ridiculous Man* (1981) and *The Last Emperor* (1987) originated from diverse sources. Bertolucci returned to literature in *The Sheltering Sky* (1990), adapted from Paul Bowles's novel.

In *Before the Revolution* Kline relates his concept of "absent presence" to dream work with its representations of the forbidden, in particular incest, as well as to photography and to the film's source, Stendhal's *The Charterhouse of Parma.*

Struggles and death in the filial-paternal dyad are portrayed in *The Spider's Stratagem, The Conformist,* and *Tragedy of a Ridiculous Man.* In *The Spider's Stratagem,* a young adult son is summoned to solve the complex mystery of his father's assassination twenty years earlier. Derived from a Borges short story, "The Theme of the Traitor and the Hero," as well as from Verdi's *Rigoletto* and from Shakespeare, the film is interpreted by Kline as an oedipal struggle, viewing the father as both hero (to be emulated) and traitor (to be eliminated as the seducer of the coveted mother).

He discusses the pervasive use of betrayal in Bertolucci's cinema. In *The Conformist* the protagonist betrays his former mentor as Bertolucci betrays the source text, of Moravia (the "author-ity") and Goddard. The clinician would add that pseudo-conformity is used to defend against sadism, homosexuality, and oedipal struggles and to provoke others to act out one's impulses.

1900 covers forty-five years of Italian history through the intertwined family and political sagas of two boys—the son of a peasant and the son of the padrone—born on the first day of the century. Kline finds confusion in the film's attempt to couple personal and historical reality and ambiguity in combining political idealization and realism. On a more positive note, Kline writes, "As in *Last Tango* and *The Conformist*, Bertolucci's camera begins with a kind of

seductive, passive voyeurism and subtly substitutes a form of complicity with violence which the spectator must confront as a natural extension of voyeurism itself" (p. 145). He interprets Bertolucci's most acclaimed *Last Tango in Paris* through the Orpheus-Eurydice myth, rescue fantasy, mourning ritual, doubling, and betrayal. In regard to Kline's emphasis on the process of doubling, the psychoanalyst would ask for greater interpretation of its levels of meanings. Kline names doubling as a primary aspect of dream work but, surprisingly, omits explicit reference to visual representation.

Kline presents an exemplary model of blending psychoanalytic ideas with those of literature, mythology, and the other arts to understand Bertolucci's *oeuvre* as well as the nature of film-making. As multiple viewings of Bertolucci's cinema reveal the complexity of his dream loom, so rereading Kline's fluid and astute interpretations reveals his rich contribution to applied psychoanalysis.

BRUCE H. SKLAREW (CHEVY CHASE, MD)

CINDERELLA. A CASEBOOK. Edited by Alan Dundes. Madison: University of Wisconsin Press, 1988. 316 pp.

LITTLE RED RIDING HOOD. A CASEBOOK. Edited by Alan Dundes. Madison: University of Wisconsin Press, 1989. 251 pp.

These volumes bring together a number of interpretations of two widely known folktales. The essays are drawn from different fields over the period of the last hundred years; in some cases, the works were translated for inclusion in these volumes and would otherwise be difficult of access. The editor's goals are to provide readers with the opportunity to see for themselves various modes of analysis and to encourage "eclectic and improved scholarship in folkloristics." It is not entirely clear to whom Dundes is directing these books, but one can imagine several dimensions on which psychoanalysts might find such collections interesting: as examples of applied psychoanalysis, in relation to philosophical and cultural examination of imaginative material, in relation to child development, and in the correlations between folktales of a particular culture and individual histories.

The psychoanalytic reader without expertise in the field of folkloric studies is introduced in these books to a fascinating array of

approaches and explanations, as well as a plethora of versions, of stories we may naïvely have thought we "understood." Indeed, in his very incisive and comprehensive introductory notes to each selection, Dundes makes frequent reference to the limitations of traditional psychoanalytic views of fairy tales and exhorts the psychoanalytic reader to do better homework before undertaking explication on the basis of only one or two familiar versions of a tale. Dundes succeeds admirably in both volumes with his elegant and humbling critique of those writers limited by parochialism, whether they be French folklorists of the early part of the century, intent on reducing all tales to seasonal myth-ritual significance, or psychoanalysts inferring universal meaning from the Grimm brothers' particular literary creations.

Each essay is interesting, if only as a curiosity in some cases. There is a wealth of incidental knowledge to be gained, for instance, in the description of Javanese social structure in Danandjaja's paper, "A Javanese Cinderella Tale and Its Pedagogical Value," or Zohar Shavit's account of the development of children's literature in her use of Little Red Riding Hood to discuss "The Concept of Childhood and Children's Folktales." Just as recent descriptions of the influence of contemporary scientific thought on Freud's thinking have proved illuminating in understanding the evolution of psychoanalytic theory, so the samples Dundes provides of sociological or anthropological explanations of fantasies in the form of folktales enrich our knowledge of the intellectual climate in which psychoanalytic thinking about group culture has taken place.

Current intellectual approaches to data are exemplified in Dundes's inclusion of a structuralist critique of Cinderella in David Pace's "Lévi-Strauss and the Analysis of Folktales," and in papers which utilize feminist-inspired insights, such as Jane Yolen's "America's Cinderella," which analyzes what has happened to Cinderella as a role model or stereotype for girls in the mass-market popularizations of the story. Jack Zipes's paper, "Little Red Riding Hood as Male Creation," discusses the effects of men collecting and rewriting female-centered tales with the goal of curbing and regulating female sexuality and suggests the interaction of cultural needs or biases with the favored form of the tale.

Dundes ends the Little Red Riding Hood book with his own 1988 paper, "Interpreting Little Red Riding Hood Psychoanalytically."

He provides a lucid survey of the history of commentary on versions of this tale and an elegant discussion of earlier psychoanalytic formulations. Róheim's neglected interpretations[1] are reconsidered to emphasize the cannibalistic aspects of oral tales. Dundes proceeds to demonstrate the persistence in the story of unconscious infantile wishes from all levels of psychosexual development, with particular stress on anal elements which he feels have been relatively slighted in earlier analyses. He concludes that "the moralizing effect of Perrault's cautionary tale version and the Grimm brothers' recension have not been successful in stifling the underlying content of the oral tale." His assertion that the tale "will remain important to children and adults in decades to come" (p. 227) seems amply proven and alludes intriguingly to the possibility of demonstrating the timelessness of the unconscious through the study of folktale forms and themes.

KERRY KELLY NOVICK (ANN ARBOR, MI)

RENSAL THE REDBIT. By Eugene Mahon. Southampton, NY, 1990. 61 pp.

Eugene Mahon has written a dreamily whimsical, charming little book that is lovely to read and a delight to review. It is as poetic as it is philosophical, as undefinable in purpose as it is recognizable in the array of concerns expressed in it, as private as it is broad in its appeal.

In a fantasyland that also is recognizable as our very own world, lives a young *redbit* (very like a rabbit but infinitely more singular, with his colorful pelt and piercingly inquiring mind). He romps and plays, as the young will do when circumstance allows. Increasingly, however, he is interrupted in his carefree child's pleasures by observations of the nature around him and the nature within him. These command his attention and force him to stop what he is doing, cock his head, and wonder what and why.

One day, he stumbles upon a marvelously Lincolnesque "tall one" who somehow has not forgotten what it was like to be awak-

[1] Róheim, G. (1943): The dragon and the hero. *Amer. Imago,* 1: Issue No. 2, 40-69; Issue No. 3, 61-94; (1953): Fairy tale and dream. *Psychoanal. Study Child*, 8:394-403.

ened out of youthful innocence by increasingly coalescing glimpses of the wonderful and the terrible that constitute the animate and inanimate world that surrounds us and of which we are a living, breathing, feeling, acting part. Quizzically ambiguous, sadly sagacious, but ever patient and unintrusively kind and loving, he is ideally suited as an interested listener, a compassionate comforter, a wise facilitator, and a source of necessary bits of information that cannot be easily enough obtained elsewhere.

The redbit makes regular visits to the tall one, who becomes his welcome friend. As they refresh themselves with endless cups of tea and slices of toast, augmented on occasion by a handful of fresh-picked berries plucked from the bounty around them, they converse about life and its manifold mysteries. Birth, death, love, hate, the warmth of safety and security, the thrill of daring and adventure, the here and now, the worlds that can be visited only with the soaring imagination, the awe-inspiring universe, the universal awfulness of the redbit (i.e., human) world of which they are a part, all is grist for their mill.

Is this a parable about child psychoanalysis? Is it an inspiring but sadly poetic depiction of the joys and sorrows of parenthood? Is it a bittersweet expression of the nostalgic yearning for a youth which adults can no longer have except vicariously? As you will. The reader has prerogatives as well as the author. As for me, I find myself impelled to give responsive expression in the form of the following lines of verse, which I offer in gratitude to the author of the slim volume which gave me joy to read.

What happens when an analyst who is a child at heart
Is captured by an Irish Muse that pulls his life apart,
That sears his mind his eyes his ears to mischievously start
A flow of prose-like poetry to tip his applecart?

He twists, he turns, he shakes, he squirms, he tries with all his might
To shed the awful malady that's made his life a fright.
But try his best, he gets no rest. Beleaguered day and night,
He shrugs, he sighs, he shuts his eyes and gives in to his plight.

He calms down then, takes up his pen, or laptop if you will,
And opens up the floodgates that would keep in check the spill
Of feelings, thoughts, and images that pour out from the mill
That *has* to spin and spew and spawn before it can be still

On fur and feathers, toast and tea, on stars and flitting flames,
On birth and death and wonderment, on love and newborn names,
On spite and hate and enmity, on friends and children's games,
On thinking, dreams, and sundry themes that clamor for acclaim.

Oh Rensal, may you find your way, wee child of Mahon's art,
To people who are warm and wise, who, prejudice apart,
Won't meet you just with ears and eyes and brain, however smart,
But greet you as a kindred soul, and read you from the heart.

MARTIN A. SILVERMAN (MAPLEWOOD, NJ)

SCHREBER. FATHER AND SON. By Han Israëls. Madison, CT: International Universities Press, Inc., 1989. 376 pp.

This book is the translation of the author's 1980 doctoral thesis in sociology for the University of Amsterdam. It is a handsomely bound edition in which the inside flap quotes Janet Malcolm praising the work as "brilliant" and gives Peter Gay's approval as well. The author thanks Kurt Eissler, among others, in his Acknowledgments. This impressive and promising start is, unfortunately, not sustained in the body of the book. The text is filled with well-researched but essentially trivial facts about the Schrebers. The tone the author uses is at times startlingly similar to that of a sarcastic adolescent taunting a schoolmate with what he believes to be a devastating truth. The author contends that his carefully researched sociological focus has exposed analytic and psychiatric hypocrisy, sloppy methodology, and unfounded speculation. The sting of this criticism dissipates as the analyst-reader quickly becomes aware that Israëls is analytically uninformed. What is more disturbing is the possibility that the general public might receive this work as proof of the author's viewpoint that analytic thinking is silly, shallow, and unproven.

In explaining how he chose the topic for his thesis, Israëls notes how prominent the Schreber case has been in the psychiatric and psychoanalytic literature. He further notes that in Schreber's *Memoirs*, Freud "detected latent psychoanalytic insights," but that "the psychiatrist Morton Schatzman, too, found he could discern the true significance of Paul Schreber's book" (p. xiii) and that Schatzman used this to attack Freud's views. After reviewing the many authors who have felt that their differing viewpoints were con-

firmed in the Schreber case, Israëls quotes Niederland: "If there existed a biographical outline of Schreber's life before he fell ill at the height of an impressive professional career, it would be relatively easy to give an anamnestic account of the events which ultimately led to his hospitalization. . . ."[1] Israëls purports to present such a biography. But his aim is to expose Niederland's contention not only as false, but also as "entirely negative in regard to the theory" (p. xx). He refers to his own work as "pruning" unsupported theoretical positions by obtaining sociologically researched facts about the Schrebers' lives.

For example, in discussing Daniel Paul Schreber's childhood experiences with his mother, Israëls notes that "it ought not to be necessary for me to pay more than passing attention to the stupidity" (p. 96) of those (i.e., Niederland, Chasseguet-Smirgel, Kohut, and Shengold) who saw Frau Schreber as powerless and subordinated to her husband, Moritz, on the basis of the way he had treated a nanny: Moritz has been viewed as a tyrannical and intrusive father for dismissing a nanny for the sole "crime" of sharing a piece of her pear with the crying Daniel Paul rather than obeying Moritz's insistence that she teach his son "the art of renouncing" (p. 89). One cannot refrain from wondering about oedipal issues when a father keeps his son from enjoying forbidden fruit, the nanny's pear. Continuing in a dynamically obtuse manner, Israëls includes another episode in which Moritz crushes everyone's banana at the dinner table, causing his five-year-old son to cry.

To counter what he dismisses as stupidity on the part of other authors, Israëls emphasizes the social context: that German families had a strict, unequal hierarchy that could lead to such things as the maid's room having a ceiling so low that she could not stand upright. He also feels that Moritz's being strongly in favor of a mother's breast-feeding her child disproves the idea that he was destructive to the mother-child bond. Israëls accepts Moritz Schreber's statements as facts that refute the efforts of various analysts to reconstruct complex emotional issues, including unconscious impulses. This kind of misunderstanding constitutes the general basis

[1] Niederland, W. G. (1959): The "miracled-up" world of Schreber's childhood. *Psychoanal. Study Child*, 14:384-385.

for the author's criticisms. He focuses on various statements about analytic views of inner, psychic reality that are based on informed speculation and treats them as simple facts. He then shows how poorly researched some of these "facts" are, using his sociologist's measure, much as a debater or litigator tries to undermine an adversary's position by uncovering flaws in facts offered.

Some further examples will make this clearer. In one that is characteristic, Israëls (p. 103) goes to considerable length to show that Niederland referred to a "letter from [Schreber's sister] Anna," although he never saw the letter and had only a verbal report, which actually referred to a letter from another of Schreber's sisters. Another correction: Moritz Schreber did not found the Schreber Gardens; they were named in his honor. Feeling he is uncovering more sloppiness, Israëls incorrectly attributes to "the dogmatism of psychoanalysts and their 'solidarity' with Freud" (p. 296) the continuing respect for Freud's 1911 emphasis on the libidinal aspects of the son's relationship with his father, although Freud and others later expressed views emphasizing aggressive drive derivatives. He does not understand that both observations are valid.

Israëls has indeed uncovered some inaccuracies and even some sloppy work, but he offers little that adds significantly to our understanding. Issues of scientific methodology and the value of analytic work have been far better covered by numerous authors (Wallerstein, Spence, Edelson, etc.). The bio-psycho-social overview is often touted as presenting the most complete framework for clinical work. Schreber's case has been put to a great deal of psychological scrutiny. Israëls adds a sociological view that contributes little. His work is not aimed at an analytic audience but is designed to skewer analysis, for whatever reasons he has to do so.

ANDREW SCHIFFMAN (NEW YORK)

Addendum to the review of Erna Furman's book, HELPING YOUNG CHILDREN GROW: "I NEVER KNEW PARENTS DID SO MUCH." Madison, CT: International Universities Press, Inc., 1987. 427 pp.

In my review (see Vol. 59, 1990, pp. 315-317), I quoted from Mrs. Furman's book as follows:

> "Nudity is natural. I think children should see their parents in the nude from the start because then they will not think of it as sexual" (p. 325). "Are the aggressive urges really innate or are they a response to frustration?" (p. 281).

In the interest of clarity, let me emphasize that this quotation consisted of a statement and a question posed to Mrs. Furman by students, and certainly did not reflect Mrs. Furman's views. She indicated in her book that exposure of children to parental nudity, although a complex matter, can be detrimental and that aggressive urges are both innate and stirred by frustration, views with which psychoanalysts in general would agree.

ALLAN JONG (NEW YORK)

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

Psychoanalytic Inquiry. IX, 1989.

James R. Edgar

To cite this article: James R. Edgar (1991) Psychoanalytic Inquiry. IX, 1989., The Psychoanalytic Quarterly, 60:4, 702-715, DOI: 10.1080/21674086.1991.11927328

To link to this article: https://doi.org/10.1080/21674086.1991.11927328

Published online: 27 Nov 2017.

ABSTRACTS

Psychoanalytic Inquiry. IX, 1989.

Abstracted by James R. Edgar.

The Nature of Psychoanalytic Theory: Implications for Psychoanalytic Research. Marshall Edelson. Pp. 169-192.

The author discusses the common ground shared by psychoanalytic research and other types of scientific research. He describes in great detail just what kind of theory psychoanalysis is explicating: its domain, fundamental concepts, causal claims, and explanatory strategies. Given the nature of psychoanalytic theory, he proposes the case-study method as an especially felicitous research strategy, but points out that it is only one strategy among many, and that each strategy will have its advantages and disadvantages.

A Note on Psychoanalytic Facts. William W. Meissner. Pp. 193-219.

Meissner reviews some of the new theoretical options for psychoanalysis (linguistic discipline, form of historical knowledge, existential enterprise, etc.) prompted by challenges to the scientific status of the existing metapsychology. At present no one theoretical orientation is capable of encompassing all the observable data, but he suggests a return to a pre-theoretical assessment of the basic facts in an attempt at conceptual clarity. The psychoanalytic facts are (1) historical/genetic, (2) observational, (3) associative, and (4) introspective/empathic. Meissner argues that only the historical is verifiable; other psychoanalytic facts arise only within the analytic situation, and, as such, have little or no claim to objective verification. This must be taken into account when considering the theoretical status of psychoanalysis. However, he resists the argument that psychoanalysis belongs to the interpretive disciplines and, because of its use of observational data and the objectifying attitude, places it firmly in the domain of natural science.

"Either-Or": Some Comments on Professor Grünbaum's Critique of Psychoanalysis. Léon Wurmser. Pp. 220-248.

The author challenges each of Grünbaum's criticisms of psychoanalytic theory (contained in his 1984 book, *The Foundations of Psychoanalysis*) by tracing the development of such concepts as conflict causality, repression, therapeutic efficacy, and free association. In many cases he shows how Grünbaum's criticisms are actually straw men based on an overly restrictive interpretation of concepts that have multidetermined, complex meanings. For Wurmser, the central question concerns "scientific truth." Should "scientific truth" be approached dogmatically or pragmatically? He feels Grünbaum's approach, that scientific truth is knowable independently from our conditions of knowing, is dogmatic. According to Wurmser and many other philosophers of science, scientific truth is pragmatically knowable only in its usefulness as part of the methods of knowing. Wurmser rejects the logical positivism and neo-Baconian inductivism inherent in Grünbaum's critique as the only scientific method. Philosophically, he identifies three tests of truth: correspon-

dence theory, coherence or consistency theory, and pragmatic conceptions of truth. He proposes a new "complementary concept of truth" and suggests that psychoanalysis is a science *sui generis* evolving its own criteria for scientific truth.

A Reconstruction of Freud's Tally Argument: A Program for Psychoanalytic Research. Wilma Bucci. Pp. 249-281.

Bucci points out two inherent oppositions in psychoanalytic research: the nature of the data, i.e., subjective representations as opposed to mutually observable events; and the conflicting role of the analyst as scientist and clinician. These oppositions demand a new approach to scientific psychoanalytic research. She discusses Freud's "Tally Argument," Grünbaum's "Necessary Condition Thesis," and Kerz's "Coherence Theory," pointing out the inadequacies of each as research methods. Freud's theory of mental representation characterized by a type of verbal-dominance model is compared to a dual-code model in which experiences are registered in either verbal or nonverbal codes. The nonverbal domain is a perceptual-motoric-emotional (PME) schema. The verbal domain is the abstract code of language and logic. Using this model, the goal of psychoanalytic treatment is to change the structure of the PME schema through verbal codes using referential links. This model allows for a reconstruction of the "Tally Argument" and significant research possibilities in the area of measuring referential activity (RA) and identifying PME structures.

On Specifying the Scientific Methodology of Psychoanalysis. Henry M. Bachrach. Pp. 282-304.

The author defines scientific methodology as rational and empirical attributes that apply to the psychoanalytic situation. He next explains "the psychoanalytic situation" in some detail, both clinically and as a research method. Like all research methods, the psychoanalytic situation has its limitations. Bachrach distinguishes a "scientific attitude" from "scientific methods." Becoming obsessed with, or idealizing, "scientific methods" often makes impossible a "scientific attitude." He distinguishes psychoanalytic research from research about psychoanalysis. Findings from one type of research may not be useful to the other without first establishing a way to compare concepts and methods. However, this interface of research methods can be productive if one is careful to ask the right kinds of questions and not be overly reductionistic. A careful theoretical/methodological evaluation of each research paradigm is required so that one does not end up comparing apples with oranges.

Models, Theory, and Research Strategies: Toward the Evolution of New Paradigms. Robert Langs. Pp. 305-331.

Langs describes his particular approach to psychoanalysis and psychotherapy ("communicative approach"), traces the history of its and his development, and shows how he feels it is useful as a research paradigm.

The Developmental Perspective in Psychoanalysis. Prologue. Estelle Shane and Morton Shane. Pp. 333-340.

In this article, the editors introduce Issue No. 3 with a statement of their belief that psychological development is a lifelong process, distinctly contrasting that with

the view of adulthood as an endpoint of earlier developmental phases that culminate in adolescence. This view of development, of course, influences their ideas about analytic process. Those who feel that psychological development is lifelong emphasize the importance of the relationship with the analyst as a potential real new object. Those who do not, emphasize the interpretative function. A developmental perspective is not limited to one theoretical orientation but finds support from many areas, including child analysis, separation-individuation theory, self psychology, and object relations theory. The authors give examples in each area. This developmental perspective can influence the analyst's decisions about who can be analyzed. By recognizing the need for "new-object functions" in certain patients over and above the structural changes brought about by interpretation of transference relationships and responding to them, the authors feel they can make many seemingly unanalyzable patients more amenable to the analytic procedure.

The Sea Worms: A Case of Arrested Development. Mary Newsome. Pp. 340-363.

The author describes the analytic treatment and transference experiences of a woman in her late twenties. Her understanding of the material presented by the patient relies on concepts from developmental psychology, learning theory, and communications science. She feels the patient's primary difficulties started before she had the capacity to symbolize and, because of this, the use of empathy by the therapist is essential for "development of the capacity for intersubjective relatedness." Through this process she feels she is able to verbalize "unremember-able" experiences of the patient. A more traditional way to view the patient would be as an obsessional character with preoedipal fixations who felt she has achieved an oedipal triumph and then regressed from that position. However, interpretations based on this understanding did not lead to progress in the analysis. The author presents much clinical material to bolster her premise that the new way of understanding and approaching the patient was successful.

The Interplay of Therapeutic and Developmental Process in the Treatment of Children: An Application of Contemporary Object Relations Theory. Calvin F. Settlage. Pp. 375-396.

Settlage was stimulated to think about the interrelation of therapeutic and developmental processes by his work with several children who appeared to have made favorable change while resisting his attempts to establish a traditional therapeutic process. He postulates that this favorable change, which included the gradual ability to enter into a therapeutic relationship, was caused by a developmental process stimulated by the relationship with him. He reviews his ideas about the developmental process, psychic structures, and the history of the close relationship between therapeutic and developmental processes, pointing to many authors' contributions to the concept of psychoanalysis as a developmental process. Defining developmental process as "the function and structure forming mental process that is conceived to derive from the parent/child interaction," he points out that it is similar to the therapeutic situation with its different gradients of structural and functional capa-

bility between analyst and patient. He highlights the therapeutic alliance that first seemed tenuous with his patients and reviews preoedipal development, ego psychology, separation-individuation theory, object and self constancy, and the common defensive maneuvers of preoedipal pathology. He then presents clinical material from the first year of work with an eight-year-old boy, Roger, in whom he perceives significant interference in preoedipal development resulting in impairment in developing trust and adequate object and self constancy. This led to a heightened need to maintain control over his inner equilibrium and external world. His need to control the treatment situation is carefully explored in the clinical material and how it changed over time. Settlage summarizes the change in treatment in regard to (1) the play that was observed, (2) the change in the therapeutic relationship, (3) the accessibility to previously repressed fantasies and feelings, and (4) the identification with the analyst as a new developmental object. He points to Anna Freud's statement that the child can use the analyst for many purposes, not only as a transference object but also as a new person, a new love object, a new object for identification. Settlage believes that this use of the analyst as an object for identification lends support to the concept of a developmental process within the therapeutic relationship.

On Boundaries and Externalization: Clinical-Developmental Perspectives. Gil G. Noam and Robert G. Kegan. Pp. 397-426.

Although psychoanalytic psychology and Piagetian psychology share a developmental point of view, they have had relatively little impact on each other. One school, called "clinical-developmental psychology," has brought Piaget's theories closer to clinical theory and psychotherapy. The authors take two concepts important to psychoanalysis—"psychological boundaries" and "externalization"—and reinterpret them in a "clinical-developmental" framework around three cases, in hope of furthering the dialogue between psychoanalysis and Piagetian psychology. The relative scarcity of attempts to integrate these theories is due to Piaget's and his early followers' heavy emphasis on cognitive factors. The more recent social-cognitive theorists building on Piaget's theory are more interested in moral development and other clinical phenomena that may make dialogue possible. The authors sketch some of the recent developments in social-cognitive theory, identify some of the leading theorists, and introduce us to their own developmental stages. They next return to the concepts of boundaries and externalization and the related concept of projective identification, pointing out the clinical importance of and yet the lack of clarity about their meaning and exact mechanisms. These concepts seem to them to represent the intersection of ego psychology and object relations theory. They believe that psychoanalysis currently treats boundary phenomena as an exclusively early development issue, and self-object phenomena as only a quantitative, and not also qualitative, issue. A "clinical-developmental" point of view provides a "life span developmental" perspective that considers not only early life experiences, but also an ongoing self-other experience. Noam and Kegan present three case vignettes to help clarify their points. They suggest that concentrating on boundaries and externalization might lead to more fruitful dialogue between psychoanalysis and Piagetian psychology.

The Struggle for Otherhood: Implications for Development in Adulthood. Morton Shane and Estelle Shane. Pp. 466-481.

This paper discusses mature altruism ("otherhood") that is not primarily defensive but occurs for the expansion of another sense of self. The authors connect this kind of mature altruism to adult development as first conceptualized by Erikson (his stage of generativity). They trace the notion of psychological development as a lifelong process from Erikson to Benedek's ideas of parenthood as a developmental process, Loewald's adult analysis, including a developmental thrust apart from insight and conflict resolution, and Kohut's self-enhancement through the resumption of normal development in the narcissistic sphere. The authors delineate the range of mature altruistic ("otherhood") experiences in adult life in which another's emotional needs have priority over one's own. These include relationships in which the two participants exist on different emotional gradients, e.g., teacher-pupil, parent-child, and others in which there is less of a difference in the emotional gradient, such as husband-wife. "Full adult empathy," the capacity to comprehend and respond to one's objects in their own right, is required. The Shanes also believe that this type of response is a basic need throughout life, not just in infancy. They briefly outline Stern's concepts and use them to identify three "otherhood" functions. Even in mature altruism, one is at the same time either consciously or unconsciously satisfying one's own needs. They turn to three clinical cases to clarify these theoretical points. Their focus is not directly on the transference, however, but on the patients' reports of their interactions with significant persons outside the transference. One case is reported in detail and over a long period of time, so that the development of the capacity for "otherhood" can be seen. The authors separate out what they believe to be the effects of the analysis, the patient's marriage, and his fatherhood on the development of this "otherhood."

Bulletin of the Menninger Clinic. LIII, 1989.

Abstracted by Sheila Hafter Gray.

Between Patient and Doctor: Improving the Quality of Care for Serious Mental Illness. Ira D. Glick, et al. Pp. 193-202.

Recent discoveries in neurobiology have vastly expanded psychiatric knowledge, but there has been a significant lag in the application of these new findings to patient care. Programs of postgraduate education often do not integrate this new scientific information or the attitudes that support it; they seem to favor ideology and theory, psychological or biological. This is reflected in clinical practice as professional advocacy for a particular treatment model, uncritical reliance on expertise, and preference for tradition that limits treatment options for the patient. The dominant obstacle to effective psychiatric treatment may be the mode of financing medical care. Inpatient-based treatment and technical procedures have taken precedence over outpatient and cognitive services, to the detriment of seriously mentally ill patients who require long-term out-patient care. Familial, political, and social forces also tend to subordinate the needs of the patient to those of others. The authors outline strategies to provide excellent and cost-effective psychiatric care for all patients.

The Impact of Litigation and Court Decisions on Clinical Practice. W. Walter Menninger. Pp. 203-214.

Menninger reviews current literature and court decisions on psychiatric malpractice under five headings: patients' acts of violence; patients' suicide; physical and emotional injuries to a patient that arise out of negligent diagnosis or treatment; faulty initiation, conduct, or termination of treatment; and liability arising for employer, supervisor, or consultant. Recent legal cases have addressed failure to consider the full spectrum of etiology and treatment, biological and psychodynamic, of a psychiatric disorder. Psychiatrists of all orientations are susceptible to this charge and to an associated claim of failing to educate themselves about new findings in the specialty. Sexual intimacy between patient and psychotherapist is viewed as malpractice. Increasingly, courts acknowledge and compensate for emotional injury that results from it. The Menninger Staff-Patient Relationship Study Group has identified characteristics of patients and therapists who are likely to become involved in such encounters. The author offers specific advice for preventing or mitigating malpractice in each category and for coping with lawsuits.

Long-Term Treatment of Chronically Suicidal Patients. Robert E. Litman. Pp. 215-228.

The author reports on his thirty years' experience in dealing with threatened and consummated suicide at the Suicide Prevention Center in Los Angeles. He found that rapid intervention at the pre-suicidal stage frequently results in natural recovery in relatively well-adjusted persons who are in true psychological crisis. However, follow-up studies of patrons of the author's crisis intervention telephone service revealed that this approach often fails to avert the death of chronically mentally ill, suicidal persons. The central element of the care of the latter group is a long-term, stable doctor-patient relationship that actively confronts the patient's mental disorder. An extended treatment team that includes the patient's relatives is useful to support both doctor and patient in this undertaking. Extensive, detailed clinical records are necessary to provide the base for periodic clinical review of the patient's condition. The contemporary trend toward less frequent and briefer hospitalization seems not to have influenced the suicide rate at all. Litman offers specific advice for dealing with suicidal tendencies in patients who suffer from chronic depression, drug and alcohol abuse, schizophrenia, and personality disorders.

Evolving Concepts of Borderline Personality Disorders. Martin Leichtman. Pp. 229-249.

The term "borderline" was initially used in the late nineteenth century to describe a class of severe mental conditions that were similar to but less malignant than the psychoses. With the development of ego psychology, the notion of analyzable disorders of secondary-process ego functions gained prominence. The British psychoanalysts viewed these conditions as disorders of object relations. Later, these views were incorporated into the current psychoanalytic concept of borderline personality organization that refers not to a specific syndrome but to an adaptive or defensive stance that originates in very early trauma. The authors of DSM-III and DSM-III-R

offer descriptive-phenomenological definitions of a group of borderline conditions that blend psychoanalytic and biological-genetic findings. Leichtman points out that the absence of diagnostic criteria for disturbances of thinking may attenuate their usefulness for psychoanalysts. Future research will be oriented toward separating these broad syndromes into specific components, each with its own etiology and treatment. The comprehensive bibliography includes contributions from both dynamic and biological psychiatry.

An Update on Sleep Disorders. Rocco L. Manfredi; Alexandros Vgontzas; Anthony Kales. Pp. 250-273.

The authors present detailed scientific information on normal and disordered sleep. They offer a set of biopsychosocial protocols that an office-based psychiatrist may use to diagnose and treat most sleep disorders. These include insomnia, sleepwalking, night terrors, and nightmares. The basic assessment of sleep apnea and narcolepsy can also be performed by the psychiatrist, but special observation in a sleep laboratory will be necessary to confirm the diagnosis. There is a comprehensive bibliography.

Posttraumatic Stress Disorder. A Historical Perspective on Diagnosis and Treatment. Mary Jo Peebles. Pp. 274-286.

The term post-traumatic stress disorder was created in 1980 for DSM-III. It became popular because it validated the chronic anguish of Vietnam veterans and victims of rape, abuse, and natural disasters. The role of psychological trauma in the etiology of mental disorders was proposed by Breuer and Freud and explicated by succeeding psychoanalysts who studied battlefield casualties in World Wars I and II. Current theories of trauma use information-processing models of the mind to understand how people perceive, process, and integrate overwhelming external stimuli. Normal individuals will respond to trauma with compulsive repetition alternating with denial of or withdrawal from the memory, and they recover spontaneously. Ego psychology and self psychology have added to our understanding of the internal world of trauma victims who develop complicated, pathological stress responses. These require long-term treatment that focuses on repair of damaged ego structures. Most recently, investigators are studying the contribution of biological and social factors to this disorder. The author presents treatment strategies based on various theoretical models. She advocates a biopsychosocial approach.

Becoming a Constant Object for the Borderline Patient. Charles P. Cohen and Vance R. Sherwood. Pp. 287-299.

The authors note that individuals with borderline personality disorders experience time in distorted ways. Being unable to envision a future, they tend to perceive themselves frozen in the present. This accounts for the urgency and impatience they express in psychotherapy. Effective treatment of borderline conditions is based less on classical interpretations or strategic interventions than on the therapist's simply being there long enough to become a constant object that the patient may experience over time. Patients' initial response to this stance is anger at the frustration of

their efforts to involve the therapist in their problems. They will construe the therapist's detached attitude as abandonment, since need gratification is, for them, the sole basis for emotional attachment. The therapist's calm attitude in the face of intense affect and disappointment serves eventually as a model that the patient will internalize and emulate.

Countertransference Dilemmas with Borderline Patients: The Contribution of Psychological Testing. Fred Shectman. Pp. 310-318.

Borderline patients, by definition, tend to evoke intense and often unpleasant countertransference attitudes in the psychotherapist. The latter may respond with an attitude or behavior that is deleterious to the treatment. The author demonstrates the use of psychological testing to ascertain these pitfalls. One patient, for example, exhibited a stubbornly uncooperative stance in therapy. His test responses showed that he experienced the psychiatrist as a deceptive, intrusive, and dominant figure who, he feared, would rob him of his special secret. His negative, seemingly unproductive attitude was a way of protecting an amorphous, undifferentiated self. Armed with this information, the clinician could focus on the patients' adaptive use of secrets to maintain autonomy in the therapeutic situation. Two additional case illustrations are given.

The Provocative Masochistic Patient: An Intersubjective Approach to Treatment. Sanford Shapiro. Pp. 319-330.

Masochistic patients characteristically provoke their analysts to engage in sadomasochistic interactions with them. This behavior is foreign to the analyst's self-perception. The classical ideal of work with masochistic patients is to comport oneself in a way that avoids such temptations. The clinician frequently accomplishes this by viewing these as an expression of the patient's aggression. Interpreting the provocations as a manifestation of the patient's neurotic hostility often leads the patient to feel censured and defective. It impairs the patient's fragile self-esteem. Eventually, the treatment alliance breaks down. Understanding the provocation as a transference repetition of an early traumatic experience which the patient must master to complete an essential developmental task suggests alternative interpretations which the patient may apply to continue the process of emotional growth. There is a case report that illustrates clearly the difference between the two approaches.

Preventing Staff-Patient Sexual Relationships. Stuart C. Averill, et al. Pp. 384-393.

A study group reviewed all known cases of staff-patient sexual relationships that had occurred at the Menninger Clinic in a ten-year period. It was found that the patients characteristically were treatment-resistant individuals with serious personality disorders who had a propensity to seek out affect-intensifying experiences. They were, for the most part, involved in lengthy intensive treatments. The male patients were primarily desperate and dependent people. Some staff members were young men and women for whom exploitation was a way of life. Another group consisted of isolated middle-aged individuals whose disappointment and despair seemed to resonate with their patients' feelings; they often entertained fantasies of

a love cure. The authors report that education and support prove to be essential elements in preventing this behavior. Staff members' vulnerability must be addressed in an open and accepting fashion. Techniques for managing seductive transferences can be developed and taught. We can now identify early those patients who are at risk, and offer special support and encouragement to their therapists.

The Threshold of the Male Oedipus Complex. Thomas H. Ogden. Pp. 394-413.

The author proposes that the boy who enters the oedipal phase has the dual task of distancing himself from the overwhelming preoedipal mother while he takes the oedipal mother as the object of his strivings. While the little girl takes a new object that is uncontaminated by preoedipal experiences or fantasies, the boy initially regards oedipal gratification in terms of the simultaneously blissful and terrifying loss of ego boundaries that characterizes the earlier developmental phases. Primal scene fantasies help the boy mediate between the two internal views of mother. Initially, the child perceives himself as an actor in a primal scene that is a frightening battle among sexual and aggressive part-objects. Then, through a series of transitional fantasies and complicated identifications with his mother's internal objects, the little boy discovers his own position as a phallic third party in the family setting. In the differentiated primal scene fantasies that follow, the boy casts himself as an outside observer. This creates sufficient distance from incestuous wishes so that the boy may identify with the phallic individual, the father. He can then take the mother, and, by extension, another woman, as the objects of his phase-appropriate desires.

Unrequited Love and the Wish to Kill: Diagnosis and Treatment of Borderline Erotomania. J. Reid Meloy. Pp. 477-492.

Delusional erotomania is characterized by a belief that the beloved returns the subject's love. Meloy suggests we use the term borderline erotomania to refer to cases in which the patient knows the love is not reciprocated, but in which there is a significant discrepancy between the behavior of the loved one and the intensity of the erotomanic individual's own attachment to the love object. His forensic clinical experience indicates that these individuals suffer from a DSM-III-R personality disorder in the Cluster B range. Defensive splitting allows them to maintain contradictory perceptions and affects. Thus, they idealize and devalue, love and hate simultaneously. When this is coupled with marginal reality testing they may commit violence on or in relation to the beloved. Extensive, sophisticated clinical evaluation is necessary to discriminate between the delusional and borderline erotomanias, and to discover the paranoid or psychopathic traits that tend to be associated with violence, since many patients readily conceal their beliefs while they continue to harbor them. There are outlines of the clinical and forensic management of delusional and borderline erotomanic conditions and a comprehensive bibliography.

Two Subtypes of Narcissistic Personality Disorder. Glen O. Gabbard. Pp. 527-532.

The psychoanalytic literature describes a range of narcissistic personality disorders, while the DSM-III-R diagnostic criteria for narcissistic personality disorder

help clinicians distinguish only the arrogant, boastful, demanding narcissistic patient. In this brief communication, Gabbard delineates two subtypes which stand at the poles of the continuum on which most cases of narcissistic personality disorder will fall. The Oblivious Narcissist has no awareness of the reactions of others, is arrogant and aggressive, is self-absorbed, needs to be the center of attention, has a "sender" but no "receiver," and is apparently impervious to the hurt feelings of others. The Hypervigilant Narcissist is highly sensitive to the reactions of others, is inhibited, shy, or self-effacing, directs attention toward others rather than toward self, avoids being the center of attention, listens carefully to others for evidence of slights or criticism, has easily hurt feelings and is prone to feeling ashamed or humiliated. The article includes some clinical vignettes and a discussion of the implication of this approach for psychotherapy.

Journal of the American Academy of Psychoanalysis. XVIII, 1990.

Abstracted by Lee Grossman.

Erotism and Chaos. P. L. Giovacchini. Pp. 5-17.

Giovacchini contends that sensation in the prementational ego is at first the undifferentiated manifestation of homeostatic balance and imbalance; only later will it differentiate into erotic feelings. Affects, erotic feelings in particular, have an organizing function that binds a primitive inner agitation that is characteristic of the prementational stage which precedes psychological processes. Patients with "characterological defects" use sexuality to attempt to calm an "inner chaos that stems from an amorphous, inchoate psychic state." In some instances, these patients are able to get their therapists to "absorb their inner chaos" and act out sexually with them.

The Assets of the Mentally Handicapped: The Interplay of Mental Illness and Creativity. F. Fromm-Reichmann. Edited and introduced by A.-L. S. Silver. Pp. 47-72.

Silver provides an edited and condensed transcript of some lectures given by Frieda Fromm-Reichmann at the Washington School of Psychiatry in 1950. Childhood experiences are kept from awareness for any of several reasons, including attempts to glorify the past to compensate for present suffering; to avoid blaming the parents; and to obscure the compensatory mistreatment of one's own children. Childhood amnesia also stems from "the fact that one can only remember events in the modality in which they first appeared," an idea she attributes to Kurt Goldstein. In psychotherapy, the "schematization and conventionalization" that characterizes adult experience is made partly unbearable, which makes it possible to recover memories of some childhood events, which may be the source not only of the patient's illness, but also of certain creative powers developed to evade anxiety. Fromm-Reichmann gives examples from self-reports of mental illness by Clifford Beers, Anton Boison, and an anonymous nineteenth century autobiography entitled *The Philosophy of Insanity*. She distinguishes, in nontechnical terms, the experience of dealing with manic-depressive and schizophrenic people. The former do not expe-

rience real closeness with others; whereas the latter have great introspective gifts, as a consequence of dealing with an overly interested adult in childhood. It is this special sensitivity that motivates the emotional withdrawal of the schizophrenic. She illustrates with clinical vignettes and literary descriptions of and by schizophrenics. She presents the poems of a schizophrenic woman, whose poetry came from "the same source that originated her illness," i.e., the same sensitivity. The poems stem from her symptomatic loneliness. She then considers the alternative of sublimation, which she defines as combining mentally disturbed tendencies with socially acceptable behaviors, in the lives of Robert Schumann and Nijinsky. Schumann expressed himself in music instead of in interpersonal experience; in a long biographical sketch, Fromm-Reichmann describes how aspects of his schizoid difficulties became the basis of several innovations in his music, until he became frankly psychotic. Nijinsky's schizophrenia rendered him inarticulate to the point of muteness, yet his illness provided him with the capacity to express himself in bodily movement. It is possible that artistic expression also helps keep some people from becoming psychotic. She closes with a story about a man who had no "creative outlet" and became schizophrenic.

Parent-Child Effects on Performance, Thinking, and Communication in Families of Normal and Schizophrenic Sons. D. C. Fort. Pp. 73-98.

The author reports a study to test the hypothesis that parents and children mutually influence one another, and that a deficit in schizophrenic communication contributes to the development of the disorder by adversely affecting the parents. Twelve families with a schizophrenic son, and twelve normal families, were studied. Each participant was asked to interpret a proverb. Then tapes of the interpretations were played, and each participant was asked to match the recorded interpretation to a proverb. Sons listened to tapes made by their own parents, by parents of a schizophrenic, and by parents of a normal boy. Parents listened to tapes made by their own son, by a schizophrenic boy, and by a normal boy. All subjects did worse on the matching task after listening to tapes made by schizophrenics. Fort concludes that the reciprocal hypothesis is supported in these tasks. But children, whether normal or schizophrenic, showed no increase in "attentional distractors" in their speech after listening to schizophrenic tapes over normal tapes. Parents, whether of normal or of schizophrenic children, showed more attentional distractors in their speech after listening to tapes of schizophrenics. On this measure, the results are not reciprocal. The author feels that this means that the theory that deviant parental communication plays a major role in the etiology of schizophrenia is not supported. She suggests that a complex bidirectional set of influences between the child and parents, unfolding over time, is a more accurate picture.

The European Teachers of Dr. Frieda Fromm-Reichmann. B. D. Petratos. Pp. 152-166.

Petratos traces the influences of Kurt Goldstein, Johannes Schultz, and especially Georg Groddeck, on Fromm-Reichmann's work, prior to her exposure to Sullivan. She assisted or collaborated with each in turn. Goldstein, a neurologist who was to become a psychiatrist, considered brain injuries from a holistic perspective, empha-

sizing the organismic attempt to adapt to injury. He saw symptoms, including schizophrenic symptoms, as "answers" to environmental demands by a modified organism. Schultz, who pioneered autogenic (i.e., biofeedback) training, was one of the first psychiatrists to suggest that psychosis could be treated by psychotherapy. Fromm-Reichmann recalled that she was not satisfied with his "simplistic use of dream analysis," and shortly thereafter sought analytic training. During her training she met Groddeck, whom she ranked with Freud, Goldstein, and Sullivan as her teachers. Groddeck taught that the understanding of unconscious processes was central to the treatment of all diseases; he did not believe in a distinction between organic and mental disease. Groddeck's theme of disease as a form of symbolic self-expression pervades Fromm-Reichmann's work. Her dedication to learning from her clinical experience, without preconception, came from Groddeck's example; as did her avoidance of jargon. She was influenced by his conviction of the universality of bisexuality, and the envy each sex has of the other. Groddeck was among the first to emphasize the importance of the early relationship with the mother, which became a cornerstone of Fromm-Reichmann's thinking about schizophrenia.

Preoedipal Factors in "Little Hans." D. I. Joseph. Pp. 206-222.

Joseph offers a look at Little Hans from a developmental perspective. He emphasizes the role of frequent enemas, of exposure to bedroom scenes and to the birth of a sibling, and of the mother's threats and seductiveness, in interfering with normal separation-individuation processes. He suggests that the phobic object, besides representing the oedipal rival, also stands for the "castrating preoedipal mother." In the treatment, Hans was able to see his father as an ally to help him through preoedipal difficulties.

The Evolutionary Functions of Repression and the Ego Defenses. R. M. Nesse. Pp. 260-285.

Nesse addresses the problem of integrating psychoanalytic thinking with recent advances in evolutionary biological theory. Because of the expenditure of energy necessary to maintain repression, he finds it "implausible that repression exists merely to control impulses or to simplify mental life." He elaborates on the theses of the biologists, Trivers and Alexander, that by concealing motives from the self, repression makes it easier to conceal motives from others, which confers an adaptive advantage. He contends that deception often serves to maintain secure relationships, and that defenses can be understood as specialized methods of deceiving others. He describes how each of several specific defenses may contribute to the ultimate goal of deceiving others in order to establish and maintain sexual relationships, and therefore confer genetic selective advantage.

Free Association and Changing Models of Mind. L. Aron. Pp. 439-459.

Aron observes that the trend away from an exclusively intrapsychic model of mental life, and toward a more relational model, has been accompanied by a neglect of the method of free association. Relational models of the mind see both patient and analyst as the source of transference, and associations as responsive to the situation. This is in contrast to the traditional intrapsychic model, in which trans-

ference is central only insofar as it helps the analyst to interpret resistances to free association, to move from manifest to latent content. The traditional model, as exemplified by Arlow, uses the method of free association as a "rubric under which to hide the extent to which the analyst affects every aspect of the patient's associations." Gill, on the other hand, abandons the emphasis on free association in favor of an interactive model that assumes that interpreting the hidden references to the analyst always takes priority. Many interactionists wrongly reject the free association method because they see it as based on the mistaken idea that the analyst is not a participant—which they (and Aron) attribute to drive theory. Aron's position is that the method is not bound to drive theory. In his view, there is no "mind" that can be studied in isolation, but the method of free association is useful as a way to study "mind" in a specific interpersonal context. Attention to the patient's associations provides information that may be pre-empted by the imposition of the analyst's theories, e.g., that his or her subjective experience is an accurate representation of the patient's experience.

The Concept of Dissociation. R. M. Counts. Pp. 460-479.

Counts reviews the history of the concept of dissociation and its relationship to repression. He then redefines it as the ubiquitous mechanism by which mental structures or contents are disconnected from one another. Anxiety is the usual motive to split off an impulse, a memory, an affect, or a part of oneself. Repression, splitting, intellectualization, and other defense mechanisms rely upon dissociation.

Exploring an Object Relations Perspective on Borderline Conditions. S. Tuttman. Pp. 539-553.

Tuttman surveys the history of the "borderline" concept in A. Stern, H. Deutsch, Knight, Stone, Frosch, Kernberg, Mahler, Masterson, Rinsley, Abend et al., and Kohut. He feels that their findings all support the point that treatment requires that the analyst be able to accept and contain intensely loving and hating projections. He divides analytic approaches into two categories: a neutral, interpretive position, exemplified by Kernberg, and a nurturing, reconstructive experience, such as Kohut's. The former is necessary, but by itself it can be experienced by the patient as an accusation, and lead to hostile stalemates, which the latter is needed to undo. Tuttman believes that an object relations perspective provides an emphasis on both the intrapsychic, structure-forming aspect of objects and the world of human subjectivity. The analytic process involves both a real interpersonal relationship and a transferential, fantasy relationship based on past experiences.

Thoughts about the Origins of Femininity. M. Kirkpatrick. Pp. 554-565.

Kirkpatrick presents her thoughts about three areas of female experience: core gender identity and the inner genital; maternal instincts; and the sexual life of women. She suggests that the emphasis on biological counterparts to passive, receptive, creative femininity, is based on trying to adapt female development to a male preconception about women. Gender identity is much more psychological and less biological than we had thought. It originates with the parental assignment of sex, which influences the perception of the female genital as much as the other way

around. Maternal desire, like core gender identity, is also learned in the early mother-baby dyad, rather than being innate. The wish for a baby does not depend on the conversion of penis envy through a heterosexual oedipal resolution. Parental assignment also begins the training for gender roles. The inhibition of aggression is as important in defining the feminine sexual role as anatomy. Object relations and early ego development profoundly influence sexual drive organization in girls. Women's sexuality is more flexible than men's in aim, object, and capacity for sublimation; male sexuality is more driven and more subject to serious disturbance of gender identity. The higher frequency of perversions in men may have to do with the difference in the meaning of orgasm between men and women. For men, it is required for mental balance. This dependence on orgasm is rare among women.

Emotional Induction: Communication via the Countertransference. A. Lotterman. Pp. 587-612.

Lotterman selectively reviews the literature about the utility of countertransference, in order to examine the means by which the patient stimulates emotions in the therapist which correspond to those of the patient. This phenomenon, which he calls "emotional induction," occurs with patients who have difficulty conceptualizing their experience. With a series of dramatic examples, Lotterman shows how these patients evoke reactions in the therapist that mirror their own experience. He conceives of them as unconsciously arranging things, as a way of communicating, using means that are analogous to the evocative techniques of the theatre. He recommends that the therapist identify and disclose the relevant emotions induced in himself or herself, as a way to make contact with otherwise inaccessible patients. By deciphering nonverbal messages, the defensive erasing of the patient's inner life may be transformed. This is accomplished by the therapist's demonstrating that intense feelings can be named and tolerated, without requiring action or causing catastrophe.

The Impact of the Psychoanalyst's Serious Illness on Psychoanalytic Work. J. H. Gurtman. Pp. 613-625.

Gurtman argues that the analyst who withholds information in the name of neutrality when serious illness threatens the treatment may be behaving inhumanely, out of his or her own countertransference and denial of illness. It may be helpful to validate the patient's perceptions; and, in the absence of opportunity to analyze transference fantasies, it may be sadistic not to disabuse the patient of them. Using her own analysis as an example, Gurtman contends that her analyst's informing her of his impending surgery provided her with an opportunity to cope with the various ramifications of serious illness in her family history. She also describes something of the impact of the disappointment in realizing her analyst's human limitations before she would otherwise have done so, and the subsequent difficulty in resuming her analytic work, especially at termination. Her disclosure to a patient of a friend's illness coincided with her own termination difficulties. She considers briefly her patient's caretaking response to her countertransferential needs, and her own similar reactions to her analyst on his return.

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

Meeting of the Psychoanalytic Institute of New England, East

Robert Figman

To cite this article: Robert Figman (1991) Meeting of the Psychoanalytic Institute of New England, East, The Psychoanalytic Quarterly, 60:4, 716-718, DOI: 10.1080/21674086.1991.11927329

To link to this article: https://doi.org/10.1080/21674086.1991.11927329

Published online: 27 Nov 2017.

NOTES

MEETING OF THE PSYCHOANALYTIC INSTITUTE OF NEW ENGLAND, EAST

December 4, 1989. A RECONSIDERATION OF THE CONCEPT OF TRANSFERENCE NEUROSIS. Gail S. Reed, Ph.D.

Dr. Reed reviewed the literature on transference neurosis, which contains a wide range of definitions of and attitudes toward the concept. She then discussed the results of her interviews with twenty-two psychoanalysts from the American Psychoanalytic Association. The interviews had been conducted to investigate the meanings that the term, transference neurosis, had for the analysts. In view of the value of oral transmission in psychoanalysis, Dr. Reed paid close attention to the exact transcriptions of her interviews with the twenty-two analysts. The respondents frequently referred to the "classical description" and compared or contrasted the data from their cases to this definition. Two major areas of differences among the respondents were noted. The first was in their varying definitions of transference and transference neurosis; the other was in the different degrees of importance attributed to the patient's conscious involvement with the analyst. Various connotations of the term, transference neurosis, were identified, and Dr. Reed presented material from the interviews "to illustrate . . . the breadth of phenomena associated with the term and some of my respondents' clinical emphasis."

Dr. Reed gave her own current working definition of the term: "I prefer to think of the transference neurosis in terms of the patient's unconscious cathexis of the object representation of the analyst in such a way that the relationship with the analyst suffuses and informs the patient's current experience." The relationship permeates whatever the patient is manifestly talking about as well as the form in which he or she talks about it. In her discussion, Dr. Reed elaborated on the phenomenon of "form." In addition, she stated: "I propose a process definition in which the term transference neurosis is reserved for the . . . unfolding and understanding of *increasingly specific* transferences and their related unconscious fantasy/memory complexes through the psychoanalytic process. *Specific transferences* constitute new compromise formations involving the analyst as object entwined with pre-existing object representations from childhood and adolescence, including those that comprise the nuclear infantile neurosis."

Dr. Reed then described "characterological transferences" as separate from the transference neurosis, in that they are "habitual" and not a product of the analytic experience. Her definition is consistent with Freud's description of the transference neurosis as a new symptom (compromise formation) and an enactment of the infantile neurosis, with its emphasis on infantile sexuality, specifically the oedipus complex. She added that the infantile neurosis and subsequent transference neurosis arising in the analysis need to be understood in light of and as defined by the

influencing psychological matters (i.e., traumas, memories, fantasies) of the preoedipal, latency, and adolescent phases of life. "We need to revise the concept of the infantile neurosis to include these important precursors to and later editions of the oedipus complex. Thus, what precedes the infantile neurosis must be seen as influencing its oedipal structuralization and what follows must be seen as conceivably modifying its first resolution. All these variations may appear as aspects of the transference neurosis." Dr. Reed considers the interpretation of this material essential to analytic technique.

Because the transference neurosis is unavailable for "objective" observation, it is defined through each analyst's experience. Therefore, the influence of the analyst's unconscious must be taken into account. Speaking about the "imperfect oral tradition" of psychoanalysis, Dr. Reed asked who had influenced the analysts in the development of their attitudes about transference neurosis. She noted a difference between what was talked about in her interviews and what has been written about the concept, and she commented on the importance of authority and transference among analysts in the development of the science of psychoanalysis.

DISCUSSION: Dr. Howard Levine spoke of the importance of the training analysis and continuing self-analysis in regard to the analyst's attitudes about transference neurosis. Dr. Alexandra Rolde noted the relative absence of countertransference descriptions in Dr. Reed's clinical examples. Dr. Arthur Valenstein said that in an attempt to insure that psychoanalysis would be seen as a science, technical papers since Freud had created a "neoclassical obsessive adherence to rules, a sense of abstemiousness which could be equated with surgical asepsis." Dr. Reed said that during training, a classically defined transference neurosis had too often become a "touchstone, a standard," the presence or absence of which in a control analysis was seen as an indicator of the candidate's ability. "It is important," she continued, "to free ourselves from a narrow definition of it, particularly from the idea that it develops without the analyst's influence." Dr. Valenstein agreed that if viewed within a one-person psychology, transference neurosis would be defined in a constricted way. He emphasized the importance of the unique genetic component in its elaboration by each patient. Dr. Ana-Maria Rizzuto described two levels of psychic functioning that are involved in its development: the unconscious representation and cathexis; and the enactment process that takes place in action, reaction, or the absence of action. She asked how these two levels can be integrated in our efforts to understand the evolution of the meaning of transference neurosis. Dr. Reed replied that it has become a convention to speak of it only from the patient's point of view. Dr. Levine said that we sometimes comfort ourselves by thinking we can be neutral and that the patient is a constant. Dr. Gary Goldsmith noted that aspects of the transference neurosis were sometimes only subjectively felt through the analyst's perception of gesture and tone. Dr. Sheldon Roth commented on the importance of countertransference in both the development of the transference neurosis and the analyst's capacity to use it for analytic purposes. Dr. Reed said that the analyst's personal history, his or her own previous transference neurosis, and those of his/her other patients were all relevant to the analyst's understanding of the term and its use in the conduct of an analysis. Dr. Axel Hoffer, noting the dramatic nature of the

cases presented by Dr. Reed, spoke of the complex phenomena involved in the analyst's remembering and reporting.

ROBERT FIGMAN

A seminar titled CONTINUUM OF CARE FOR CHRONIC PSYCHIATRIC PATIENTS will be held April 28-May 2, 1992, at the Caribe Hilton and Casino, San Juan, Puerto Rico. The seminar will be sponsored by the Departments of Psychiatry and of Social Work Services of Hillside Hospital, by the Long Island Campus of the Albert Einstein College of Medicine, and by the University of Puerto Rico. For further information, contact: Ann J. Boehme, CMP, Associate Director for Continuing Education, Long Island Jewish Medical Center, New Hyde Park, N.Y. 11042.

The 50th Anniversary Meeting of the AMERICAN PSYCHOSOMATIC SOCIETY will be held March 31-April 4, 1992, at the Sheraton Centre Hotel and Towers, New York, N.Y. For further information, contact: Carol Ann Kiner, Associate Director, American Psychosomatic Society, 6728 Old McLean Village Drive, McLean, VA 22101.

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

Name Index

To cite this article: (1991) Name Index, The Psychoanalytic Quarterly, 60:4, 719-724, DOI: 10.1080/21674086.1991.11927330

To link to this article: https://doi.org/10.1080/21674086.1991.11927330

Published online: 27 Nov 2017.

NAME INDEX

KEY: (N) Note of paper presented at scientific meeting
(R) Book review

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

Subject Index

To cite this article: (1991) Subject Index, The Psychoanalytic Quarterly, 60:4, 725-735, DOI: 10.1080/21674086.1991.11927331

To link to this article: https://doi.org/10.1080/21674086.1991.11927331

Published online: 27 Nov 2017.

SUBJECT INDEX

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