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THE INFLUENCE OF SPHINCTER CONTROL AND GENITAL SENSATION ON BODY IMAGE AND GENDER IDENTITY IN WOMEN

BY ARLENE KRAMER RICHARDS, ED. D.

The development of one aspect of feeling female is hypothesized to account for certain phenomena in the treatment of young women patients. Fear of loss of genital pleasure experienced as contractions of the anal and genital-urinary sphincters is seen as the central issue in conflicts manifested in genital, oral, and anal modalities. It is suggested that the female's awareness of her genital arises from the generalization of sphincter sensation in the little girl, which is then represented in the body image. The body image is postulated as a link between genital pleasure and the valuing of femininity.

Everyone in me is a bird.
I am beating all my wings.
They wanted to cut you out
but they will not.
They said you were immeasurably empty
but you are not.
They said you were sick unto dying
but they were wrong.
You are singing like a school girl.
You are not torn.

From "In Celebration of My Uterus"
ANNE SEXTON (1981)

We know what we mean when we say that men are afraid of castration. And many psychoanalysts believe they know that when women are afraid of castration, they are afraid of losing a

fantasied penis or they are afraid of their masochistic wishes in reaction to their wish to castrate a man. True or not, this seems to me not to be the whole story, or even the primary part of it. In this paper I am going to present some evidence for the idea that women believe they have an internal (and an external) sexual organ which is a source of pleasure and which they fear losing. Anne Sexton's poem says so. Some women I have analyzed think so. Mayer (1985) and Renik (1990) think so, too. For Sexton, the fear is fear of the loss of her uterus, a uterus experienced as "singing like a school girl," an internal source of pleasure.

When a woman says that she is afraid she will lose her femininity, she could be talking about secondary sexual characteristics, the external genitalia, or, like Sexton, she could be referring to her inner genital. The experience of the interior genital and its relation to an aspect of body image, as well as to an aspect of the gender identity of women, is what I would like to explore here. I think that contractions of the perineal musculature in toilet training result in sexual excitement which is felt as genital by the oedipal girl and which she fears losing as a punishment for oedipal wishes. The question to be addressed is: To what extent is the female's fear of castration a fear of loss of genital sensation? The following case examples are intended to show how this fear appeared in the analyses of some women who differed from one another with respect to kind and level of pathology.

CASE EXAMPLES

A young executive who had quickly reached the highest levels in her career, entered a four-times-a-week analytic treatment because she wanted help in deciding whether to end her relationship with her lover; if the relationship continued, she needed help in improving it. Her success had left her feeling cut off from her roots. When she realized that her lover was from a

wealthy family, she had begun to lose her spontaneity with him. She believed that his mother disapproved of their relationship, and she complained whenever he took her to family events. Yet she clung to him desperately, tolerating neglect and abuse from him. As treatment progressed and he became less abusive (because she provoked him less about his close relationship with his family), she lost interest in him.

During the waning of this relationship, in the fourth year of her analysis, she got into a taxi one day on her way home from work. The driver told her that if she would come home with him, he would "eat" her. She went and enjoyed the encounter, with no sense of fear or shame. As she explained in her session the next day, when she did this, she did not have that image of her father standing at the foot of the bed, watching her and disapproving, which she had regularly experienced when having sex with her lover. We came to understand that she felt too powerful and too phallic with her lover, but felt feminine when degraded by the cab driver. I interpreted that this was related to her belief that her father had wanted her to be a boy. She thought he had wanted a son, but she also believed that he detested masculine women. What she both valued and depreciated in herself was her femininity.

She was afraid that if she stayed with her lover, the sexual roles would be reversed. Her need to be treated as inferior, dirty, an outsider, and immoral derived from her disdain for sexual activity of any kind. It also derived from her guilt over her wish to be penetrated by her father and, most terrifying of all, from her fear that she would lose her femininity and the possibility of ever having children if she succeeded in her career and in her relationship with her lover, who was too deferential to women.

Her dilemma had plagued her as long as she could remember. For example, she was the only girl her father and uncles took along when they went to their hunting cabin each fall. She was also the only girl in her class who did better in math than she did in other subjects. At puberty she had continued to do well in

math and science, but believed, as a result, that there was something wrong with her as a girl. She had acquired a boyfriend as soon as she could and had remained with him, believing that she could not be less of a woman than the others if she had a man. Any lapse of what she considered masculinity on the part of her man threw her into a panic. She had left her boyfriend when he decided to go into an artistic field in which he would never earn as much money as she would earn in business. The femininity she was afraid to lose was her orgastic potential. What she said she valued was the "fluttering" sensation in her vagina, which I understand to represent the sphincter clenching of orgasm. That fluttering sensation corresponds to Sexton's image: "Everyone in me is a bird." This case illustrates something that I have observed with other women patients: some women who fear losing their femininity are afraid of losing the inner experience of the female genitalia.

Like this patient, other women who succeed in traditionally masculine occupations seem to me to be especially prone to allowing themselves to be exploited by men because they need to prove themselves desirable and feminine rather than masculine. Any perceived softness or openness in a man is frightening because it threatens role reversal and consequent loss of genital sensation. The hypermasculine man is valued by such women because they can feel more feminine in contrast to him. They are likely to be the victims of impostors (Gediman, 1985) because they feel themselves to be impostors as women when they succeed in masculine roles. This was even more pointedly illustrated by a patient whose ordinarily regular menses suddenly appeared two weeks early, just at the moment she was giving a lecture in which she would be seen as a serious and successful scholar by a very large audience. Her pride in her accomplishment was countered by her embarrassment at not being able to sit down again on stage after she finished at the podium. The achievement, which felt masculine to her, was countered by her bodily reminder to herself that she was only a woman, but this was also a comfort, a reassurance that her achievement had not

cost her her femininity. The social role of successful career person may be understood by such women as a threat of loss of feminine genital function.

Another patient, a writer in a three-times-a-week treatment, had an eating disorder. She drank quarts of artificially sweetened coffee every day. Much distressed when her doctor told her that her recurrent bladder infection was probably related to her caffeine and saccharine intake, she determined to try to stop drinking so much coffee. Yet she had to eat lemon cookies while she wrote, and only coffee went well with the cookies. She had learned to write from her father, who used to keep these cookies on his desk. I interpreted her identification with him. But, she protested, her father did not drink coffee. We came to understand the coffee as a poison she used to punish herself for indulging in fantasies of being her father's darling, as well as fantasies of being just like him and doing everything he could do. The symptom of endless desire for coffee had become exacerbated when she became more successful than he. It abated when we understood it as a bid for his love and for the attention and concern of her physician and of her mother. Using the coffee to become sick would put an end to her striving, which she saw as too masculine and therefore castrating to her as a woman. I interpreted the self-filling as a masturbatory equivalent of being penetrated. I told her that she was penetrating herself with food, but in fantasy she was being penetrated by her father. Therefore, she had to punish herself by taking in the poisonously sweetened coffee.

The oral displacement upward of the genital wish to be filled represented control over sphincters, conflating glottal closure with vaginal sphincter control. She used eating as an area in which she could maintain control, reassuring herself that her vocational activity, which, to her, represented masculine activity, did not destroy her femininity. She became able to give up the coffee when sphincter control was brought into the analytic discourse as the issue which linked her sexual concerns with eating.

Clenching and unclenching the perineal sphincters becomes

important when the need for mastery is evoked by trauma resulting from physical or sexual abuse. The ordinary experience of mastery obtained in the course of toilet training can become a nodal point for regression when the girl feels threatened with intrusion or penetration. This sphincter mastery can also serve to ward off other threats, as in the following instance.

A young woman analysand with an intense devotion to ballroom dancing was able to gather the courage to tolerate a break with her abusive lover when she began to understand her complex need for an abusive and antisocial sexual partner. She had been unable to even contemplate leaving him as long as she remained terrified of confronting him. An interpretation of her use of ballroom dancing to allow him to lead, yet to keep him behaving within an acceptable social pattern, made sense to her. She then uncovered a memory of being terrified by her parents' quarrels when she sat alone in the back of the family car. She recalled having hummed to herself while crouched in the space between the front and back seats of the car, clenching and relaxing her perineal musculature to the rhythm of her music.

Recalling the soothing effect of this intense preoccupation with her own inner sensations, she was able to accept my interpretation that her sense of her own power to tolerate the disruptive parental quarreling derived from her awareness of the power of her sphincters. This made her feel powerful enough to end her affair with her abusive lover. She said that she no longer needed him "to be the bad guy." I understood this to mean that she no longer needed the opportunity to project her aggression onto him and seduce him into acting it out for her.

In attempting to understand the origin of her early solution to the shattering effect of her parents' quarrels, she recalled that her artist mother would spend hours painting what looked to her like abstractions, but required that her father pose nude while her mother painted what were supposed to be pictures of him. As a little girl she had felt intense envy of her father's body and especially of his penis. She had believed that her mother allowed him to do anything, to break any rules, because she

wanted to be allowed to look at his body. The early fantasy that the man's body is so beautiful to look at that he can have anything in exchange for the favor of exhibiting it contrasted with her attitude toward her own body.

She described her own body as being "strong, like a peasant or a machine. Not fine, well defined, or elegant." Her fantasy of the primal scene involved a gangster-type man, elegantly groomed and dressed, but doing bad things and getting away with them. She envisioned the woman as a love slave, enthralled by the man's "suave" penis. The parental quarrels had been so frightening to her partly because they evoked the primal scene fantasy too vividly. I interpreted that she must have wished they were making love instead of fighting and that she must have felt so powerless to stop them that she had used masturbatory clenching and unclenching in order to feel powerful and loved. Her position in the car had guaranteed that she was alone, protecting her from feeling like she was intruding. Thus, I now think, she was protected from superego condemnation for intrusion on the primal scene. She remarked that one good thing about her lover's antisocial activities was that by contrast with him, she always could feel like a good person. In my opinion, she projected her guilt onto her lover in order to allow herself what she perceived as the guilty pleasure of making love actively.

For this patient, anything was all right as long as she could blame the other person. Adult masturbatory clenching and unclenching was bad because she was doing it on her own initiative. Ballroom dancing was not bad, even though she had the same kinesthetic experience, because she could rationalize that she was just responding to the music and to the partner who led her. She could enjoy it while appeasing her superego by seeing herself as only a passive tool.

For all of these women, the complaints about their social role, their interactions with men and women in their environment, and their self-understanding seemed to me to be colored by their experience and valuing of genital sphincter sensation. Is-

sues raised by these observations are: (1) How does the girl's awareness of her inner genitals develop? (2) How does awareness of inner genital sensation relate to castration fears in women? (3) What does the female's awareness of her anatomy contribute to the development of object relations? (4) What is the relation between this awareness of inner genital sensation and perversion?

INTERIOR AND EXTERIOR

The psychoanalytic treatment of adult women has given rise to a complex view of the development of female gender identity. Bernstein (1990), Mayer (1985), Kestenberg (1956, 1968), Horney (1924), and others see female psychosexual development as being an elaboration on early, specifically female gender identity. It seems to me that several different strands of development converge to produce the adult woman's sexual orientation and view of her own sexuality. While penis envy may be part of it, and feelings about early objects certainly enter into it, the strand of female sexual development highlighted here is a line based on the kinesthetic experience of the interior genital.

Freud (1932) saw sexuality as the most complex and difficult to trace of motivators. He encouraged women analysts to expand understanding of female development. From the start, they emphasized primary femininity. This is in contrast to Freud's view (1931) that female psychological development starts out male, veers with the girl's discovery that she does not have a penis, and is ever after determined by that fateful turn. Early attempts by women to understand vaginal awareness addressed the problem. Bonaparte (1953) pointed out that vaginal mucosae have almost no sensitivity, even to heat or pain. She believed that arousal depends on sensitivity of the vulva, meatus, or perineum and kinesthetic sensitivity of the erectile tissue lining the vagina. Beating fantasies symbolize stimulation of the vagina by blows of the penis. I infer that beating fantasies would

have developed from the sensation of flexing the sphincters and would then provide the mental representation linking the early sphincter experience with later coital sensation.

Laqueur (1990) asserted that Freud's "vaginal orgasm" was known to be anatomically impossible by the time Freud wrote about it, because it had long been well known that the supply of nerves in the vagina is quite sparse, while the supply of nerves in the vulva is luxuriant. Of the "vaginal orgasm" Laqueur said: "It involves feeling what is not there. Becoming a sexually mature woman is therefore living an oxymoron, becoming a lifelong 'normal hysteric,' for whom a conversion neurosis is termed 'acceptive' " (p. 243). This absurdity could not have escaped Freud. Thus, his humble conclusion that he did not understand female sexuality was justified.

The idea of vaginal orgasm seemed finally to be laid to rest by Sherfey's (1966) careful and exhaustive review of the anatomical and developmental data and behavioral evidence derived from the data of Masters and Johnson. Sherfey concluded that there is no vaginal orgasm, and that clitoris, labia minora, and the lower third of the vagina function as a unit during intravaginal coitus. More specifically: ". . . *there is no such thing as psychopathological clitoral fixation; there are only varying degrees of vaginal insensitivity and coital frigidity*" (p. 101). My understanding of this is that instead of a transfer of sensitivity, there is an integration of clitoral sensitivity into the larger functioning of the complex assembly of part organs.

This leaves the question of how this interior space is reached. The idea of a body opening with no sphincters, and therefore no control of access, appeared in Barnett (1966), and was elaborated by Bernstein (1990). It seems to me that while this idea may be relevant to the sensation of no control over menstrual flow, it fails to account for the toddler girl's awareness of the presence of a competent set of muscles in the female perineum. The girl cannot be unaware of this musculature since voluntary control of it is necessary to toilet training (Kestenberg, 1956). Even though the voluntary control of the sphincters is not in

awareness at all times, it becomes the center of a girl's attention several times each day.

Erikson (1950) found that girls built enclosures and played *in* them, while boys built towers, roadways, and houses and played outside them. He concluded that girls were motivated by their interior genitals as boys were by their exterior ones. Piaget and Inhelder (1966) described early learning as sensorimotor. By this they meant that early learning occurs through gross motor activity. It is while the girl is in this early sensorimotor stage of development that gender identity is formed (Fast, 1984). At the same stage, toilet training takes place. In addition, the crucial events of separation-individuation occur (Mahler, et al., 1975). The meaning of gender is therefore influenced by the girl's discovery of it in the context of toilet training.

The most significant event of toilet training for the development of the girl, I believe, is the discovery of voluntary control of the anal and urethral sphincters. The girl gains control of these sphincters as early as eighteen months. Mothers universally report that little girls are toilet trained earlier than boys. One mother of twins described her experience: "Jane was trained by eighteen months. It seemed like she wanted to be. It took forever with John. He was three and a half" (Bond, 1990). I believe that the sense of mastery that the girl achieves in controlling her sphincters is magnified by the sexual pleasure she achieves by this control. Cloacal fantasies bother women throughout life (Goldberger, 1991; Spitz, 1955). Making the distinction between the highly valued genital product and the devalued anal one is so important to women that any threat to this distinction can invoke danger (Stein, 1988). The woman writer with the eating disorder suffered from this confusion, never knowing whether her product was "great" or "shit."

The little girl's pleasure in her control of her sphincters may be the origin of her tendency to enjoy cleanliness, neatness, and orderliness. Montgrain (1983) posited oral and anal roots of vaginal erotism as foci for regressive psychic representation of the vagina. According to Barnett (1966): "The complete se-

quence of normal female development may be based totally on orifice and cavity cathexis" (p. 130). From oral to anal to vaginal cavity, the girl may always experience sexual pleasure from internal mucosae. This may be the prototype of how pleasure from interior or exterior stimulation is experienced as vaginal (Glenn and Kaplan, 1968).

The writer with an eating disorder was greatly concerned with elimination. This paralleled her conflict over intake. Her generalized sphincter concerns, I believe, defended against the superego prohibitions over experiencing genital sensations while engaged in activities which she associated with her father.

Bernstein (1990) said: " 'Wetness' necessarily invokes a regressive potential to all the anxieties and conflicts surrounding early bladder and sphincter control . . ." (p. 154). The bladder in particular is the source of genital stimulation in girls from the earliest years of life. Urinary retention, with tightening and relaxation of the sphincters to release urine, are the prototype of vaginal excitement and orgasm in women. Galenson and Roiphe (1976) asserted that the little girl is awed by the discovery of the male urinary stream as much as by the penis. I believe that this follows from her pleasure in regulating her own urination. The vulva as a whole is squeezable and distendable from the earliest years. Little girls can and do squeeze and release their sphincters rhythmically to gain pleasure from their sexual organs (Clower, 1976). Latency age girls have been reported to masturbate by running, horseback riding, gymnastics, bicycle riding, rubbing their legs together, and similar activities. Their passionate attachment to these activities may attest to the high value they place on the pleasure they get from them. It seems to me that fear of the loss of this capacity, experienced as fear of forcible penetration or rape, is the basic female sexual fear.

In normal development, the sensory experience of the girl is not of an isolated clitoris or vagina, but of a global area around the inner upper thighs, the vulva, and the lower abdomen (Sherfey, 1966), including the anal area; there powerful sphincters of the anal, urethral, and vaginal openings are brought

under conscious control and experienced as the site of stimulation from the bowel movement, the urinary stream, and the shifting positions of the abdomen. Because little girls are taught that it is not socially appropriate to communicate these sensations (Lerner, 1977), I believe that they learn to enjoy the feelings without registering them in conscious thought. Hägglund and Piha (1980) described this process as one in which access to the inside is by means of sensations induced by manipulations outside. Girls experience the inner and outer portions of the genitalia as connected through the sensation of pleasure. Mastery attained in this way can defend against the unpleasure associated with aggressive impulses which are unacceptable to the girl. The patient who rocked in the back of her parents' car used her sphincter sensations as a defense against awareness of her rage at her parents for failing to protect her and her fear that they would kill each other.

The executive described above recalled being convinced throughout latency that she was not like other girls. It was not a matter of being better or worse, only different. For her, the mind was inside and her pride in her mental functioning bolstered her sense of being female until the situation became more complex as she began to understand her intellect as masculine. Once that happened, she needed to bolster her sense of femininity by having a lover as an external sign of her feminine identity.

CASTRATION FEARS

A woman patient expressed the fear that her vagina would dry up like a raisin and fall out. This form of castration fear in a woman contrasts with the view that women only fear loss of a fantasied penis. Girls, like boys, value genitals for the pleasure to be derived from them. Fear of loss of the pleasure genitals provide is common to both sexes. But the exquisite innervation of

the genitals which produces pleasure also entails vulnerability to pain. It seems to me that these fears of loss of pleasure and the experience of pain are necessary and sufficient to account for castration anxiety even in children who have never been threatened with castration. Ideas of specific ways in which the loss of pleasure and the experience of pain can occur elaborate pleasure and pain into fantasy. Bonaparte (1953) regarded "castration fear," or loss of an imaginary penis, as secondary in women, with what she called "fear of perforation" as the more general problem. Bernstein (1990) understood rape fears as fear of penetration rather than castration. This accords well with Bonaparte's "fear of perforation" and Barnett's (1966) idea that the girl suffers from fear of lack of muscular control over the vagina. Bernstein showed how female castration anxiety is manifested as fears about "access," "penetration," and "diffusivity."

Girls' genitals, which are highly pleasurable from infancy onward, are located so close to the organs of excretion that excretory functions are confused with genital ones. Thus, disgust with excretions and the excretory function endangers genital pleasure. McDougall (1988) described the girl's castration anxiety as fear that "her mother will attack her whole inside" (p. 67). This view of female sexuality emphasizes the internal and makes vivid the equation of rape or forced penetration with death and the fantasy of death as turning the body into feces (Bach and Schwartz, 1972).

Mayer (1985) showed that female castration anxiety is best understood as fear of loss of the female genital. She based her view of female development on the girl's awareness of her vulva. For Mayer, the girl's development parallels that of the boy, in that the small girl experiences her own body as the prototype of what a body should be and experiences the difference between the sexes as a defect or deformity in the male, just as the little boy experiences that difference as a defect or deformity in the female. I agree that the visual sense of the vulva and surrounding area are crucial to the value the woman attaches to her

genital openness. But I want to emphasize the role of the invisible but kinesthetically perceived sphincter muscles as generating the body image.

Renik (1990) described a female patient's fears related to her active phallic strivings as he uncovered her wish to penetrate and impregnate her male analyst. He attributed these strivings to denial that she could actively seduce through her feminine sexuality. To wish for the sexual equipment of the opposite sex implies castration for women as for men. To have a penis is something women wish for but also dread, because having it would entail loss of the treasured source of pleasure. The ballroom dancer was dependent on a man to dance with because she needed to deny her female power to seduce as well as because she envied and feared male power. Fear of loss of internal genitalia is explicit in Sexton's poem to her uterus, written in response to a recommendation of hysterectomy. It was hidden in the symptoms my patients presented, but the symptomatic relief produced by this interpretation confirmed that the fear of loss of genital sensation had played a role in forming the symptoms.

The executive who worried about being too controlling and powerful with her lover believed that the external power she wielded would destroy her internal control. In treatment she set up a choice between having frequent sessions or using her money for surgery to have her "too high arches" restructured. I interpreted to her that she could change inside or outside, but not both. Changing the outside seemed less frightening, and it protected from her the greater danger of changing inside. Since she believed that I wanted her to continue to advance in her career, she needed the surgeon to take her money so that she would not have so much treatment that she would become too masculine. Treatment would also deprive her of the fantasy of being wounded and inadequate and therefore the sort of woman her father would choose. In this sense, her dilemma could be seen as a choice of whether she was to be castrated outside, on her feet, or inside, in her mind.

ANATOMY OR OBJECT RELATIONS

Wisdom (1983) emphasized the extent to which society defines what constitutes femaleness. While Person (1980) viewed sexuality as determined by object relations rather than by a biological "drive," she agreed that gender "plays an organizing role in psychic structure similar to other modalities of cognition, such as space, time, causation and self-object differentiation" (p. 49). Chodorow (1989) contrasted the concept of primary genital awareness with that of parent labeling as explanations for female gender development. She cited Galenson and Roiphe and Kestenberg in the first camp and Stoller, Kleeman, Lerner, and others in the second. Money and Ehrhardt (1972) might well be added to the latter group. The idea that sphincter awareness contributes to body image and thus to gender identity supports the importance of primary genital sensation in the formation of sexual identity. I believe that new evidence from the history of science supports this view.

A history of theories of female sexual anatomy was offered by Laqueur (1990). Laqueur showed that the idea that female sexual anatomy is inverted male anatomy pervaded medical and scientific thought in the Western world until relatively recent times. In this view, a female is an imperfect male. Laqueur dated to the eighteenth century the idea that the uterus is different and that this difference determines the physical and mental life of the person who has one. Here the female is the opposite of the male. This belief, restated by Freud in his famous dictum, "anatomy is destiny," places an emphasis on the biological difference which Laqueur believed the facts do not support. Thus, female anatomy produces sensations specific to a muscular sphincter covered by a mucosa which is partially hidden from view but rich in sensation, a specifically female organ which should not be defined in terms of difference from the male or in terms of lack of the male organ.

In contrast, Laufer (1991) agreed with Freud's (1933) idea

that the girl accepts femininity only with the oedipal realization that she cannot take father's place with mother because she lacks a penis. Laufer viewed self-mutilation, anorexia, bulimia, and suicidal behavior as responses to a harshly punitive mother image which appears to the girl when she attempts manual masturbation at or after puberty. The adolescent girl sees her body as a punitive object attacking herself. For Laufer, therefore, the object relation with the mother determines the girl's body image. Here Laufer is similar to Chasseguet-Smirgel (1988) who said that "the first category is mother/father" (p. 126). For Chasseguet-Smirgel, the awareness of difference between male and female is not based on one's own anatomy, but on the differences between the primary objects. Parens (1991), in contrast to Laufer, stated that the girl starts out non-specific and develops a feminine identity in the late preoedipal period.

According to Fisher (1989), early relationships with parents predict later sexual behavior, which speaks for the primacy of object relations over anatomy in the development of body image. He did not take into account the possibility that recall of early interactions with parents may be affected by subsequent sexual and cognitive development. Such linear thinking may hamper understanding of female development. According to Ritvo (in Panel, 1989),

> . . . gender identity formation is not a simple dichotomous variable or a fixed normative endpoint in a linear developmental sequence. It should be viewed instead as a complex construction which includes the possibility of retroactive transformations of previous meanings in the light of libidinal and aggressive aims (p. 801).

Thus, thinking about anatomical development is needed to supplement what is known about development from the object relations point of view. I believe that we can now specify one more aspect of this early female development: the experience of the sphincters.

To illustrate the complex interaction between object relations and bodily sensation in the formation of adult gender identity, I would like to return briefly to the cases with which I began this paper. The executive had developed a fantasy of her father wanting her to be a boy to explain to herself her own wish to be a boy, its disavowal because of the threat to her femininity if it were fulfilled, and her need for her father's love. This fantasy had developed into the idea that as long as she had a lover she was not too masculine. This, in turn, had led her to become subservient to her lover and unreasonably demanding of proof of his masculinity. Any man who could be macho enough to make her feel feminine, however, was so unsuitable and so unable to accept her achievements, that she could not accept him. I view all of this as based on her female genital pleasure, a pleasure she was unwilling to give up.

The writer also had fond memories of being special to her father. She experienced severe conflict because she both identified with him and wanted his love. When she believed herself to be like him, she experienced herself as too masculine to be loved by him. Again, this object relations view of her conflict was a simplification, in that it needed to be supplemented by understanding of the sphincter control issues which, I believe, contributed so much to her psychopathology.

The ballroom dancer identified primarily with her artist mother. Her need for a man to lead her placated her superego. Instead of feeling guilty for seeing her father naked and for being present at her parents' quarrels, she admired the antisocial activities of her lover. But this also had a physical component. She enjoyed the ballroom dancing as a kind of stimulation that would not force her to punish herself for masturbating.

FEMALE SEXUALITY AND PERVERSION

The early recognition of sexual perversion in women (Richards, 1990) was followed by a relatively long period in which most

analysts thought that women did not have sexual perversions at all (Richards, 1989). Denial of sexual perversions in women reflected the view of female sexuality as passive, responsive to the male, or simply absent. For Chasseguet-Smirgel (1978), perversion is a negation of the oedipal prohibition, a denial of both the generational taboo and the differentiation between the sexes. Stoller (1985) held that a hostile desire to humiliate the other is central to perversions. These definitions allow for female as well as male perversions. Recognizing the existence of perversions in women entails recognition of spontaneous female sexual desire. As we have seen in considering anatomy and object relations, the sphincter sensation may be one basis for female sexual desire.

Stoller reported varieties of female sexual experience, including erotic vomiting, which illustrate the interplay of internal and external genital imagery. In bulimia (Sours, 1974), a girl enacts a wish to gain and to repudiate the huge belly and breasts which the little girl fantasies are emblems of the mother's capacity for pregnancy. The wish to be pregnant may, in turn, relate to the wish to fill and empty an inner space. This fantasy was seen in the patient who had to eat the lemon cookies and drink coffee, and is an extension of early sphincter pleasures.

Such fantasies make gender a complex achievement, from the toddler's labeling the self as a boy or girl to the mature adult's negotiating gender identity, gender role, object choice, and object relationships. Dahl (1988) put it this way:

> "Gender identity" is not a fixed normative end point in a linear developmental sequence but a complex construction involving the interrelationships between body and mind and between inner and outer reality.... The mind must find a balance between the needs and demands of outer reality and the needs and demands of the body . . . it does so through the creation of the configuration of fantasies we subsume under the term "gender identity" (p. 363).

SUMMARY

The experience of female sexuality seems to have to do with experiences of both the exterior and the interior portions of the female genitalia. Mental representation of this experience seems to interact with early perceptions of the parents and their roles, and with socially normative maleness and femaleness, in producing the fantasies which govern the possibilities for female sexual development and functioning. A vital and, I believe, insufficiently emphasized aspect of female genital representation is the flexing of perineal musculature, originally in the voluntary control of the anal and urethral sphincters, and later in the involuntary contractions of the orgasm. The degree to which this is the preferred method of masturbation may have important consequences for the girl's development. The concept of a body image based on a model of body activity rather than on visual image alone is an important and neglected factor in formulating a theory of the development of self-representation and body ego. I believe that paying attention to this aspect of female sexual development in the clinical situation can enrich our understanding of our female patients.

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SOME VICISSITUDES OF AGGRESSION IN THE INTERPRETIVE PROCESS

BY DAVID L. RAPHLING, M.D.

Interpretation is a product of compromise formation that requires optimal use of the analyst's aggression to be an effective analytic intervention. Aggressive aims useful for the interpretive act are problematic for analysts and have led both to clinical difficulties and to various theoretical reactions against considering interpretation essential for analytic progress. In analysis, diverging aims of analyst and patient are highlighted in connection with the analyst's function as interpreter. The interactions between patient and analyst pertaining to interpretation provide insights into the patient's intrapsychic conflicts that may be less apparent in other material.

INTRODUCTION

The analyst's interpretive work is central to the definition of psychoanalysis as a therapeutic technique. It is the product of compromise formation, as are all other technical functions. The aggressive component of the compromise creates particular difficulties for the analyst in formulating and implementing effective interpretations. Aggression called forth by the interpretive act is problematic for analysts and is, I believe, largely responsible for the persistent trends in psychoanalysis that have aimed at reducing the importance of interpretation for analytic technique. This is seen in theories of technique that modify interpretation or redirect its aim away from its central purpose of conveying insight to a patient about his or her unconscious mental life. Although analysts may accept the aggressive aspect of interpretation intellectually, the act is frequently experienced by

them as assaultive; this can generate anxiety in analysts and an exaggerated expectation of patient vulnerability.

A fundamental antagonism exists between analyst and patient around the analyst's central activity as an interpreter. This opposition is a counterpoint to the mutual aim of facilitating analytic work through cooperation. Freud (1912) pointed out that an analyst cannot count on the patient's cooperation in doing analytic work because a patient does not really wish to do what he or she agreed to, and is far from unequivocally allied with the analyst. A struggle inevitably develops between analyst and patient as the external representation of the patient's own agonizing intrapsychic conflicts. This discord in the specific area of interpretive interventions provides a valuable opportunity for insight into the patient's intrapsychic conflict. The analyst's and the patient's (sometimes) mutual search for the insight provided by interpretation may be actively opposed by the patient, since interpretive insight can be perceived as a danger even while it is welcomed as an opportunity (Rangell, 1983).

The sequence of a patient's development of resistance, the analytic interpretation of the resistance, and the patient's subsequent reaction to the interpretation has been proposed as a basic unit of psychoanalytic work (Boesky, 1988; Weinshel, 1984). It is also a measure of patients' attempts to deceive themselves. Their experience of themselves as they know themselves—the continuity of the experienced self—is threatened by this process. Interpretation is opposed as an alien disturbance of psychic equilibrium's status quo. Interpretation introduces another reality, or the possibility of an alternative subjective experience, as a discordant note into the harmony of the psychic reality and experiential state out of which patients construct a familiar and stable self-image. They experience interpretation as a potential interference with aims of gratification and defense expressed in their resistance and transference.

Accepting the patient's psychic reality as material to be explored analytically is a necessary prelude to arriving at interpretations that are informative and insightful about issues which

are not in accord with the patient's more immediate experience. Good technique requires attention to the "experiential immediacy" of surface material as a tactical necessity for arriving at interpretations that will ultimately delineate unconscious components of conflict. The danger of sticking so close to the surface, however, is that interpretations can fall short of their defined purpose by not truly addressing unconscious material. Exploration of the psychic surface may then become an end in itself that encourages resistance to knowledge of deeper matters. An effective interpretation will relate to the immediate experience of the patient, but will also go beyond it. What begins reasonably as an analyst's empathic resonance with a patient's presentation of surface manifestations must be validated by objective observation from a vantage external to the patient's view of reality. This is necessary if the analyst is to avoid overidentification with that aspect of the patient's experience of reality that acts as a resistance.

Patients' convictions about their immediate experience and version of reality, taken at face value, can become powerful obstacles to analytic inquiry into new and previously unrecognized views of the hidden motives behind manifest experience. If interpretations do not ultimately offer alternative views of the significance and meaning of patients' personal reality for their consideration, then useful analytic work is not being done. Such interpretations, however, are opposed by patients' fears of losing or negating their self-representations and personal mythology. Interpretation, in order to convey insight, of necessity assaults or challenges patients' psychic equilibrium. Disturbing patients' self-deceptive complacency with what is truly the radical view of an effective interpretation is ideally a neutral technical activity that nonetheless draws heavily on the analyst's aggression.

CLINICAL ILLUSTRATIONS

Ms. A, a forty-two-year-old married woman with two children from a first marriage, had been in analysis for about one year

when she and her husband decided that they wished to have another child. They tried unsuccessfully for the next eighteen months before consulting a fertility specialist who found no specific cause for infertility.

The material in the clinical vignette to follow emerged during a session three years into the analysis. Ms. A had still not been able to conceive. Earlier in the analysis she had spoken of how a successful analysis might help her become pregnant, but she ridiculed the notion she had heard about patients' actually wanting a baby from the analyst. In the week prior to this session she had been quite irritated with analysis and with me. She had been feeling ready to give up trying to become pregnant since she already had two nice children, though not by her present husband. She complained that she felt like she had been wasting her time and money in analysis these past few weeks, ruminating about whether she could or still wanted to become pregnant. She reported suddenly being seized with the unexpected concern that her car might be towed by the police from a space outside my office. She thought if she discovered after her hour that this had happened, she would want to return to my office and have me assist her. She said this was a fantasy and that she would not have actually come back until her next analytic session. She said it would be breaking the rules of the analytic situation, and she imagined that I would not do anything about her plight anyway. She felt it would be unreasonable for her to expect me to help her in this way.

At this point I was about to interpret what I clearly perceived as her guilty wish, presented with more immediacy than it had been earlier in the analysis: the wish for me to give her a baby. However, thoughts about an analyst whom I imagined not making such an interpretation came into my mind and caused me to hesitate. I imagined he would have considered the interpretation confrontational and inconsiderate of the patient's defenses. But I then went ahead and told Ms. A that the reason she was irritated with me, feeling she was wasting her time, and concerned with breaking rules, was that she wanted me to help her by impregnating her, even though she thought it an unreason-

able wish that aroused in her a sense of guilt. She next spoke of a recent TV drama about an infertile woman who finally became pregnant by artificial insemination. She had thought, as a last resort, that she might become pregnant with sperm from a donor through artificial insemination. She said after a pause, "Somehow the idea of wanting you to impregnate me is understandable, but I'm just not at all aware of really wishing for it." I then said, "It must bother you to so directly wish for a baby from me since what you thought of instead was an anonymous sperm donor." There were a few moments of silence, and then the patient responded, "It must be difficult for me to talk about it, but I've been noticing that I'm becoming aroused as *you* speak of it." After another brief silence she asked herself aloud, "Do you want him to impregnate you? And I answer myself, no. Now I fear that I'm being seductive or playing hard to get by protesting."

In this example I identified with my patient's reluctance to hear about her wish for me to impregnate her. I believe my hesitation was due to a transient inhibition of the aggressive impetus I required to generate a disturbing interpretation. In the face of Ms. A's previous defensively aggressive condemnation of the idea that an analysand might want a baby from her analyst, my fantasy of a colleague criticizing me for being too forceful can be viewed as a clue to the opposing forces mobilized. Her response to the interpretation, however, was an affirmation, a provocation, and a suggestion that her experience of my intervention could itself be sexually gratifying.

A second clinical vignette comes from a supervised analysis and illustrates how a patient reflexively used her subjectively experienced state of mind to disavow what seemed to be a tactful and well-timed interpretation before allowing herself to associate spontaneously to what she had heard from the analyst.

The patient had recently given birth to her first baby during the second year of her analysis. This had stirred guilt related to an unconscious sense of oedipal triumph that had been inter-

preted previously in connection with other areas of her life. In her transference reactions the patient typically defended against her rivalry with her female analyst by masochistic self-devaluation and angry submission to anticipated criticism from the analyst. In this instance the analyst pointed out that the patient's abjectness during an hour expressed a need to feel criticized as a way of dealing with guilty feelings over her intense rivalry and momentary sense of superiority to the analyst, whom she imagined as childless. The patient responded, "I hear you and it makes sense, but I just don't experience feeling competitive with you. That would imply that I'm better than you. If I talk about the baby, it seems like bragging and gloating. I just don't feel that way. It's not based on any reality. I know this is based on my mother, and I know I am better than she. [Pause.] In here with you I come across as withholding and contrary, but it's because I'm concealing that I'm bragging and gloating. When I'm feeling good about myself, I'm somehow putting you down, so I guess it *is* competition with you."

Another example of the patient's using her subjectively experienced sense of reality in order to object to an interpretation occurred a few sessions later. This time her sense of conviction about her immediate conscious experience also expressed the transference significance for her of the act of interpretation. Following an interpretation of the patient's denial of her mother's recent mistreatment of her, and her own repressed rage, the patient became quite distressed. She protested that she did not think she was angry and that by saying that she was, the analyst had taken her completely by surprise. She further commented that the analyst had voiced her comments very strongly and had sounded extremely sure of herself. After some silent reflection, the patient said, "Now I feel I have to back down. I feel I have nothing to say. I'm all confused. I feel like you are my ally, but the moment you tell me something useful I get upset and angry with you." Here the patient's subjective experience, by contradicting the analyst's interpretation, led to the patient's discovery of her intense rivalry with the analyst; this was based on a trans-

ference image of the analyst's ability to interpret what the patient could not see for herself.

A final clinical vignette will provide an illustration of a fairly commonplace clinical situation in which discord at the interface of interpretation can lead to a countertransference reaction rather than to a useful analytic exploration.

Mr. B, the patient, vigorously denied the analyst's interpretation that Mr. B viewed a current authority figure in his life as a phallic rival, just as he had his father in the past, and that he envied both men their sexual relationship with a mother figure. The analyst met Mr. B's objections with an equally vigorous restatement of his initial interpretation in slightly modified language, though the content was essentially the same. Mr. B found another way to disagree on the basis of experiencing the analyst's interpretation as "not feeling right," and added that the analyst seemed to disbelieve him. The analyst rejoined by reassuring Mr. B that he took him at his word, and then marshaled his evidence for the "correctness" of his interpretation.

Although the analyst's interventions were all variations on an essentially accurate interpretation, they remained ineffective because the analyst was under the sway of his aggressive response to the patient's powerful negation. He was unable to recognize in the heat of the moment the presence of a more subtle resistance: a transference enactment in which the patient, by being blatantly resistant and denying the efficacy of the interpretations, was robbing the analyst of phallic power corresponding to that of his envied father. The process interpretation that the analyst failed to make was problematic because it was influenced not only by the constructive use of aggression necessary to make an interpretation in the face of a patient's objection, but by a disorganizing intensification of the analyst's aggression in response to the patient's castrative wishes, aimed at the analyst's phallic and narcissistic investment in his interpretation. By the end of the hour the patient appeared to have finally acknowledged the accuracy of the interpretation in an apparently non-

defensive way, though this was, in fact, another manifestation of resistance that required further interpretation: submission to the analyst's authority. In this instance the aggression latent in the analyst's interpretive function, instead of being useful, manifested itself as a countertransference response leading to interpretations that were deleterious, or at the very least, of diminished usefulness.

DISCUSSION

Sterba (1934) believed that interpretation fosters self-observation by awakening mistrust in the patient's acceptance of experienced psychic reality. A patient's reality naturally differs from that of the analyst. The patient's experience of the analyst's differing view of him or her through interpretation, however, is what allows the patient to be open to new analytic insights and freed from the confines of a psychic reality predicated upon faulty reality testing and other defensive operations. Interpretation of resistance disturbs a patient's compromise formations. A dynamic sequence follows in which new compromises are formed and new interpretations are made possible, which deepen and refine understanding of the unconscious conflicts (Arlow, 1987).

Wallerstein (1965) has drawn attention to the remarkable contrast between an apparent absence of goals for the technique of analysis and its ambitious therapeutic aim to restructure personality. However, analysts are not completely without goals in the application of their technique. Each analyst follows a preferred theoretical model that guides his or her technique for analytic exploration and gives a consistent perspective to the conduct of analysis. Psychoanalytic technique is based on general theories regarding the operation of the psychic apparatus and the formation of pathology. The strategic aims of interpretations are in accordance with the analyst's theory of technique and therapeutic action. The aims are quite purposeful and reflect not only

theoretical and technical biases, but personal values based on significant compromise formations of the analyst. A theory of pathogenesis organizes to a great extent the analyst's use of analytic data for interpretations. While theory predicts the development of a patient's analytic material in a general way, the analyst is not bound by the predictions if they do not accord with the material at hand in the immediate clinical context. Nor does the analyst need to be blinded to material that conflicts with his or her expectations; rather, the theory of technique can be used to guide the continuing inquiry.

The analyst's values and goals implicit in interpretations are definite forces that do not coincide with the patient's interest in maintaining the status quo via resistance. Neutral interpretation is a complicated task requiring of the analyst an abrogation of an authoritarian role without, however, relinquishing the authority vested in an interpretive approach dictated by a theory of technique and the experience of applying it in analysis. It goes without saying that the analyst must be vigilant regarding the patient's reactions to interpretive technique (Blum, 1986) and to how the application of the technique can be subverted by countertransference enactments (Jacobs, 1986).

To be an effective interpreter, the analyst oscillates between uncritical acceptance of the patient's material and active judgments about its unconscious meaning. The analyst moves between credulousness and skepticism, believing everything and believing nothing; between empathic perception of the patient's subjective experience and an objective appraisal of the patient's projections and distortions as they contribute to the patient's view of him/herself. An interpretation based too much on empathic closeness to the patient's experiential psychic reality may turn out to be uninformative, while interpretation too remote from immediate subjective experience will risk being ill timed, too intellectualized, or incorrect (Poland, 1984). After all, that which is experience-distant for the patient has the ready potential for becoming quite immediate (Friedman, 1985) with the help of cogent interpretation. In fact, it is not uncommon for an

interpretation of something that has not been readily accessible to the patient's immediate experience to elicit a response of familiarity: "I have always known this."

When an analyst listens to the patient's material with an ear as free from prejudice as possible in order to further exploration and inquiry, the patient's views are accepted *provisionally.* The analyst is neither ignoring them nor neglecting the concealed motives behind them. That the analyst accepts, but does not settle for, the patient's psychic reality "means depriving the patient of his illusions . . . while at the same time valuing them for the possibilities they represent" (Friedman, 1969, p. 151). In order to go beyond accepting the patient's experience as valid and necessary material for neutral analytic explorations, the analyst assumes some authority regarding his or her own perspective, which, though not necessarily more correct, will offer a different point of view to the patient. The analyst's expertise, notably the inferential conclusions based on explicit analytic data, is not usually within the grasp of the patient prior to interpretation. The analyst's acceptance of the patient's material for what it claims to be must be tempered by a "non-congruent persuasiveness" (Friedman, 1969, p. 151). Although the analyst does not claim that his or her knowledge of the patient is any more the absolute truth than the patient's own, the analyst has a duty to share that version of the truth with the patient. It is clear that the analyst's view of the patient's reality is more relative than once believed, and is vulnerable to mistakes or misguided perception (Chused and Raphling, 1992). The analyst's knowledge of the patient is an approximation of the truth that is subject to confirmation and refinement by further analytic inquiry and attention to clues given by the patient's subjective experience. With the help of the patient's serial elaborations of content and process in response to individual interpretations made in an interactional context, a consistent line of interpretation develops and becomes more authoritative as analysis progresses.

The realization that an analyst's objectivity and grasp of real-

ity can be considered greater than the patient's only in a relative way (McLaughlin, 1981) is consistent with the contemporary understanding of analysis as a dialogue (Gardner, 1983; Leavy, 1980) in which both parties, patient and analyst alike, are subject to the regressive influences of intrapsychic conflict and transference distortion. Unfortunately, this relativistic concept has also led to doubts about the ability of analytic interpretations to contain an objective view of a patient.

Some analysts—Gill (1979), Schwaber (1983), and Kohut (1984), among others—believe that an interpretation of the patient's intrapsychic reality from the analyst's external vantage point is an authoritarian imposition of the analyst's view of reality on the patient. They emphasize, rather, the authority of the patient's subjective experience. Schwaber (1986), for one, has questioned the authority of interpretations, and wishes to "[suspend] any notion that we can 'know' what is 'correct' " (p. 911), since "the only truth we can seek is the patient's psychic truth" (p. 930). Indeed, the patient's subjective view is an important commentary on an interpretive insight, offering direction for further understanding, as well as clues to possible misunderstanding. This commentary, however, can be deceptive to analyst as well as to patient if taken at face value and not subjected to further analysis of its latent meanings.

The structure of the psychoanalytic method, though open to the distortions of subjective and regressive influences on the analyst's functioning, allows the analyst to hold on to a more objective position from which to observe and formulate conclusions about the patient. The analyst's experience—especially with the central phenomena of transference and resistance—and familiarity with unconscious processes, including his or her own, constitute the expertise that contributes to the greater objectivity. The analyst has the ability to validate empathic perceptions with theoretically informed observations based on a formal assessment of the thematic configuration of the patient's associations (Arlow, 1979).

A patient's transference wishes and idealization of the analyst

often predispose the patient to experience analytic interpretations as expressions of absolute authority. Perceptions of the analyst and of the interventions as authoritarian, though they may be in some cases accurate assessments of the analyst's character or specific transference to the patient, can be expressions of transference and resistance that would benefit from exploration and interpretation. Patients may challenge the analyst's selective focus and may experience it as critical: a sign of lack of empathy, sympathy, and support, or a sign of arbitrary authority and suggestion. Alternatively, they may acquiesce and compliantly follow its implied direction. Patients thereby assume attitudes of dependent submission, defiance, or competitiveness vis-à-vis the perceived authority of interpretations. These responses are valuable, often subtle expressions of transferences and resistances that potentially lend themselves to interpretation. When the authority of analytic interpretations is exaggerated by patients' transference motives, analysts may become uneasy with their own aggression and narcissism. They are then more likely to shrug off the authority patients attribute to them rather than explore it analytically. They may be tempted to retreat to a defensive reaction formation epitomized by investing patients' psychic reality with a commanding authority.

Regressive situations do occur in analysis, for analyst as well as patient, in which the neutral authority of an analytic interpretation may be contaminated by idiosyncratic countertransference motivated by the analyst's unmastered aggressive and narcissistic wishes (Poland, 1984). In such situations the analyst may resort to interpretation as an expression of personal power over the patient for the analyst's own defensive or aggressive purposes. The analyst's doubts about his or her prerogative to claim for interpretation an independent view of a patient's subjectivity are related to concern over the possibility that interpretive authority could become analytic authoritarianism instead. In a tenuous situation exemplified by my last clinical vignette, there is indeed a danger that the power of interpretation will unwittingly succumb to the power of suggestion and persuasion,

thereby sacrificing its potential for analytic insight (Gray, 1982). The potential for authoritarian interpretation can obscure the value of an *authoritative* statement of a reasonably likely truth. This has unfortunately made many analysts skeptical of the authority of interpretations and has caused them to back away from viewing interpretation as a valuable communication. Relinquishing the privileged position accorded by the analyst's professional authority, however, can lead to blind spots and other transference-countertransference problems as readily as does rigid authoritarianism (Abend, 1989).

Gray (1982) has reminded analysts that our approach to interpretation of resistance is one that has evolved along with the development of a theory of technique based on the structural and conflict model. Since resistance is a complex compromise formation that reveals as much as it conceals of the various components of intrapsychic conflict, we no longer think of overcoming it (by force of authority or suggestion). We attempt modification through our interpretive understanding of the resistance as an expression that has a dynamic connection with what is motivating it. This is no simple matter, however, since there are always resistances against analyzing the resistances (Freud, 1937) that aggressively oppose insight. Even Gray's (1973) technique of teaching patients to observe their intrapsychic processes involves suggestion. Patients perceive in this method a subtle directive to conform to its expectations; their defiance or compliance must therefore also be subjected to analysis.

Patients' attempts to heed the fundamental rule of free association are soon subordinated to their transference and resistance demands in spite of their best conscious efforts. They press their claims on the analyst for conformity to the subjective experience of their own inner world. In the interest of obtaining a deeper understanding of and appreciation for the patients' state of mind, analysts are receptive to this imposition of their patients' material. However, it is necessary that the more passive

aim of analytic role responsiveness (Sandler, 1976) shift to a more active one when analysts begin to organize and formulate their own ideas and experience into an interpretation. The genesis of an interpretation (Arlow, 1979) is a sequence undoubtedly involving vicissitudes of aggressive energy as the analyst moves from the receptive mode of *experiencing with* the patient to the active mode of *interpreting to* the patient.

At times the analyst is vulnerable to manifestations of transference and resistance that evoke a level of aggression beyond what is required to initiate interpretation. The aggression derives from ready countertransference impulses to harm the patient, either because of inherent sadism or in reaction to the patient's devaluing or threatening the analyst or the analytic progress in one way or another. Brenner (1985) has pointed out that one of the many possible motivations for becoming an analyst embodies derivatives of an unconscious wish to see another suffer.

Although an aggressive component is always present in interpretation, it is optimally expressed as part of a compromise formation whose aims are the neutral communication of insight. When aggression is used adaptively as an impetus to more creative interpretive work, the authority of an interpretation is allowed to remain within a neutral range and not deteriorate to motives of power and influence in favor of communication of insight. Analytic work continually challenges the analyst's energy, imagination, and resourcefulness to creatively channel his or her own aggressive response into neutral interpretations that further the analytic process.

Interpretation, however, does have the capacity to mobilize unproductive and more frankly destructive aggression in both parties. The analyst's larger strategy of understanding and communicating insight to the patient is easily undermined by the aggressive potential of this situation. A neutral interpretation is only relatively neutral, since it can contain metacommunications of power, hostility, and erotism that are unwittingly conveyed in

timing, phrasing, inflection, and manner, even when the content is virtually neutral.

Interpretations are heavily invested with the analyst's narcissism. The analyst's aggression is mobilized in venturing an interpretation derived from a commitment to a highly personal integration of theory, responsiveness to the patient, and cognitive understanding—in anticipation of an ambivalent reception by the patient. Countertransference attitudes fueled by unmodulated aggressive impulses can infiltrate the interpretive process if the analyst desperately attempts to impose authority and to force submission to an interpretive view. The analyst's use of the authority of interpretations to bolster his or her narcissistic equilibrium unfortunately only provokes the patient's counteraggression, and with it, a regression into a power struggle.

Both analyst and patient are in a dynamic flux of accommodating to one another's views. Both parties to the analysis try to integrate their own unique approaches into a harmonious working together in the form of a continually evolving series of compromises around interpretation and response, at the same time that each tries to impose his or her way on the other. The analyst's technical strategy and tactics, for the most part reasoned, deliberate, and conscious, though subject to countertransference distortion, are countered by the patient's own strategies and tactics based on the pleasure principle demands of transference and resistance, complicating the well-intentioned efforts of both parties to analyze. The process by which the patient's and the analyst's aims diverge in the interpretive process can generate great affective intensity and, when analyzed, can result in refinement of the analyst's interpretations and, in turn, of the patient's insights.

A patient's attempt to assimilate any interpretation necessarily evokes a complex affective response that expresses the patient's efforts to obtain gratification of drive derivatives and to satisfy superego demands; it also serves defensive needs, in powerfully evocative (and provocative) forms of transference and resistance. The analyst is liable to construe these responses to inter-

ventions as inimical to his or her analytic intent, which in part they frequently are. In the heat of the analytic interchange any response of the patient may be subjectively experienced by the analyst as antagonistic to the aims of the analysis, may thereby stimulate an aggressive counter-response that readily undermines the analyst's ability to more completely and accurately comprehend the actual intent of the patient's unconscious motives.

Analysts are inclined to accept the problematic manifestations of transference and resistance rather than calling upon their aggression and risking disturbance of their own equilibrium by interpreting from a vantage point that differs from the patient's. This can become an unconscious collusion with the patient that is frequently rationalized as empathic and therapeutic. Aggression can prompt analysts to divert interpretations, for the sake of self-defense, away from their purpose of imparting insight. Masochistic surrender is an extreme of this defensive posture that is often the only evidence by which we can learn how aggression is involved in making interpretations.

The impact upon the process of interpretation of an analyst's defensive efforts ranges from relinquishing the authority of interpretations and uncritical acceptance of the patient's psychic reality, to inhibition of interpretive activity and substitution of some form of gratification, supportive therapy, or corrective emotional experience for interpretation. Legitimate concerns about imposing authority, the possibility of multiple psychic realities or many potential versions of truth, as well as elevation of the concepts of uncertainty and relativism, can become exaggerated, elaborate rationalizations by which an analyst may avoid interpreting resistances.

The dynamic interplay of aggressive motives between patient and analyst over the act of interpretation optimally provides a repeated experience for the patient in constructive handling of aggression. The patient sees that his or her own aggression does not actually harm the analyst, and that the analyst's interpretive

aggression brings no harm. Analysts' problems with the vicissitudes of their aggression in the process of interpretation can become a part of the appeal of "humanistic" techniques, which, by downplaying the role of interpretation and insight for analytic progress, ultimately restrict the patient's opportunity for growth.

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The Wish to be Soothed as a Resistance

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THE WISH TO BE SOOTHED AS A RESISTANCE

BY MORRIS L. PELTZ, M.D.

As the analyst makes the correct interpretations of resistance in the opening phase of an analysis, the patient begins to feel understood, often for the first time. This feeling allays anxiety and depressive affects, and the patient comes to experience the analyst as a soother. These initial exchanges may lay the foundation for a positive transference which acts as a buffer against turbulent transferences. In some patients this positive transference develops rapidly, often with prompt symptom remission. In others—children as well as adults—the analyst must persistently interpret defensive regressions before a stable, positive transference can emerge. In either case, in order to avoid the analysis of conflict, some patients become resistant to the analysis of the wish to be soothed. Many of these patients have had a childhood filled with traumatic parental stimulation or rejection. Two clinical accounts illustrate these contentions.

INTRODUCTION

Often during analysis a transference configuration emerges in which the patient experiences the analyst as comforting and consoling. I will call this aspect of the positive transference the

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soothing transference.[1] This transference may contribute to the forging of an analytic bond and thus help create conditions conducive to the analysis of conflict. In some patients, however, the wish to be soothed by the analyst may develop into an entrenched resistance that limits analytic achievement and, in extreme instances, brings analytic work to a complete halt.

Patients begin analysis for the purpose of obtaining relief from painful feelings. Calef (1987) observed that the recognition and correct interpretation of the patient's initial resistances in the opening phase of an analysis enable "the patient to feel understood for the first time, a hope previously experienced and unfulfilled" (p. 15). This experience of being understood often has a calming effect on the patient. These initial exchanges—the analyst's correct interpretation and the patient's sense of being understood—lay the foundation for a robust, positive transference. From this point of relative strength and safety, the patient is increasingly able to free associate, and derivatives of unconscious conflict can begin to reach consciousness. Ideally, as the analysis progresses, there is an ebb and flow of painful and exciting feelings which become anchored to transference fantasies about the analyst.

During the opening phase of an analysis, patients are understandably resistant to the emergence of irrational erotic and hostile transferences to the analyst. Hence, in the early stages of analysis, the exclusive or dominant conscious transference may be the affectionate transference, which limits the analyst's opportunities to interpret the patient's hostile and/or erotic transference reactions. For example, although feeling friendly toward the analyst, a patient may become excited or angry when describing a current conflictual relationship. On the one hand, the analyst may correctly understand the patient's heated portrayal as a defensive displacement, but judge that it is neither

[1] Soothing transferences emerge during the analysis of both adults and children, but probably more frequently with the latter group.

timely nor prudent to interpret the defense. On the other hand, the analyst may not find plausible evidence that these descriptions of a friend or a lover are displacements. In either case, the task is the same: the interpretation of conflict expressed in the transferences to the love objects and hated rivals populating the patient's life.

Other writers (Brenner, 1976; Leites, 1977; Stone, 1967) have also asserted that the analysis of transferences to the analyst is not necessarily the sole or principal job of the analyst. Blum (1983) recently re-emphasized the value of the so-called "extra-transference interpretations." He wrote that these interpretations

> may include transference to objects other than the analyst, the real relationship to the analyst or other objects, or may refer to the sphere of external reality rather than the psychic reality of transference fantasy (pp. 591-592).

As Blum noted, such "extratransference interpretations" may clarify transference reactions to individuals *other than the analyst.* One must understand that these are *transference* interpretations—but not about the person of the analyst. They often lead to insights which permit the patient to become less symptomatic, less inhibited, and better able to engage in analytic work.

When patients cling to the protective mantle of the soothing transference in order to shield themselves from their more disturbing feelings toward the analyst, the analyst must decide at what point this soothing transference has become a resistance, and make the appropriate interpretation. This judgment may be difficult to make, but if such interpretations are timed correctly, they will permit the patient to understand that he or she is defending against the awareness of other potentially frightening transferences to the analyst. The intent is to enable the patient to give voice to the multiple transferences of the transference neurosis.

THE TRANSFERRED RELATION, THE REAL RELATION, AND INTERPRETATION

Freud (1912) identified a form of positive transference, the so-called unobjectionable transference, which does not need to be interpreted. He wrote that it is "the vehicle of success in psychoanalysis exactly as it is in other methods of treatment" (p. 105). Here Freud distinguished between transference as a facilitating force and transference as a resisting force. I agree with this distinction, but not necessarily with the technical prescription. On the other hand, I do not agree with those authors, Greenson and Wexler (1969), for example, who distinguish between the positive transference and the working alliance. As Gill and Hoffman (1982) have pointed out, such a distinction may be conceptually possible, but in the clinical situation, the positive transference and the working alliance invariably overlap. The same holds true, in my opinion, for the transference relationship and the realistic relationship between patient and analyst. My premise is that transferences permeate every aspect of the patient's relation to the analyst and are constantly shifting from facilitating to resisting phenomena. The *defining* psychoanalytic task, in my view, is the interpretation of these transferences when they become resistances.

There are, of course, well-known authors who conceive of the analytic task differently. In every psychoanalysis, but particularly in the analysis of the more severely neurotic, narcissistic, or borderline patients, the relationship between analyst and patient exerts a powerful therapeutic force. Different schools of thought vary in their explanation of this phenomenon. Some distinguish between the transference and the nontransference relation to the analyst, and attribute a powerful independent curative force to the latter because it permits the resumption of never completed development. Others emphasize the climate of safety generated by the new object relation, a climate which enhances the capacity to analyze conflict, a position similar to my own.

I will cite just a few writers to illustrate this vast literature. Zetzel (1956, 1966) distinguished two different relationships between patient and analyst: a conflictual one, the transference neurosis, and a nonconflictual one, the therapeutic alliance. The therapeutic alliance, modeled on the patient's earliest object relationship, ensures the capacity to tolerate intense dysphoric affects, maintain trust and self-object differentiation, and accept realistic limitations. Zetzel advised that the analyst actively promote this alliance by being sensitive, empathic, benignly mothering, if that is required. This is especially important in the opening phase of the analysis and during times of heightened resistance. Zetzel's therapeutic alliance sounds as if it might describe what I have called the soothing transference. Zetzel and I, however, propose different technical stances. Zetzel advised actively fostering the therapeutic alliance during phases of heightened resistance. I believe that ultimately the analyst must attempt to interpret the patient's fantasy of the analyst as benign mother as a defense against the awareness of conflict, that is to say, as a form of resistance.

Loewald (1960) looked at the relation between analyst and patient from a different perspective. He emphasized that the reality of the analyst as a new object exerts a potent force in the therapeutic action of psychoanalysis. Cooper (1988) wrote that Loewald believed that the analyst, like a good parent, helps the patient to resume development and "to create new integrations on the armature of maturity that the analyst provides" (p. 26). Fogel (1989) described this latter function within the interpersonal field of patient and analyst as "the metaphor of a higher organization (the analyst) in interaction with a lower organization (the patient) in the therapeutic process, with a 'tension' between, across which the patient 'reaches' " (p. 425).

Object relations theorists emphasize the affective bond that exists between analyst and patient. Modell (1988), for example, wrote that

> the psychoanalytic setting cannot be separated from the actual object tie to the analyst. And in turn, this object tie, a type of love relationship, if you will, develops as a consequence of what the analyst actually does, as an analyst, which includes the analyst's feelings toward the analysand to the extent that such feelings are communicated either consciously or unconsciously (pp. 581-582).

This is a critical ingredient of the analytic setting for Modell because it creates the sense of safety the patient requires in order to experience the full range of conflicts in the transference neurosis. This "love relationship" and the sense of safety it generates are not necessarily regarded by Modell as potential transference resistances which will require interpretation.

Self psychologists also emphasize the importance of the analyst as a new object and the security this generates. In his or her empathic stance, the analyst offers himself or herself as the curative force of a new selfobject. Considering both narcissistic patients and "classically" neurotic patients, Kohut (1984) wrote:

> A treatment will be successful because, allowing himself to be carried by the momentum of the analytic process, an analysand was able to reactivate in a selfobject transference, the needs of a self that had been thwarted in childhood. . . . According to self psychology, then, the essence of the psychoanalytic cure resides in a patient's newly acquired ability to identify and seek out appropriate selfobjects—both mirroring and idealizing—as they present themselves in his realistic surroundings and to be sustained by them (p. 77).

While none of the writers from these schools of thought eschew the importance of interpretation as an analytic technique, they all emphasize the therapeutic importance of the object relation between patient and analyst in the "holding environment" (Winnicott, 1955) of the analytic situation.

I prefer to emphasize that, in ideal cases, the patient's expe-

rience of the analyst as protector is a transference fantasy which must sooner or later be the subject of analytic investigation. This view is consistent with that of Gray (1991), who wrote:

> . . . what may be gained if such safety-seeking fantasies can be analyzed instead of used as a silent part of the therapeutic "medium" is achievement of a greater measure of capacity for exercising ego autonomy from unconsciously motivated superego activities (p. 14).

THE POSITIVE TRANSFERENCE AS RESISTANCE

Surprisingly little has appeared in the literature that calls attention to the idea that affectionate transferences, like all other transferences, will require interpretation when they become resistances. Brenner (1976) challenged the idea that there is a "benign positive transference" which need not be interpreted. He described a woman who presented as an ideal analytic case. Her friendliness and ease in social relations, repeated with her analyst, protected her from "[terrifying] (largely unconscious) murderous and suicidal wishes . . ." (p. 114). Stein (1981), in a well-known paper, described a group of patients who were able to attenuate the full force of their erotic and hostile transferences through the strength of the conscious unobjectionable transferences. Although symptoms were frequently resolved, inhibitions, particularly those relating to their sexual lives, remained in place.

> And so they go on expressing their transference feelings, predominantly positive, respectful, and sometimes affectionate, employing the very effective devices of teasing and irony (p. 872).

Stein further commented that "the loving, conscious, unobjectionable part of the transference is directed toward the analyst as the one who soothes, who induces sleep and allows the patient to

feel less frightened . . ." (p. 881). Stein advised that scrupulous attention to the details of the analytic situation may enable the analyst to make the correct resistance interpretations that awaken the patient who wishes to slumber.

Hanly (1982) examined the conscious positive transference as a form of resistance that also appears in a different patient population. In patients with narcissistic vulnerabilities, a conscious affectionate transference functions as a narcissistic defense. It represses injuries to self-esteem, wards off attendant rage, and permits disguised gratifications of the hostility. Hanly described a woman who fantasied taking care of her analyst, whom she imagined to be a lonely old man. This fantasy not only defended against her sexual oedipal wishes, but concealed the transference revival of a father who had traumatically abandoned his daughter after a divorce when she was eleven. The fantasy of her analyst as a lonely old man covertly expressed her wish for her father in his old age. The patients I will portray resemble those chronicled by Hanly. They, too, have suffered from trauma and were narcissistically vulnerable. Neither Stein nor Hanly, however, considered that group of patients in whom defensive regressions result in a clinical picture marked by florid symptoms, impaired object relations, and behavioral adaptations constrained by guilt and self-punitive trends.

The clinical examples which follow illustrate the soothing transference functioning as a persistent resistance in two different kinds of patients. The first exemplifies patients whose symptom pictures at the beginning of treatment include a high level of conscious dysphoric affects. They want relief from their suffering and easily find comfort in their relationship with the analyst. Emotional turbulence often pervaded their development as youngsters and adolescents. They longed to escape from hostile environments. Once these patients achieve a tranquil frame of mind, they may cling to it tenaciously, imbuing the analyst and the analytic situation with near magical power to console and comfort. Associations to and references about the

analyst may be minimal or completely absent. When the analyst points this out, the patient may deny having any special thoughts or feelings about the analyst, and may even become impatient with what appears to be a suggestion to think about the analyst.

If pressed, such patients may acknowledge that they have friendly feelings about the analyst, but see no reason to talk about them because they are not problematic. In some cases, the patients' communications may turn into banal and boring recitations of current events, yet from dreams and unexpected acting out, the analyst can identify the presence of repressed conflictual transferences which have been locked out of the analytic dialogue. For these patients, interpretive persistence and therapeutic patience often resolve what appears to be an analytic impasse.

Patients in the second group may also have had experiences of traumatic overstimulation or emotional deprivation when growing up. Unlike those in the first group, they attempt to find relief from their pain with clamoring demands for gratification, redress, or restitution. The opening phase of these analyses may be quite turbulent. Such patients may react with intense hostility to the analyst's neutrality. Interpretations intended to clarify the wish for enactment with the analyst are ineffective. Initially, it may be unclear whether the manifest behavior is the expression of a regressive defense or of fixation and developmental failure. Here the technical task will often be to use interpretations to facilitate the emergence of the positive transference with its capacity to soothe. If this happens, patients of this second group may subsequently cling adamantly to the experience of their analyst as pacifier.

With patients who seem unable to surrender the image of the analyst as a magic transitional object even for brief periods of time, the analyst must reassess the analysis. Has the analyst been sufficiently aware of and correctly interpreted the patient's attempt to be gratified in order to ward off anxiety (Renik, 1990)? Has the analyst unknowingly colluded with the patient's seeking

to avoid anxiety and depression in a transference-countertransference enactment? There are patients who, in spite of the analyst's persistent interpretive attempts, do not surrender their fantasy of the analyst as a magical protector. These patients, although not engaged in an analytic endeavor as I define it, may nevertheless experience a significant psychotherapeutic improvement. Then the analyst must choose between several alternatives: permit the patient to continue at a standard frequency and use the couch to pursue his or her vision of the analytic task; suggest decreasing the frequency of sessions and engage the patient in face-to-face psychotherapy; or, with regret, confront the patient with the stalemate and interrupt the work.

The Wish To Be Soothed in an Adult

The first clinical case illustrates that some effective interpretive work was accomplished with a patient who persistently experienced me as comforting. Ultimately, this transference fantasy proved to be an intractable resistance to the analysis of the man's hatred of and sadism toward women and his fears of homosexual surrender.

Mr. C, a thirty-one-year-old single attorney, sought treatment, desperately afraid he was about to have an "episode." He knew the prodromal symptoms and dreaded what they heralded. First came the acute anxiety, which was followed by months of depression. During these periods, he had difficulty working at his job and maintaining his interest in women.

In the initial consultation, Mr. C described the events which precipitated the recent anxiety attack. He had placed a bid on a house; then he became giddy and excited, and went out drinking with his buddies. At evening's end, to quell his sexual excitement and calm himself, he sought out a prostitute who masturbated him. When he awoke the following morning, he was remorseful, guilt-stricken, and extremely anxious. Although he

knew better, he was terrified that he had contracted a sexually transmitted disease.

Mr. C vividly remembered his first "episode" ten years before. During his sophomore year of college, he suffered three disasters in rapid succession: a bungled herniorrhaphy which caused a shrunken testicle; an alarming call about his despairing father who had threatened suicide; and the break-up of his first love affair. At the end of that year, while waiting for a train for a weekend at home, he became acutely anxious, felt faint, and was beset by strange and disorienting sensations. The anxiety attack gave way to a depression for which he sought psychotherapy.

Mr. C identified various events of the past decade which triggered symptoms: moves entailing separations from friends and family; fear of the expectations of new teachers and new bosses; and the remorse and deflation he occasionally experienced after masturbating, especially if he had had an unbidden homosexual fantasy or had just watched a pornographic video film.

During the first months of the analysis, Mr. C became particularly puzzled and ashamed about incidents during which he became inordinately angry with service people who he felt had short-changed him in some way. Ordinarily, he was cool and in control of his behavior. As we investigated the symptom, it soon became clear that his behavior was both a defensive displacement and a safety valve for his stoppered, congealed rage. Mr. C expressed his conviction that he had more than sufficient reason for his chronic bitterness. Feeling "short-changed" had a long history.

Mr. C was short, and he became furious whenever he felt devalued because of his height. He said, "I live in my body so I am not aware of it. But I am really appalled when people make an issue of it." He fought to establish himself as a competent athlete in spite of his height. He fought to become a top student in high school, college, and law school. He was fighting to attain partnership in his law firm, but was afraid that he was being incorrectly evaluated by the partners. He believed they were mistaking his quiet, restrained manner for a lack of aggressive-

ness. The stress he felt in his job contributed to the anxiety he experienced.

As the analysis progressed, it became clear that Mr. C did not understand that his lifelong battle to excel was at odds with a powerful wish to be indemnified for the calamities suffered during that second year at college, as well as for his feeling "short-changed" by his parents. He asserted that the continual intense marital strife between his parents had robbed him of every kid's right to grow up in a tranquil, secure family. Nights were the worst. His parents' bedroom adjoined his, and his sleep was regularly shattered by their screaming: mother alleging and father denying that he had been out with his girlfriend. Mr. C would awake frightened and often had stomachaches. Pain or not, he would go into his parents' room and complain of his aches with the real aim of distracting the embattled couple. Although a façade of civility was temporarily restored by Mr. C's nocturnal intrusions, the parents altogether failed to recognize the corrosive effect their fights were having on their son and his three-year-older sister.

Mr. C was particularly bitter about his father's hypocrisy. Publicly, the father extolled morality, emphasizing honesty and fidelity. These virtues often were the themes of the bedtime parables he told his children. In fights with his wife he had righteously maintained his innocence of any marital misconduct, although it was openly acknowledged after the divorce.

Mr. C was also furious with his father because he saw him as pathologically passive. The father did little around the house to help the mother. He continually postponed decisions and actions. The prime example was his father's failure to take any action against the doctor whose surgery had led to the disastrous postoperative sequelae. No confrontation, no apology, and no monetary compensation!

Mr. C was also aggrieved with his mother, who was so often depressed and withdrawn when he was a child. In the first months of the analysis, he remembered a dream he had had when he was a little boy.

> I must have been quite little because the dream involved our old Peugeot. I dreamt that I was in the old Peugeot with my mother, and I think we were driving up toward the school, but we were on a horseshoe-shaped street. It wasn't exactly a cul-de-sac, but my mother left me off at the end of the street, and she drove off without me.

The patient reflected, "I guess I feel the dream has something to do with feeling neglected and battered by my mother."

Were it not for his sister, there would have been no one to comfort Mr. C during those growing-up years. He and his sister half joked that the reason he had suffered more than she was because his bedroom adjoined his parents', and it was he, not she, who heard the constant nocturnal battles.

Mr. C disclosed his yearning to find a woman, "a partner for life," who would be as consoling as his sister had been. He was puzzled that he had failed in this pursuit. He had had many brief affairs, but only a couple of long-term relationships. He and his current womanfriend had planned to move into the house he had considered buying. He now understood that his doubts about the wisdom of that decision contributed to the anxiety attack which preceded the analysis. To live with his friend was to have been the first step on the road to an engagement and marriage. Although sexually excited by her, he was uncertain about the depth of his affection. She did fulfill the requirement that she be comforting. He reported that he liked to put his head on her lap or have her put her head on his lap. Elaborating, he said,

> I just think of those times when I'd be in my room hearing my parents argue and fight. What I wanted most was to have someone come in and hold me and tell me everything would be okay. I spent all of my time when I was a kid trying to be good to help my mother come out of those bad moods she was in after a fight with my father. I think the wish to be comforted has something to do with what a sexual animal I am. Being in bed with a woman, that's the ultimate kind of acceptance and the ultimate kind of mutual soothing. I'm pretty good with the

> women I go out with. I treat them very well. I get positive feedback from them about the kind of good person that I am, unlike my futile attempts when I was a kid with my mother.

He remembered that he was even less successful in comforting his mother after his parents were divorced. He had just had his Bar Mitzvah. He had become a man—but he was no substitute for his father. If anything, his mother became more querulous and withdrawn. Feeling rebuffed and defeated in his attempts to cheer her up, he avoided her as much as possible. He pursued his adolescent quest for autonomy and privacy with a vengeance. He turned to friends, men as well as women, for excitement and comfort.

As the analysis proceeded, Mr. C struggled to understand the many tugs he felt in his relationship with his womanfriend. He came to see that she, like his mother, constantly contended with depression. He became aware of his wish to rescue her from her black feelings. At the same time, he began to identify his reservations about her: although she was a successful professional, he regarded her as inarticulate and not well read. He tried discussing these deficiencies with her. Then he recalled with hatred how his father most effectively disparaged his mother: he would impugn her intelligence. Mr. C now understood that his behavior toward his womanfriend was a veiled and refined edition of his father's criticisms of his mother. And he, like his father, had become a womanizer. Consciously seeking to find an intellectual equal, he repeatedly found instead women for whom he soon developed contempt, and then lost interest in.

As Mr. C became more aware of his skepticism about his friend's suitability, he became frightened of being trapped in a loveless marriage. This worry was part of the day residue of a dream whose manifest content was triggered by the gang attack on a jogger in New York's Central Park. The dream was as follows:

> I was involved in a situation like that. A bunch of guys were chasing a group of girls. I was also being chased, and I was

> friendly with these girls. I was protecting them. The bunch of guys caught up with me, and I was trying to protect the girls from being taken away, but I couldn't protect them. Were they being beaten up? Were they being sexually assaulted? I saw the faces of the assailants, and I knew them. I couldn't do anything because I was cornered by this one guy. I became this guy's sexual prisoner. Both he and I were lying or sitting on the ground with no clothes on. He made me have sex with him, but it was restricted to mutual masturbation. In the dream, I was thinking two things. It was as if I were touching him, but it didn't feel any different from me masturbating myself. The other thought in the dream was that I had an orgasm, but it was not an enjoyable one. A reluctant orgasm. I ejaculated without pleasure. It was clear in the dream that he was forcing me to do this as his captive.

Mr. C's associations to the dream included his fear of hurting his womanfriend, as he contemplated breaking off their relationship. He noted with anxiety the occasional homosexual fantasies which intruded when he masturbated. Nowhere in his associations, however, were there any references to me or to the analysis, which had been in progress for about a year.

On more than one occasion, I had suggested to Mr. C that it was inevitable that he would have thoughts and feelings about me and the work we were pursuing. He acknowledged the plausibility of this, but ideas about me never occurred to him. I interpreted that he must experience me and my office as comforting and soothing. I had become a source of the solace that he had always longed for and had found rarely in his mother, sometimes in his sister, and often in his womanfriend. He might be reluctant to have this feeling disturbed in any way. He concurred, but my repeated versions of this interpretation did not lead to his experiencing me in any way other than consoling.

I reflected on this one-dimensional view of me, with its exclusion of other transference reactions. I concluded that the work we were pursuing was nevertheless resolving some conflict through limited insight. We had analyzed some of the barriers

he had erected against distressing affects, and he came to experience them without feeling overwhelmed. Some motivating maladaptive unconscious fantasies had been identified. Mr. C understood how current anxiety could evoke depressive affects originating in the calamities of his childhood and adolescence. Some of the unconscious sadistic transferences to his woman-friend were analyzed, thereby freeing Mr. C of potential bondage to her. There was a persuasive revival of the past in the present as confirmed by memories. He confessed to a brief episode of sex play with his sister when he was eight. She was the prototype of the woman he longed to find: a soother and an exciter. We discovered his unconscious identifications with his womanizing, misogynous father. His kinship with his long-suffering mother and his passive homosexual longings remained unknown to him.

In the six months prior to the interruption of the analysis, Mr. C pursued the same course: analyzing conflicts enmeshed in transferences to persons other than the analyst. For example, he had been assigned primary responsibility for preparing a complex legal brief in an area in which he had had little experience. He was furious with his boss and felt vulnerable to anticipated rebuke and criticism. With this day residue, he reported two dreams.

> Some man has been making anti-Semitic slurs against me. I had him up against a wall, pummeling him physically. I seemed to be also verbally abusing him.

The second dream, initially described as having to do with his operation, was remembered with some difficulty.

> I am in bed with a woman. She is fondling my scrotum and begins to—and this is difficult to describe—untangle my testicles. In untangling them, I realize I have three or four testicles.

After telling the dream, Mr. C laughed, noting ruefully that he is always aware of his shrunken testicle when having intercourse because it is tender and occasionally painful.

I told Mr. C that I believed he was frightened of his anger at his boss and that he feared being punished for that anger. There was no greater punishment than his shrunken testicle.

Although dubious about the interpretation during the hour, Mr. C remembered two instances later that evening which confirmed it for him. When he was nine, at the Bar Mitzvah of an older cousin, Mr. C was persuaded by a group of boys to take a drag on a cigarette despite his many compunctions. The next day when he fell from his bike and broke his leg, he wondered if God had been watching and judging. As a young adult, Mr. C found himself musing in a similar fashion. The summer after his freshman year of college, Mr. C and his womanfriend engaged in coitus—the first time for both of them. Afterward his womanfriend cried, overcome with guilt. Only a couple of months later, Mr. C had the calamitous herniorrhaphy. He wondered once again about divine punishment.

When Mr. C was obliged to set a termination date because he was moving to a distant city, he began to talk about our work together. He was saddened to interrupt the "process," as he called it. It had been so helpful and illuminating. He spoke of feeling guilty about leaving me—much as he had felt guilty about leaving his mother after graduating high school, I interpreted. This was the first evidence of a consciously conflicted transference to me.

While I certainly wondered to what extent Mr. C's decision to move was motivated by the need to flee from the experience of conflictual transferences, I was largely convinced that the move was not primarily a rationalized form of resistance, however much it served as a support to that aspect of his response to analysis. It is clear that the transference resistance I have described remained in force and limited the analytic achievement. It is impossible to say whether it would have yielded in time, thus later permitting a more conventional transference neurosis to emerge. In my view, some genuine analytic progress was achieved during the twenty months we worked together, despite

the persistent exclusion of erotic and hostile transferences to me from the analytic field.

Developing a Soothing Transference in a Child

For my second illustration, I will describe the first half of the nearly five-year analysis of an eight-and-a-half-year-old boy who was depressed, regressed, and helplessly excited when we began our work.

The challenge and the hope in the prolonged opening phase of the analysis was that interpretations could explain to this boy the reasons for his anger and his silly, often wild, behavior. In fact, the insight he acquired enabled him to relinquish his regressive stance, and his transferences became both less hostile and less erotic. But after the positive transference was established, it also proved to be a formidable resistance.

The starkness of Andy's initial depression was apparent in his parting observation as he left the first consultation. Fingering a dent in the side of a toy rubber cow, Andy reflected with little emotion, "Skinny cow. No milk." Andy was having severe troubles at home and at school. His parents and his teachers were despairing and had little hope for his future. His virtual inability to read aggrieved his intellectual parents, as did his destructive behavior at home.

When he was not acting the clown or the demented fool, he was furious, and his temper erupted in volcanic outbursts. He would so tease his sister, Janet, fourteen months his senior, that she would yell, "Stop! You're crazy." This only infuriated him further, escalating the turmoil. He had an aloof relationship with his mother, and turned to father when he needed help with his homework, but the exchanges with father frequently ended badly. Andy often regressed, became silly, and would attempt to slobber over his father like a dog. Indeed, his most constant companion was the family dog with whom he would roll on the floor, rubbing her vulva with mounting excitement. Andy could

be sweet without becoming silly only with Peggy, his younger sister. He was forever preoccupied with standards of fairness and justice. He was terrified of shots, of being contaminated by germs from his mother and sisters, and of being arrested by the police.

Many of the dynamic and genetic factors of Andy's psychopathology could be inferred simply from the initial history. In contrast to mother's experience during the labor and delivery of Andy's older sister, her labor with Andy was long, frightening, and painful. A month after Andy's first birthday, his mother became pregnant for the third time, an event which marked the onset of Andy's developmental disturbances. He was very slow to acquire speech: he was two and a half before he began using words, three and a half before he could be easily understood. (He had residuals of infantile speech when he began his analysis.)

Because Andy was such a cheerful child, his mother believed he could do very well on his own, freeing her to take care of her new baby. Toilet training began shortly after Peggy's birth. Although Andy easily gained bladder control, he had great difficulty regulating his bowel movements. He frequently became constipated, retaining stool for two or three days before having a painful bowel movement. This symptom was, in fact, resolved by his mother's correct, interpretive response to a question Andy asked when he was three. "I'm not going to have a baby, am I?" "No," answered mother, "boys and children do not have babies." By this time his mother felt she had lost all emotional contact with Andy, who, she claimed, had become distant and self-absorbed.

When I first saw Andy, he was a sturdy, well-built boy whose good looks were undermined by his mien of a mentally retarded youngster. His clothes were dirty and shabby, and his face distorted by a vacuous grin, with saliva dripping from the corners of his mouth. He claimed to have no idea about any problems he might have, insisting rather that what he really needed from me

were gifts of money. For months he begged me for a dollar. "Please, won't you say yes. I'll do anything you want if you give me that dollar bill." Many times I interpreted his hope that I could make him feel better with gifts so he would not have to know how frightened and sad he felt. He became angry at my refusals. He threatened and sometimes attempted to damage and destroy objects and furniture in the office. When I asked him to tell me about his angry feelings, he typically would fill his mouth with wads of Kleenex which both gagged him and dramatized the fantasy that I was filling his mouth, sating his appetites.

The analyst of children, unlike the analyst of adults, must occasionally interact physically with the child to limit sexual and aggressive displays. I did not feed Andy or give him the money he demanded. I did not let him search my pockets and would not let him destroy my office and its contents. He was unable to engage in symbolic play or games which could have permitted him to express his feelings in a more socially conventional fashion. In fact, he had a very hard time settling down long enough to engage in any phase-appropriate latency activity.

Only after many months did Andy begin to play a game which seemed to comfort him—hide-and-seek. There was no place in my office which concealed his large frame, but that did not make any difference. He hid, I found, and he was happy. He did not easily brook my interpretations of his wish to hide frightening or sad ideas and feelings. He was not at all impressed with my notion that his pleasure in my finding him must be like the way a lost child feels when he is found by his mother.

These interpretations apparently helped Andy to diminish his need for the defensive regressions which fueled his enactment attempts. Andy began to play cards. Occasionally he played with me, but his favorite card game was clock solitaire, which he played with quiet concentration. Deeply immersed in the game, he did not respond to my comments or questions, but he was calmed. He had found a way to soothe himself, and peace

reigned in the office. His newfound capacity to soothe himself, coupled with the increasing comfort he felt in my office, permitted me to undertake analytic work in a higher gear.

It became possible to understand the fantasies and affects which precipitated Andy's demands and regressive flights. Becoming bored with card games, he switched to making paper airplanes which he sailed through the office hoping he could fly them out the window, both in spite of and because of my request that he confine their flight paths within the office walls. As he continued this play intermittently over several months, we identified that his airplane industry was busiest around the times his father was about to depart by plane on a business trip.

When his father left for a two-and-a-half-month trip during the second year of analysis, Andy not only doubled his aircraft production, but disclosed some fears he had. He was worried about mental patients who killed presidents. "Do you see mental patients?," he anxiously asked. He next dictated a story to me about a messy boy who left home because his father got mad at him. The boy spent the night in a church, terrified as he watched cats eating rats. Soon Andy asked me to draw a picture of a serial killer, then retracted the request and made the drawing himself. He said of his picture, "He's drunk, so he's crazy in the head." He captioned a second drawing of a balloon-headed monster with a serrated head and huge teeth, Time Bomb. "That's a picture of me," he reflected aloud.

As the analysis progressed, Andy stopped begging for money and instead began begging for answers. I interpreted that no matter how many questions he asked, and how many times I answered, he could never feel full and reassured about his worries and sad feelings.

Andy next began enacting his demands for answers in a teasing game which replaced his whining verbal appeals. He frequently darted out of the office, claiming he had to go to the bathroom. Instead he would hide outside the door, peeking at me through the crack. During one of the many hours in which

he played this game, he excitedly reported watching a couple get married on TV. But he was indignant that "Here Comes the Bride" was not played.

I talked with Andy about his wish to spy on me. I told him that it might not only be his attempt to get answers to his questions, but might also be connected with something which had really happened but had confused him. I amplified, "I can imagine you peeking into a room, and you weren't sure what you were seeing. [His mother had told me that for a long time Andy was convinced he needed glasses and occasionally wore lensless spectacles around the house.] You rubbed your eyes. Maybe they burned. Perhaps you saw something going into or coming out of a person's mouth. You were frightened and wondered how much you had seen and how much you were imagining."

Andy partially confirmed the construction in the following way. He argued, "No, that didn't happen, but I did see once, I can't remember where it was, this guy who put a sword in his mouth. Except the sword kinda rolled up on itself like this tissue does, though it really wasn't going inside of him." He added parenthetically, "But I didn't tell you my eyes burned when I read too much—I told you they hurt." Sometime later Andy confirmed yet another dimension of the construction. He remembered when he was about four, he wanted to look into a darkened horse trailer. His father picked him up so he could look over the tailgate. Out of the darkness, a dog leapt at him, biting him on his face near his eye.

The occasions when Andy actively participated in the analytic work were like brief melodic interludes in an otherwise minimalist composition. When he was not insisting that we play quietly without talking, he would busy himself folding origami birds intended as gifts for his mother. Yet the transference wishes asserted themselves, and the begging frequently recurred. When the anger and frustration got the upper hand, Andy would wage a war of stony silence. I told him he was not giving me anything because I was not giving him anything. I

must seem much like his teachers at school and his mother at home. I wouldn't give him things because I was stingy and because I preferred girls to boys.

Andy immediately knew what I was talking about. In repeated instances, he insisted that I close my eyes so he could scamper into my lap to hug me and talk to me in a girlish falsetto voice. His dreaded wish to be a girl—to be loved and filled with babies—was dramatized more frankly in play after his dog became pregnant. Andy lay on my couch, encircling with his arms the space above his abdomen. The fantasies were enacted in the transference as Andy came to hours with his pockets stuffed with sundry items. He insisted I guess what was inside of his pockets, just as he was constantly guessing at how many pups his dog would have.

The wish to be a girl, and pregnant, evoked fantasies of a dangerous punishing mother. He recounted ghost stories to me. His favorite was "The Monkey's Paw," in which the first of three wishes granted to a mother results in the amputation of her son's hand, and the third leads to his death.

Andy's fear of his mother (and his warded-off love for her) were recurrent themes in this long and successfully concluded analysis. He became more affectionate and less sullen with his mother. She was able to respond reciprocally. In the comfort of their newfound relationship, the mother confessed to me a secret she had consciously withheld. She acknowledged her responsibility for the emotional disengagement between herself and Andy when he was a toddler. Andy had become identified in the mother's mind with her older brother who had died when she was three years old. The mother had grown up increasingly embittered that she had never been able to compete with the memory of the dead idealized brother for her parent's love.

Andy's insistence that we play soothing games and his begging receded toward the end of our work. Only with the greatest reluctance did he give up his wish that I be a comforting, all-giving mother (and father) who would make restitution for all the calamities he had suffered: the loss of his mother as she

withdrew from him after his sister's birth; the loss of feces fantasied as body parts and babies; the loss of love as punishments for his regressive sexual behavior.

Persistent interpretation of his wishes to be fed and soothed permitted Andy to experience his deep anger and frightening sexual feelings. This was a first step which led to the emergence of multiple transference configurations that could be analyzed. Andy wanted me to soothe and comfort him so that he would not know about his hostile and competitive wishes toward members of his family. He wanted a soothing mother to protect him from his fantasy of exciting exchanges with a sexually aroused but castrating, blinding mother—a fantasy enacted with the family dog. The soothing transference was to have been his blanket which would magically shield him from forbidden desire and dreaded punishment.

DISCUSSION

Soothing transferences, like other transferences, are condensed, complexly organized compromise formations. They sustain the conviction that the analyst is a benign and protective listener who is not exciting, dangerous, critical, or judgmental. The central figure of this soothing transference is usually an idealized image of mother or father which is neither sexual nor hostile. This mental representation of the neutral benevolent parent, who consoles and calms, sustains the illusion that the analysis and analyst will always be a safe haven. The soothing transference shares with other transferences the following qualities: it is amalgamated from real experience and from fantasy; it has conscious and unconscious content; it is elaborated throughout development; and it is intended to ward off forbidden fantasy and/or to repair the effects of trauma.

Current psychoanalytic technique correctly emphasizes the meticulous analysis of the multiple erotic and hostile transferences to the analyst—the transference neurosis. Nevertheless, some conflict can be analyzed when the patient experiences the

analyst as soothing or comforting. During these intervals, the analytic task is frequently directed to an examination of the patient's current conflictual relations. These conflicts are often enmeshed in the patient's emotional reactions (which include unconscious transferences) to important persons other than the analyst. Although some of these reactions are frequently defensive displacements from the analyst, sometimes they are not. In some instances there are transferences which a patient will never experience with his or her analyst, but only with a spouse or children, for example.[2] These transferences can be profitably analyzed and can yield important insights. Yet the analyst must be aware that sustaining a sense of comfort may become an end instead of a means for the patient.

Many patients beginning analysis easily develop a positive transference. From this emotional position, they disclose the constructed narrative of their lives. Freud (1914) observed this phenomenon and wrote:

> If the patient starts his treatment under the auspices of a mild and unpronounced positive transference it makes it possible at first for him to unearth his memories just as he would under hypnosis . . . (p. 151).

The opening phase of Mr. C's analysis conformed to this description. Biographical fragments intertwined with descriptions of current conflictual relations. Analysis of these conflicts and considerations of dreams revealed, as in a developing photograph, the emerging images of motivating unconscious fantasies.

With patients who have more severe psychopathology, turbulent affects, paranoid trends, and enactment demands may dominate the opening phase. It may be a while before an affectionate transference appears.

[2] Martin Willick, in a CAPS discussion, first brought this phenomenon to my attention. He described his work with a woman who had achieved a great deal in her analysis but was never able to experience any hatred toward her analyst—an emotion which frequently erupted in fights with her husband.

Children and adolescents often require specific age-appropriate techniques. The analyst, to the best of his or her ability, tries to stop overt sexual and/or aggressive behaviors, as I did with Andy. Latency-aged children are offered the opportunity to play games, which, if not too competitive (and with generous permission for cheating), provide the ambience in which the positive transference appears. Adolescents, terrified of their sexual feelings and perverse fantasies, may initially need to be engaged in more neutral conversations which demonstrate how the analyst thinks and works.

I would like to emphasize that I did not depart from standard analytic technique in my work with Andy. Such departure would have been required had I believed Andy suffered from significant developmental defects. It was not clear at the onset of the analysis whether, for example, Andy had developed the capacity to modulate his affects and use them as signals for defense (Tyson and Tyson, 1990). Nor was it certain that his profound disturbance in his preoedipal relation to his mother was responsible for his symptoms, which also characterize a developmental syndrome of "problems in abstraction, language, impulse control and control of instincts, and problems of relating" (Hansen in Panel, 1985, p. 642). If this had been the case, a more aggressive interventional approach would have been warranted.

Although vastly different from each other, Mr. C and Andy had several things in common. Both had mothers who were episodically unavailable. Mr. C's mother was self-absorbed and withdrawn in her depressions. Andy's mother was distant and aloof because of her transference to Andy as the living ghost of her dead brother. Both Mr. C and Andy were traumatized by primal scene excitements. Both longed to be compensated for the real calamities they had endured and for their imagined injuries. Both had sisters who could be comforting. Yet Mr. C and Andy differed in their capacity to extract solace and comfort from the people in their lives. Mr. C developed this capacity to a high art. Except for his sister, Andy was almost universally in conflict. His initial transference reactions to me were simple

displacements of his provocative, begging, silly interactions at home and school. But once Andy could feel comforted by me and could find solace in himself, he, like Mr. C, tenaciously hung on to the soothing transference. This transference resistance in both man and boy consciously conveyed the nonconflictual wish to be calmed by a parent. At the same time, this transference regressively defended against frightening feminine wishes to be my girl or my woman.

When Andy began his analysis, he had little hope that he could ever soothe himself or be soothed by his parents. He had no expectation that he would be soothed by me. His self-esteem had been seriously impaired not only because of his damaged relations with his family but because of his school failures and his inability to obtain age-appropriate mastery over his drives. He believed that his only hope for comfort and salvation was through restitution in the form of gifts. Both interpretation and a neutral analytic stance (in word and deed) informed Andy that he could not hurt me, destroy objects in my office, slobber over me, or extort gifts from me. He also learned that I would not hurt or punish him for these behaviors.

The early analytic work, aided by the innate propensity of children to proceed developmentally, enabled Andy to understand there would be no sexual or hostile exchanges between us. Anxiety and depression-driven defensive regressions abated, and, grudgingly, Andy began to like me. He could feel comforted by me and play games with me, as well as comfort himself (through clock solitaire). From the safe surface of the positive transference, Andy could jump in occasionally to analyze the resistances to additional work. We began to understand the inroads his conflicts had made on ego functions, which ordinarily operate at a great distance from conflict: his ability to look, to see, to read, and ultimately to think and understand.

When Andy became less fearful that he was a demented killer who could be banished, arrested, or eaten, I was able to construct for him the primal scene which had so terrified, excited, and confused him. He now understood that looking and com-

prehending had threatened to evoke terrible anxiety. With this insight, Andy's fear about the analytic work, with its explicit task to think and understand, diminished. He felt calmed, and he could feel affection for me. This positive transference alternately gave way to other transferences (his wish to be my girl, for example) which could then be analyzed. Yet, for long stretches of time, Andy wanted a detour around conflict via the safer waters of the positive transference.

In contrast, Mr. C developed a character trait that enabled him to give and extract feelings of solace. He had become a soother! This trait served him adaptively in his love relations with women and in his work as a legal mediator. It participated in a cluster of defenses against the conscious emergence of his hostility and sadism toward women. It also helped repress his homosexual longings, permitting him to engage in congenial relations with colleagues and with me. It is not at all surprising, therefore, that he would so readily experience me as a soother. This early transference experience undoubtedly accounted for the rapid remission of symptoms once the analysis began.

But Mr. C wanted more than symptomatic relief. He genuinely wanted to investigate the reasons for his recurrent "episodes." He harnessed his prodigious intellect (uncompromised by conflict) to commence the task. Although the early months of the analysis were filled with detailed accounts of the real calamities of his life, these narratives were testaments to his unconscious wish that he be recompensed for his misfortunes and that the calamities be magically undone. Nevertheless, as the intensity of his anxiety and depressive affects receded, he began to free associate and to achieve insights that led to behavioral change. This took place as we analyzed his transference reactions to friends, family, lovers, colleagues, and bosses. The unanalyzed soothing transference facilitated this early work. Had the analysis continued, the dominating soothing transference might well have become a formidable resistance to the analyses of those conflicts which had the potential of evoking intense anxiety. As an example, I refer to the "gang attack on

the jogger" dream whose manifest content—a rapacious assault and homosexual surrender—disclosed the crimes and punishment which terrified him.

My clinical judgment, based on the myriad assessments one always makes of a patient's readiness to begin to deal with threatening unconscious contents, led me to think that attempting to utilize this dream as an avenue to the interpretation of his feminine transference to me would have been premature. I was uncertain at the time, and remain so even in retrospect, about whether Mr. C could ever have dealt with his feminine identifications and wishes, and the dangers they posed for him. The calamity of his atrophied testis at the hands of a doctor, no less, might well have lent such a quality of reality to the fantasied threat of castration as punishment for forbidden wishes that it permanently precluded the possibility of analytic modification of Mr. C's vengeful superego. Such questions, of course, cannot be answered. In any event, during the relatively brief period in which we worked together, the soothing transference remained preeminent, functioning as both resistance and facilitator to the analytic task.

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THE PSYCHOANALYTIC VIEW OF PHOBIAS

PART III: AGORAPHOBIA AND OTHER PHOBIAS OF ADULTS

BY ALLAN COMPTON, M.D.

This is the third part of a review and commentary on the psychoanalytic literature on phobias. This section takes up agoraphobia and other phobias of adults, and suggests further avenues for interpenetration of psychoanalytic and psychiatric approaches.

Part I of this work reviewed and discussed Freud's theories of phobias and anxiety. Part II took up the psychoanalytic literature on phobias of infancy and childhood. This section deals with psychoanalytic contributions on agoraphobia and other phobias of adults.

Agoraphobia

In the infantile phobia literature the most prominent issue is: By what criteria does one decide whether a phobia is present? The foremost issue in the literature on agoraphobia is: What determines the specific symptom choice? I shall focus again only on certain presentations which serve to document hypotheses or to highlight main issues, rather than striving for a truly comprehensive review.

It will be recalled from Part I that Freud offered only a few comments specifically on agoraphobia. It begins, he said, with

an anxiety attack and is part of the anxiety neurosis;[1] it has some special relation to pleasure in locomotion; it is relieved when the patient is accompanied by a special person; fear of sexual temptation, and therefore, at base, fear of castration by the father, plus "temporal regression" to an infantile state, sometimes to an intrauterine state, constitute the mechanism of agoraphobia.

Freud did not publish any clinical material on the analysis of an agoraphobia. There was the brief vignette in the Fliess correspondence mentioned in Part I (1897), which suggested a traumatic-psychodynamic (that is, hysterical) cause for the fear of going into stores alone. An extended footnote was included in *Studies on Hysteria* as an example of Freud's "pressure technic" (Breuer and Freud, 1893-95, pp. 112-114, n. 2) in a case of "anxiety neurosis (agoraphobia, attacks of fear of death, etc.)" in a woman of thirty-eight, which Freud seemed to understand as the result of a "hysterical identification" with a dead friend, somehow connected with the patient's menstrual period, at age eighteen.

Much later (1919) Freud suggested, following Ferenczi, a necessary modification in technique for the treatment of phobias.

> One can hardly master a phobia if one waits till the patient lets the analysis influence him to give up. . . . Take the example of agoraphobia. . . . one succeeds only when one can induce [agoraphobic patients] . . . to go into the street and to struggle with their anxiety while they make the attempt (pp. 165-166).

He also gave a related description (not explanation) of the development of agoraphobia:

> For instance, an agoraphobic patient may start his illness with an attack of anxiety in the street. This would be repeated every time he went into the street again. He will now develop the

[1] It is not clear whether or in what degree Freud maintained this position after 1910.

> symptom of agoraphobia; this may also be described as an inhibition, a restriction of the ego's functioning, and by means of it he spares himself anxiety attacks (1933, p. 83).[2]

Abraham, writing well before Freud published the last of the statements just listed (1913a, 1913b), mentioned a number of cases of "locomotor anxiety," which he also called "street fear" and "topophobia" (following various earlier authors). He offered the theory that these people have the usual incestuous fixations common to all neurotics, plus, following Freud, a constitutional predisposition to "pleasure in movement," which causes the particular symptom selection—that is, pleasure-seeking impulses which are conflictual come to involve locomotion because it is a preferred pleasure mode. Predisposition to pleasure in movement is offered as the determinant of the specific "choice of neurosis." Relief of street anxiety when the patient is accompanied by certain other persons is taken as a uniform feature, although unexplained. It would appear that this relief was seen as a manifestation of regression secondary to the failure of other defensive operations.

Early case reports appeared in German by Cohn (1928) and Deutsch (1928). Deutsch, writing after Freud's introduction of the ego-superego-id model and his revision of anxiety theory, in what has become the classic psychoanalytic paper on agoraphobia, briefly reported four treated cases. She described the content of the patients' fears as a fear of sudden death and said it was typical that the anxiety was alleviated by the presence of a companion. Deutsch accepted Freud's idea of a predominantly phallic-oedipal conflict picture, but added, to the general theory of warded-off sexual trends, the idea of heightened, warded-off aggression (sadism, death wishes) toward both parents as rivals, and a strongly masochistic orientation of sexual fantasies (including both copulatory and birth fantasies).[3] She emphasized

[2] If this were taken as a complete description, the implied explanation would be a conditioned fear response.

[3] This appears to be a suggestion as to why agoraphobia occurs predominantly in women.

masochistic identification with the mother as a devalued object, and she considered this identification with the object of hostile tendencies to be the characteristic element in agoraphobia (p. 114). The compromise formation takes the form of street anxiety because the street = sexual temptation = masochistic tendencies = identification with the object of aggression = prostitution. Deutsch also found especially strong exhibitionistic conflicts to be characteristic of her agoraphobic patients, again manifested as sexual temptation in public places.

The symbolic equivalent of prostitute-street walker, plus a feminine-masochistic drive disposition, thus appears to determine the specific choice of neurosis. In comparison to Abraham's idea, agoraphobia in Deutsch's theory depends more upon symbolization of conflict or unconscious fantasy. Deutsch suggested that her answers were less than complete, and subscribed both to Abraham's locomotor theory and to the (undefined) idea of a "predisposition to anxiety." She did not allude to Freud's *aktual* neurotic hypotheses. One of Deutsch's patients consciously recalled hearing her parents involved in sexual intercourse when she was a small child; otherwise, Deutsch does not mention "primal scene." She did see a "common ground" with other phobias in the projection outward of an inner danger.

Weiss (1935) cited considerable experience (more than twenty cases) in the analysis of agoraphobic patients. He made the interesting observation, though he demeaned it, that the outbreak of agoraphobia seems to be determined by "certain superficial factors," which he categorized as the patient's being required to "take a step forward in the direction of independence" (p. 65). Not surprisingly, he concluded that the street fear or fear of going out of the house usually has three "principal meanings": (1) "I am emancipated. I can do as I please" (which he equated with a fear of sexual temptation); (2) to display oneself in public (exhibitionistic temptation or conflict); (3) detachment from maternal protection. What Weiss added as a specific determinant of the symptom choice was his emphasis on the "superficial factor,"

perhaps more symbolically represented by the street or by leaving the house. Deutsch (1928) had mentioned this idea in passing and much later Ruddick (1961) also connected the outbreak of agoraphobia in three cases with life events in the category of increased independence or adult responsibility, especially marriage and parenthood.

Weiss (1935) distinguished two origins of agoraphobia: "Usually, agoraphobia arises out of a so-called anxiety-attack or, more rarely, out of a traumatic hysterical attack" (p. 64). For such patients, anxiety attacks are "confined to the emotional sphere . . . [and remain] without motor expression. . . . (in contrast to those suffering from true hysterical attacks) . . ." (p. 64). Apparently, he saw the anxiety attack as devoid of psychic content, that is, without conscious or unconscious meaning, "an internal traumatic experience" (p. 64). Thus, unlike Deutsch, he was apparently adhering to Freud's idea of *aktual* anxiety at this point. He also distinguished between two kinds of phobias: those in which there is an exaggerated fear of a situation or animal, which is seen as a real danger; and, on the other hand, agoraphobia, which seems to start with anxiety attacks and becomes only indirectly related to an external situation. Somehow, Weiss concluded, in contrast to Deutsch, that projection is prominently involved in the first type and minimally involved in agoraphobia. What the agoraphobic patient feels, Weiss said, is the continued threat of an attack (p. 71).[4]

Weiss did not attempt to relate this hypothesis to his "superficial factor," and there consequently appears to be a contradiction. If agoraphobia is precipitated by a step into adult life, as it were, and if the symptoms have the meaning of dangerous sexual temptations and defenses against them in one's emancipated state, then how can the anxiety be without (even unconscious) content? And why would one say that the patient is afraid of

[4] Here, again, is a striking similarity to the theory embedded in DSM-III-R "Panic Disorder with Agoraphobia."

another attack and only that? These seem to be two incompatible theories combined as one, or, perhaps, once again, a mixture of a descriptive view and an explanatory attempt.

Bergler (1935) reported the analysis of a thirty-two-year-old agoraphobic woman, with gradual onset of symptoms over several years, a severe intervening depression, and eventual inability to leave the house without a companion. The agoraphobia began when she gave up a relationship with a highly unsuitable partner and worsened when she began a relationship with another, even more unsuitable, as Bergler saw it. He felt this analysis confirmed the factors suggested by Deutsch (masochistic identification and exhibitionistic conflicts) and Abraham (pleasure in movement), as well as by Freud (sexual temptation, castration fear, regression to an infantile mental state). He added an important role for an unconscious sense of guilt and called attention, for the first time in the psychoanalytic literature, specifically to the association of agoraphobia and depression.

Eisler's patient (1937) developed an agoraphobia following a "panic attack" at age twenty. The difficulty of categorizing phobic content is clear in this case report: the patient initially panicked on a train, thought she was going insane, and subsequently dreaded entering closed places or any situation from which there was no ready exit; she also could not go on the street alone. The phobic symptoms vanished within a few months of starting treatment (unlike some of the cases reported by Deutsch, Weiss, and Bergler, discussed below). She also had obsessional symptoms, however, and later on developed a fear of eating in restaurants, which caused her to return for further analysis. Eisler called this a case of "multiple phobias." In fact, such multiple and seemingly incompatible fears (closed places and open places) are regularly found in agoraphobic patients.

Hitschmann (1937) and Katan (1937) also reported cases of young women with agoraphobia. Katan added several details which are relevant to other areas and more recent work. Primal scene experience seemed to her necessary to account for the

anxiety. This appears to be an alternative to the hypothesis of *aktual* anxiety or Deutsch's hint of a "predisposition to anxiety," in the sense of anxiety being generated in the present with no justifiable psychic content, conscious or unconscious. She noted variation of the meaning of the phobic situations (street, bridge) at different points in the analysis (see my discussion of Tyson's 1978 paper [Compton, 1992]). She also said, following Ferenczi and Freud:

> To recognize and interpret this symbolism is of as little therapeutic value as is purely symbolic dream interpretation. Only the interpretation that the stubborn clinging to her agoraphobia simultaneously served as a safeguard against the dreaded re-displacement on to her infantile conflicts was therapeutically effective. The first interpretation explains only the contents of the anxiety, the second reveals its function and, in conjunction with the first, implements the therapeutic goal (p. 49).

Such insistence that the patient "do something" about her phobic symptoms amounts to what is currently called "exposure."[5]

Katan also, following Freud's idea that the central mechanism in phobia formation is displacement, attempted to augment understanding of agoraphobia at a theoretical level. She saw what we ordinarily think of as "transference," and also the formation of other adult relationships, as manifestations of the mechanism of displacement. The detachment of sexual desire from its infantile objects at puberty is accomplished by displacement, a defense mechanism. She saw the operation of displacement in that developmental circumstance as irreversible, because, she said, the transformation extends to the id, but otherwise is the same as other displacements. These ideas raise some difficult issues which will require discussion.

Fenichel (1944), apparently on the basis of the literature cited

[5] I. M. Marks (e.g., 1987) presents extensive evidence that exposure *by itself* causes agoraphobic symptoms to disappear, that the effect is lasting, and that no "symptom substitution" occurs.

here thus far, as well as his own work, differentiated agoraphobia from other phobias on the grounds that it is a projection of excitement, an externalization of an inner danger, rather than a substitution by displacement of one external object for another (p. 314). He recognized that the presence of a companion for relief of anxiety is not an invariable, and therefore not an essential, feature of agoraphobia (pp. 314-315). He also suggested that a specific conditioning may be (secondarily) involved in agoraphobias (p. 321).

It is not hard to see that different authors had clearly different and sometimes opposing views of the role of projection and/or externalization, apparently based on different concepts of anxiety and admixtures of hypotheses from the topographic and structural models of the mind.

Miller (1953) reported analytic data on a thirty-five-year-old woman with severe agoraphobia and attempted to synthesize earlier contributions to the clinical theory of the condition. This patient's mother apparently had an extended affair, with sexual liaisons taking place during the daytime at home. The patient's experience of these "primal scenes"—listening outside the bedroom door, with feelings of curiosity, envy, and isolation—provided the organizing theme of the analysis. The patient was prone to creating situations in which *someone else* was forced to experience those unpleasant feelings. This was manifested, for example, by provoking her husband's jealousy of the analyst. Her husband was maintained as a maternal transference figure. Curiosity (voyeurism) and warded-off exhibitionistic urges were very prominent features. Miller interpreted the street fear, following a suggestion by Deutsch (1928), as a manifestation of an infantile fantasy of giving birth. The strength of the erotic impulses in the analysis is especially noteworthy.

Passionate expression of sexual impulses in the analytic situation was also noted by Weiss (1935, 1964) and perhaps by Wangh (1959), who reported on a patient who had agoraphobia with panic attacks. He chose to de-emphasize anxiety and defense in favor of a focus on drive and object development and,

especially, on the superego—a "structural approach." He thought that his patient had tendencies toward impaired drive control that are shared by persons with "acting-out personalities." What seemed to promote the formation of the phobia *instead* of acting out were: (1) her mother re-enforced patterns of avoiding tension and substituting objects; (2) her reality sense was good; and (3) she had strong defenses against masochistic strivings.

Since the patient did not act upon her impulses, "passionate strivings" seems more appropriate to me than "impaired drive control."

Other analysts have taken a "structural approach" to agoraphobia, postulating defective superego formation (Ruddick, 1961) or "ego distortion" (Rhead, 1969).

By far the most extended psychoanalytic discussion of agoraphobia is Weiss's 1964 monograph, which he said was the first time that a series of analyzed cases had been presented in a single study. (In fact, it is the only such series to date.) Although four of the seven cases he described had been reported in 1935, his ideas on agoraphobia had changed significantly (see Weiss, 1953). He remained clearly aware of the necessity to find out what is specific about agoraphobia (e.g., 1964, p. 19). He took the position that persons with agoraphobia experience distressing sensations to which *they react* with anxiety—that is, he no longer saw anxiety as the primary event.[6] One of the ways Weiss differentiated agoraphobia from other phobias is that the fear is of an *internal danger* (p. 1). This internal danger, the paradigmatic experience which characterizes agoraphobia, is an "unbearable feeling of ill-being," including a profound sense of being ill, loss of feeling of identity (depersonalization, loss of "ego feeling"), derealization, dizziness, fainting sensations, loss of orientation—"To all of these internal experiences [the pa-

[6] This clearly resembles the current cognitive-behavioral theory of "catastrophic misinterpretation" of somatic sensations.

tient] reacts with unmasterable anxiety" (p. 3). He also recognized that distress at being confined, that is, claustrophobia, is typically part of agoraphobia.[7]

Weiss saw the agoraphobic as engaged in a struggle to remove her own repressive efforts—that is, engaged not only in an ego versus id conflict, but in an intra-ego conflict. Following Federn, he proposed that not only are drives repressed in the course of development, but "ego states" as well. "Oscillations of ego states and stimulation of blocked drives easily arouse the repressed, pertinent ego structures, thus threatening the ego's integration. Bodily and mental ego disturbances reduce the patient's confidence in his ability to act and behave properly. He is made to feel helpless and unable to function by himself. *These phenomena are precisely what constitute the frightening feeling of ill-being*" (p. 48)—that is, the feeling of ill-being seems to be a direct mental registration of structural disorganization, rather than representing a meaning. There then occurs a "regression to a dependent attachment to a mother-figure . . . [that is] the result, and not the cause, of the ego disturbance which increases the ego's need for security measures" (p. 49). But Weiss later said that agoraphobic anxiety is a reaction to the threat "of intrusion into [the patients'] conscious ego of a repressed ego stage of their childhoods which had contained the blocked sexual urges" (p. 50, n.). In this view the anxiety, too, must be secondary to the feeling of ill-being.

He mentions that in many cases "agoraphobic patients resort to enigmatic protective measures"[8] and cites examples from earlier reports (p. 52), suggesting that the canes, carts, kittens, and dark glasses, which many agoraphobics use to make going out possible or more bearable, have symbolic significance that relates to "ego feeling."

Weiss also appended to several of the case reports that the

[7] The term "agoraphobic syndrome" seems less restrictive.

[8] This is abundantly true and has been peculiarly neglected by psychoanalysts.

patients may have trouble dealing with their sexual impulses once they have been liberated from repression; in certain ways, agoraphobia is a protection against actual promiscuity. This is apparently, once again, the issue of "impaired drive control."

Weiss's cases are additionally notable in the following respects: fluctuating course of agoraphobic symptoms, remissions, and alternation with depressive states; variation from very rapid symptom resolution in treatment to very extended or multiple analyses before symptoms resolve; one failed case ("Michael") is reported (the only such case I have discovered). Not clear is whether Weiss saw some of this as specific to agoraphobia, or whether he would understand all phobias, and perhaps all neurotic symptoms, in terms of warded-off ego states.

Calef (1967) called attention to a connection between excessive alcohol intake and phobic symptoms in four cases. He linked this connection to a particular phobic content (birds) and saw the connection as stemming from a single unconscious equation.[9] Review of the material he briefly presented indicates that these women, in fact, had "agoraphobic syndrome."

Perhaps the most detailed and extensive case material is to be found in Wallerstein's (1986) monumental report on the Topeka Psychotherapy Research Project. No attempt is made there to contribute to the theory of agoraphobia. It is of interest that all seven patients with phobic diagnoses (of forty-two total patients in the study) were rated as having "very good" treatment outcomes—100%, as opposed to 40% for the whole study group, or 29% for the study group minus the phobic patients. Three of Wallerstein's patients were treated by psychoanalysis, four by psychoanalytic psychotherapy.

In a subsequent communication I shall take up current issues concerning the validity of agoraphobia as a diagnostic entity.

[9] Increased frequency of alcohol and drug use in the phobic population is now well documented in the psychiatric literature.

"*Panic Attacks*"

It was called to my attention by Austin Silber that the phenomenon so much depended upon in current psychiatric nomenclature, "panic attacks," is not, after all, foreign to analysts *in the analytic situation*. These episodes appear in the analytic literature under the rubric of "severe regressive states." These have been described by Silber (1989) as well as by Atkins (1967), Dickes (1967), and others. Probably all analysts have had experience in dealing with states of this kind, but have not thought of them as "panic attacks." Silber shows that the attacks of his patient meet DSM-III-R criteria for panic attack.

Other Types of Phobias in Adults

The agoraphobic syndrome often, or usually, includes fears that can just as well be labeled claustrophobic as noted by Weiss and others. Lewin (1935) suggested a strict definition of claustrophobia which would distinguish it from the agoraphobic syndrome descriptively: claustrophobia *if and only if* the reported experience is "a fear of being caught or crushed by a gradual closing in of the space about one. This definition . . . would exclude such fears as that of entering into a closed space . . ." (p. 48). He also suggested a set of unconscious fantasies which apply in this strictly defined form of claustrophobia: a fantasy of being disturbed while an embryo in the mother's body. The symptom choice is determined by the unconscious fantasy content. Later psychoanalytic authors did not consistently adhere to Lewin's definition. Lewin was suggesting for claustrophobia, as Calef did for "ornithophobia," that a specific unconscious fantasy might account for the specific phobic content.

Gehl (1964) and Asch (1966) asserted linkages between claustrophobia and depression. The central concepts in their work are Lewin's (1950) oral triad—to eat, to be eaten, and to sleep—

and the idea of depression, in the sense of depressive states or depressive illness, as a phenomenon based on oral-incorporative fantasies and narcissistic object relations, assumptions subsequently challenged by Brenner (e.g., 1982). Asch (1966, p. 728) saw an unconscious fantasy common to depressive illness and claustrophobia, a wishful fantasy he called "claustrophilia," and suggested that the phobia arises in someone who has that unconscious orientation and has "developed a propensity for displacement and avoidance." Gehl later (1973) extended the idea of claustrophobia to various kinds of feelings of being trapped—for example, being trapped by making a decision—and to a character type, the claustrophobic character.

While claustrophobia may or may not exist as a symptom complex distinct from the agoraphobic syndrome, erythrophobia appears to be something clearly different from agoraphobia and from the animal phobias of early and middle childhood. In Benedek's case (1925) the patient was socially inhibited because of a fear that other people were watching her and that she might blush. There is not enough clinical detail presented to discern whether the feelings of being watched were delusional. Bergler (1944) referred to a broad psychoanalytic literature (that is, not specific to erythrophobia) and stated that "those given to this kind of blushing are therapeutically difficult of access, narcissistic, and self-contained, and not infrequently express ideas that border on paranoia" (p. 43). The case he reported does not seem to fit this description. My own experience with one case (unreported), however, certainly does: the patient qualified as a borderline personality with quasi-delusional ideas of being observed. Exhibitionistic/voyeuristic conflicts activated in social situations were prominent in this case, as well as in those of Bergler and Benedek. Conscious experience of intense, focused anxiety was not a prominent feature in any of these cases.

Dosužkov (1975) reported the case of a young man with political aspirations who sought treatment because of pathological

sweating of his hands and face, and/or the fear thereof.[10] The content of the patient's fears and the situations he avoided were similar to those of reported erythrophobic patients. Both types would seem to fall into the DSM-III-R classification, "Social Phobias," without loss of psychoanalytic contribution.

Spider phobias, while they arise in infancy, appear to have a somewhat different significance than other infantile zoophobias. All of the reported cases involving spider symbolism and/or spider phobias have been severely ill, borderline, or schizophrenic adults, often with "psychosomatic" illnesses (Azima and Wittkower, 1957; Little, 1966, 1967, 1968; Newman and Stoller, 1969; Sperling, 1971). Sperling tried to address the factors involved in the specific choice of symbol. She saw the spider primarily as a representation of the "dangerous (orally devouring and anally castrating) mother" (p. 493) and believed that the phobias originate in the anal phase.

DISCUSSION

This discussion is about the agoraphobic syndrome except where other conditions are specifically indicated.

Descriptive Issues

The first problem is that of categorization of content. The patients in the psychoanalytic literature presented with a variety of fears. Sometimes there was no attempt to describe the content, designated, for example, only as "street fear." Other patients were said to be afraid of going crazy, of losing control, of wide streets, of narrow streets, of stores, of bridges, of tunnels, of open spaces, of closed spaces, of restrictive situations—and so

[10] There are categorical problems with these cases: Is the symptom the blushing or the sweating? Or is it the fear of the blushing or the sweating?

on. Others presented with much more localized fears—of birds, for example—but typical agoraphobic fears were recognized later on.

Before we can decide whether the dynamics of any syndrome show consistent features, we must have a clinical picture with reasonably well-defined boundaries; that is, we must know what the syndrome is that we are trying to investigate. The most natural boundaries, descriptively, here seem to me to include all of the above kinds of fears, since they tend to occur together in any event, even though not all may be present in any given instance. The name "agoraphobic syndrome," rather than "agoraphobia," then seems more appropriate. This agoraphobic cluster has been demonstrated by Marks (1987) and others by the technique of factor analysis.

A second descriptive issue concerns measures taken to prevent realization of the fears. These measures include both inhibitions and avoidances, on the one hand, and positive arrangements, on the other. Some of the patients were afraid to go out of the house at all; some could go out only with a particular companion, usually a parent or a spouse; some could go out with almost any well-known person. Sometimes certain limited distances from home were tolerated, or certain accoutrements made going out or entering some more specific feared situation possible. Again, this variety of protections, which includes more than avoidances, can be best encompassed by the term "agoraphobic syndrome."

Another descriptive matter is the position of anxiety attacks (or panic attacks or severe regressive episodes) in this syndrome. This has become a central controversy in current psychiatric formulations. Does the illness always or almost always or sometimes or only occasionally start with a panic attack? The question was, in fact, introduced by Freud in his early work, and his position on the matter was not clear later on. Several authors, including Freud and Weiss, have suggested that the illness begins with an anxiety attack and that what the patient is afraid of is the occurrence of another anxiety attack. This does not fit

with the cluster of fears listed above and does not provide any pathway to explanation of why the feared anxiety attack should so often start in one or another of the typical situations. It is necessary to ascertain the frequency with which the agoraphobic syndrome commences with an anxiety attack without conscious content. The issue of unconscious content is another matter, but not one about which there is agreement even among psychoanalysts.

The role of and types of "precipitating events" are also important. Freud's initial hypothesis was that the illness stemmed from impairments in current physical sexual life. Several authors more recently have suggested a background of some step into adult life—graduation, marriage, job promotion—as a category of event frequently associated with the onset of agoraphobic symptoms. This, even more clearly than the previously listed descriptive issues, is a matter for empirical investigation and statistical analysis, something for which the traditional methods of psychoanalysis are poorly suited.

The final descriptive consideration I will mention is nosologic. What is the relation of the agoraphobic syndrome to other psychopathological conditions? Other types of phobias, including infantile animal phobias and "social phobias," seem to be distinctly different, both descriptively and in terms of psychoanalytic impressions of important dynamics. Analysts have, on the other hand, repeatedly noted that depressive states may be related to, or alternate with, agoraphobic anxiety states. The regularity of this association needs investigation and, if confirmed, explanation. On the basis of the evidence in the psychoanalytic literature reviewed, plus my own experience (to be reported as part of this series of communications), alternation of depressive states with anxiety states is so regular that it should be included as a descriptor of the agoraphobic syndrome.

Certain aspects of obsessive-compulsive syndromes are often referred to as phobias—dirt phobia, germ phobia, for example. Wegrocki (1938) and Rangell (1952) presented interesting case material of this kind under the rubric of "phobia." Wegrocki's

patient was afraid of even numbers; Rangell's was afraid of dolls. Both were adult males and both were seen by the reporting author as having obsessive-compulsive neuroses. These patients appear to share little with those discussed as having infantile phobias, agoraphobic syndrome, erythrophobia, or social phobia except for elements of attempts to cope with anxiety by avoidance. Such symptoms are best studied in the framework of obsessional conditions. Even though they conform to most aspects of our descriptive definition, they are part of a more encompassing condition.

Is there a "character type" which is regularly associated with the development of agoraphobic syndrome? Psychoanalysts loosely refer to phobic or avoidant or counterphobic characters or character traits. The DSM-III-R entity, "avoidant personality," does not coincide or even overlap with these psychoanalytic usages. Because of the complexity and breadth of the nosologic issues involved, discussion is deferred to a subsequent communication.

Treatment Issues

What happens to patients with agoraphobic syndrome in and after analysis? Treatment outcomes will be studied in a subsequent communication. Here a few examples will serve to show the variety of patterns.

Deutsch's first reported case (1928) was referred to her by a male colleague when he left Vienna. The patient had already experienced considerable relief of agoraphobic symptoms in that previous treatment. With Deutsch, there was a period when the patient was anxiously concerned about the welfare of her previous analyst, followed by a resumption of her typical agoraphobic symptoms. Deutsch hypothesized, "The vivid, conscious phantasy about the analyst acted as a wish-fulfilment and served as a protection against anxiety and a substitute for a

companion. . . . the analyst's departure was felt by the patient as a disappointment in love and produced a sadistic reaction" warded off by reaction formation (pp. 55-56).

Miller's (1953) patient similarly experienced considerable relief of her anxiety with a previous analyst after that analyst gave up on the treatment and established a social relationship with her. When he died, her symptoms became worse than before the contact. After about two years of analysis with Miller, she was said to be symptom free, but she subsequently required at least one period of further treatment because of recurrent agoraphobic symptoms.

How might the fantasy of a fulfilled love with the analyst serve as a "protection against anxiety"? Some sort of less pathological compromise formation—less pathological in the sense that unpleasure affect is diminished—must have arisen. An agoraphobic patient whom I have had the opportunity to follow for eighteen years after the interruption of her analysis, always maintained the image of her analyst in her mind and, at a time when a series of untoward life events occurred, experienced an acute exacerbation, not of her agoraphobia, but of her transference love. The protection appears to be against further regression which may be a prerequisite for typical agoraphobic symptoms.

Some of the reported cases showed symptom relief after a few months, but others only after many years of analysis. Some developed other types of symptoms in the analytic sessions, such as hysterical seizures; others subsequently developed depressive or obsessional illnesses.

The general impression that one gains about treatment from the literature is that agoraphobic symptoms tend to improve in analysis, but over very variable time periods, and with a tendency to recur. Depressive states are often a problem before, during, and after treatment. The changes that occur during treatment, at least initially, seem to be related to alterations in the affective tone of the relationship to the analyst; that is, if the affect that arises is predominantly affectionate/erotic, a "trans-

ference cure" occurs temporarily. This may have more lasting significance, however, than the pejorative "transference cure" suggests, as indicated in the eighteen-year follow-up.

The role of exposure to the feared situation is mentioned only by Freud and Katan, but is taken as a treatment essential by both of them. Future case reports should try to clarify this issue. The burden of showing that psychoanalysis does as well as, or something more than, exposure therapy certainly rests upon psychoanalysts.

Psychoanalytic Clinical Issues

What is the role of traumatic experiences in the causation and precipitation of the agoraphobic syndrome? Deutsch's first patient revealed two traumatic experiences: (1) she recalled witnessing a "primal scene" in infancy; (2) at puberty she saw her father collapse in a seizure. The overt precipitating event for the onset of the agoraphobia was seeing a man on the street have a seizure; a covert precipitating event was that she had been "sexually attacked" by her boyfriend. In the other reports traumatic precipitating events are not prominent. On the contrary, successes, achievements—steps into adult life—may be a common precipitating event.

The idea of a "primal scene" is more problematic. What constitutes a primal scene? Must the child view parental sexual intercourse? Is only overhearing sufficient? Once or repeatedly? Up to what age? Is there *anything* that can characterize the actual parental behavior required, or are we talking only about reactions which can only retrospectively be judged to have been traumatic? We shall return to this problem in the discussion of anxiety.

What is the role of the companion? Deutsch hypothesized, again from her first case, that the presence of the patient's parents served as a protection against the fear of enacting forbidden sexual wishes, and also as reassurance that her parents were safe from her aggressive wishes. In the second case, Deutsch was

more specific about the dynamics of protection: the daughter became the companion of the agoraphobic mother, assuming the role of a forbidding superego acting benignly, therefore vitiating death wishes. She calls the companion "the protected protector." In other instances the accoutrements seem to serve the role of symbols of a companion. In the case followed for eighteen years, in which no actual companion was required, the image of the analyst became a sort of internal companion which served to avert agoraphobic symptoms, more or less permanently. It is not clear, however, that this mechanism is any different from that of the formation of mental structure in general.

Does the agoraphobic syndrome proceed from some particular developmental level? The literature on infantile phobias left us with a strong suggestion that events in the sadistic-anal, early genital phase form the materials from which infantile phobias are constituted. There is nothing in the agoraphobic literature which suggests a similar pattern or even any particular connection with infantile phobias. This would seem to remain a matter to be decided by long-term developmental studies. I have already indicated my views on the oedipal versus preoedipal debate.

Are there particular kinds of conflicts which are characteristic of the syndrome? Are there particular unconscious fantasies which are regularly represented in, and in some way causative of, the symptoms? Or, conversely, is the syndrome an inevitable by-product of abnormal "generation" of anxiety? The psychoanalytic literature seems divided in respect to these questions, and not much has been added to the proposals of Freud and Deutsch in regard to dynamic content.

Theoretical Issues

Review of the agoraphobic syndrome raises a number of fundamental psychoanalytic theoretical issues. (1) How do we account for the particular set of symptoms formed—the problem of "choice of neurosis"? Analysts have been aware of the neces-

sity to explain the specific symptom pattern, but have not obviously succeeded in doing so. (2) What are the nature and scope of the concepts of displacement and projection? Given modern formulations of anxiety and agoraphobia (so far as the latter exist), do we still see a central role for projection in phobia formation? (3) What is a "primal scene"? Are there descriptive boundaries to what counts as one? (4) Are there different kinds of regression, such that agoraphobics regress in a different way than do children with animal phobias—a "temporal regression," as Freud put it? (5) Are there significant psychodynamic and psychogenetic similarities between infantile animal phobias and agoraphobia?

All of these theoretical issues take us well beyond the scope of this part of the paper. The "problem of anxiety" is involved in all of them, however, and requires further comment here. Intense, overwhelming states of fear—panic—seem to have a substance of their own, to be "thing-like" in some way, such that the "spontaneous" appearance of such states challenges hypotheses of their occurrence on the basis of meaning alone. Freud's idea, or one of his ideas, for dealing with this problem was that of traumatic states in which anxiety is generated. The theory of the primal scene experience is a way to make concrete or to locate some event which has this traumatic quality and lends it a more or less specific content. Deutsch, in passing, used the phrase "predisposition to anxiety," in a way which suggests it as a substitute for the primal scene hypothesis. Later, Greenacre (1941, 1945) developed this idea: certain kinds of events in early life may result in a permanent "diathesis" to the development of states of intense anxiety and/or chronic anxiousness. If such traumatic states or predispositions to anxiety exist, this leaves us with a question concerning signal anxiety. If we adhere to Freud's 1926 formulation, fear is always inside and danger is always outside—at least in the realm of signal anxiety. But traumatic states raise the possibility of "internal danger," roughly the danger of disorganization of the mental apparatus. Anna Freud (1936) prominently included this possibility in her book.

Weiss's theory of agoraphobia is a variant of the same idea—the anxiety is a reaction to the perception of structural disorganization *and* a manifestation thereof.

Finally, are there important dynamic mechanisms common to infantile animal phobias and agoraphobia? How can we decide whether "projection" is an important factor? Is "displacement" a candidate for a, or the, central dynamic in agoraphobia?

On the basis of the literature reviewed, one cannot say very much in answer to any of these questions. Anxiety in the agoraphobic syndrome appears to be less focused than that in infantile phobias: I am not tempted to try to explain the syndrome by applying Anna Freud's hypothesis of a massive condensation of infantile conflicts onto one symbolic object. The same nonapplicability covers displacement as it is used in the literature on infantile phobias. Katan means something quite different from symbolic substitute formation. The question of projection or externalization brings us once again to the problem of anxiety. How one understands the position and role of anxiety in neurosogenesis is the crux of the matter for psychoanalysis, not just for biological psychiatry.

It seems to me that the agoraphobic syndrome, on a descriptive basis, constitutes an entity worth investigating as such. Further detailed case reports are required in order for us to formulate clearly the questions which need to be answered from a psychodynamic viewpoint.

SUMMARY

Accumulated psychoanalytic experience suggests the following hypotheses about the agoraphobic syndrome. Clusters of related fears tend to occur together. These include fear of open places, closed places, bridges, tunnels, elevators, restrictive situations, and some specific animal fears. Relief of the anxiety is often but not always provided by the presence of a companion who is emotionally important, and sometimes by wearing or carrying

or pushing various accoutrements. The great majority of the patients are female, with onset of the illness from late teens to early thirties. The illness tends to be chronic or recurrent and shows a strong association with depressive states or depressive illness. The conscious content of the fear is of going crazy, dying, or otherwise losing control *in the phobic situation*. Analysts are divided on whether the illness starts with a contentless anxiety attack or without such an attack, and even upon whether or not there is unconscious content or only "generated"—at this point we might just as well say "primary neurophysiologic"—anxiety. An event which has the significance of a step into adult life may be a common precipitating cause.

The results of psychoanalytic treatment are not well documented but appear to be variable. Symptom relief may occur within a few weeks or months, or may require many years. There are recurrences after analysis, and the position of depressive states has not been carefully considered. There may also be transitions to other types of symptom pictures, such as obsessional neurosis or social phobia. There are data suggesting that a positive relation to the analyst is important in symptom relief, at least temporarily ("transference cure"). Actual exposure to the feared situation may be an essential part of the treatment, though this does not appear to be true in all cases.

Psychodynamically, there have been repeated suggestions that fear of acting upon sexual temptation is a central issue. A number of authors have noted that the patients tend to be particularly passionate about their sexual impulses in analysis, but only one reported patient showed anything like promiscuity. The predilection for the illness in women has been related to pronounced exhibitionistic conflicts, to masochistic identification with a degraded object (mother), and to a strong feminine-masochistic cast to the sexual fantasies. The presence of a companion, if one is required, is thought to be related not only to protection by the companion from enactment of sexual fantasies (a prohibiting superego function) but also to protection of the companion from the enactment of aggressive fantasies.

Whether or not there are more specific types of unconscious fantasies underlying the agoraphobic syndrome is presently unclear.

There is no clear evidence that an independent syndrome of claustrophobia exists. On the other hand, social phobias of adults do appear to be different. The existence of erythrophobia as an entity is questionable. Spider phobias are an anomaly of unclear status. Use of the term phobia in relation to these conditions does not rest upon any significant similarity to infantile phobias or the agoraphobic syndrome beyond the presence of overt anxiety with some degree of focused quality.

No further modifications of our descriptive definition of phobia seem necessary on the basis of the agoraphobia literature, although some of what was added on the basis of infantile phobias seems only marginally applicable.

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THE PSYCHOANALYTIC VIEW OF PHOBIAS

PART III: AGORAPHOBIA AND OTHER PHOBIAS OF ADULTS

BY ALLAN COMPTON, M.D.

This is the third part of a review and commentary on the psychoanalytic literature on phobias. This section takes up agoraphobia and other phobias of adults, and suggests further avenues for interpenetration of psychoanalytic and psychiatric approaches.

Part I of this work reviewed and discussed Freud's theories of phobias and anxiety. Part II took up the psychoanalytic literature on phobias of infancy and childhood. This section deals with psychoanalytic contributions on agoraphobia and other phobias of adults.

Agoraphobia

In the infantile phobia literature the most prominent issue is: By what criteria does one decide whether a phobia is present? The foremost issue in the literature on agoraphobia is: What determines the specific symptom choice? I shall focus again only on certain presentations which serve to document hypotheses or to highlight main issues, rather than striving for a truly comprehensive review.

It will be recalled from Part I that Freud offered only a few comments specifically on agoraphobia. It begins, he said, with

an anxiety attack and is part of the anxiety neurosis;[1] it has some special relation to pleasure in locomotion; it is relieved when the patient is accompanied by a special person; fear of sexual temptation, and therefore, at base, fear of castration by the father, plus "temporal regression" to an infantile state, sometimes to an intrauterine state, constitute the mechanism of agoraphobia.

Freud did not publish any clinical material on the analysis of an agoraphobia. There was the brief vignette in the Fliess correspondence mentioned in Part I (1897), which suggested a traumatic-psychodynamic (that is, hysterical) cause for the fear of going into stores alone. An extended footnote was included in *Studies on Hysteria* as an example of Freud's "pressure technic" (Breuer and Freud, 1893-95, pp. 112-114, n. 2) in a case of "anxiety neurosis (agoraphobia, attacks of fear of death, etc.)" in a woman of thirty-eight, which Freud seemed to understand as the result of a "hysterical identification" with a dead friend, somehow connected with the patient's menstrual period, at age eighteen.

Much later (1919) Freud suggested, following Ferenczi, a necessary modification in technique for the treatment of phobias.

> One can hardly master a phobia if one waits till the patient lets the analysis influence him to give up. . . . Take the example of agoraphobia. . . . one succeeds only when one can induce [agoraphobic patients] . . . to go into the street and to struggle with their anxiety while they make the attempt (pp. 165-166).

He also gave a related description (not explanation) of the development of agoraphobia:

> For instance, an agoraphobic patient may start his illness with an attack of anxiety in the street. This would be repeated every time he went into the street again. He will now develop the

[1] It is not clear whether or in what degree Freud maintained this position after 1910.

> symptom of agoraphobia; this may also be described as an inhibition, a restriction of the ego's functioning, and by means of it he spares himself anxiety attacks (1933, p. 83).[2]

Abraham, writing well before Freud published the last of the statements just listed (1913a, 1913b), mentioned a number of cases of "locomotor anxiety," which he also called "street fear" and "topophobia" (following various earlier authors). He offered the theory that these people have the usual incestuous fixations common to all neurotics, plus, following Freud, a constitutional predisposition to "pleasure in movement," which causes the particular symptom selection—that is, pleasure-seeking impulses which are conflictual come to involve locomotion because it is a preferred pleasure mode. Predisposition to pleasure in movement is offered as the determinant of the specific "choice of neurosis." Relief of street anxiety when the patient is accompanied by certain other persons is taken as a uniform feature, although unexplained. It would appear that this relief was seen as a manifestation of regression secondary to the failure of other defensive operations.

Early case reports appeared in German by Cohn (1928) and Deutsch (1928). Deutsch, writing after Freud's introduction of the ego-superego-id model and his revision of anxiety theory, in what has become the classic psychoanalytic paper on agoraphobia, briefly reported four treated cases. She described the content of the patients' fears as a fear of sudden death and said it was typical that the anxiety was alleviated by the presence of a companion. Deutsch accepted Freud's idea of a predominantly phallic-oedipal conflict picture, but added, to the general theory of warded-off sexual trends, the idea of heightened, warded-off aggression (sadism, death wishes) toward both parents as rivals, and a strongly masochistic orientation of sexual fantasies (including both copulatory and birth fantasies).[3] She emphasized

[2] If this were taken as a complete description, the implied explanation would be a conditioned fear response.

[3] This appears to be a suggestion as to why agoraphobia occurs predominantly in women.

masochistic identification with the mother as a devalued object, and she considered this identification with the object of hostile tendencies to be the characteristic element in agoraphobia (p. 114). The compromise formation takes the form of street anxiety because the street = sexual temptation = masochistic tendencies = identification with the object of aggression = prostitution. Deutsch also found especially strong exhibitionistic conflicts to be characteristic of her agoraphobic patients, again manifested as sexual temptation in public places.

The symbolic equivalent of prostitute-street walker, plus a feminine-masochistic drive disposition, thus appears to determine the specific choice of neurosis. In comparison to Abraham's idea, agoraphobia in Deutsch's theory depends more upon symbolization of conflict or unconscious fantasy. Deutsch suggested that her answers were less than complete, and subscribed both to Abraham's locomotor theory and to the (undefined) idea of a "predisposition to anxiety." She did not allude to Freud's *aktual* neurotic hypotheses. One of Deutsch's patients consciously recalled hearing her parents involved in sexual intercourse when she was a small child; otherwise, Deutsch does not mention "primal scene." She did see a "common ground" with other phobias in the projection outward of an inner danger.

Weiss (1935) cited considerable experience (more than twenty cases) in the analysis of agoraphobic patients. He made the interesting observation, though he demeaned it, that the outbreak of agoraphobia seems to be determined by "certain superficial factors," which he categorized as the patient's being required to "take a step forward in the direction of independence" (p. 65). Not surprisingly, he concluded that the street fear or fear of going out of the house usually has three "principal meanings": (1) "I am emancipated. I can do as I please" (which he equated with a fear of sexual temptation); (2) to display oneself in public (exhibitionistic temptation or conflict); (3) detachment from maternal protection. What Weiss added as a specific determinant of the symptom choice was his emphasis on the "superficial factor,"

perhaps more symbolically represented by the street or by leaving the house. Deutsch (1928) had mentioned this idea in passing and much later Ruddick (1961) also connected the outbreak of agoraphobia in three cases with life events in the category of increased independence or adult responsibility, especially marriage and parenthood.

Weiss (1935) distinguished two origins of agoraphobia: "Usually, agoraphobia arises out of a so-called anxiety-attack or, more rarely, out of a traumatic hysterical attack" (p. 64). For such patients, anxiety attacks are "confined to the emotional sphere . . . [and remain] without motor expression. . . . (in contrast to those suffering from true hysterical attacks) . . ." (p. 64). Apparently, he saw the anxiety attack as devoid of psychic content, that is, without conscious or unconscious meaning, "an internal traumatic experience" (p. 64). Thus, unlike Deutsch, he was apparently adhering to Freud's idea of *aktual* anxiety at this point. He also distinguished between two kinds of phobias: those in which there is an exaggerated fear of a situation or animal, which is seen as a real danger; and, on the other hand, agoraphobia, which seems to start with anxiety attacks and becomes only indirectly related to an external situation. Somehow, Weiss concluded, in contrast to Deutsch, that projection is prominently involved in the first type and minimally involved in agoraphobia. What the agoraphobic patient feels, Weiss said, is the continued threat of an attack (p. 71).[4]

Weiss did not attempt to relate this hypothesis to his "superficial factor," and there consequently appears to be a contradiction. If agoraphobia is precipitated by a step into adult life, as it were, and if the symptoms have the meaning of dangerous sexual temptations and defenses against them in one's emancipated state, then how can the anxiety be without (even unconscious) content? And why would one say that the patient is afraid of

[4] Here, again, is a striking similarity to the theory embedded in DSM-III-R "Panic Disorder with Agoraphobia."

another attack and only that? These seem to be two incompatible theories combined as one, or, perhaps, once again, a mixture of a descriptive view and an explanatory attempt.

Bergler (1935) reported the analysis of a thirty-two-year-old agoraphobic woman, with gradual onset of symptoms over several years, a severe intervening depression, and eventual inability to leave the house without a companion. The agoraphobia began when she gave up a relationship with a highly unsuitable partner and worsened when she began a relationship with another, even more unsuitable, as Bergler saw it. He felt this analysis confirmed the factors suggested by Deutsch (masochistic identification and exhibitionistic conflicts) and Abraham (pleasure in movement), as well as by Freud (sexual temptation, castration fear, regression to an infantile mental state). He added an important role for an unconscious sense of guilt and called attention, for the first time in the psychoanalytic literature, specifically to the association of agoraphobia and depression.

Eisler's patient (1937) developed an agoraphobia following a "panic attack" at age twenty. The difficulty of categorizing phobic content is clear in this case report: the patient initially panicked on a train, thought she was going insane, and subsequently dreaded entering closed places or any situation from which there was no ready exit; she also could not go on the street alone. The phobic symptoms vanished within a few months of starting treatment (unlike some of the cases reported by Deutsch, Weiss, and Bergler, discussed below). She also had obsessional symptoms, however, and later on developed a fear of eating in restaurants, which caused her to return for further analysis. Eisler called this a case of "multiple phobias." In fact, such multiple and seemingly incompatible fears (closed places and open places) are regularly found in agoraphobic patients.

Hitschmann (1937) and Katan (1937) also reported cases of young women with agoraphobia. Katan added several details which are relevant to other areas and more recent work. Primal scene experience seemed to her necessary to account for the

anxiety. This appears to be an alternative to the hypothesis of *aktual* anxiety or Deutsch's hint of a "predisposition to anxiety," in the sense of anxiety being generated in the present with no justifiable psychic content, conscious or unconscious. She noted variation of the meaning of the phobic situations (street, bridge) at different points in the analysis (see my discussion of Tyson's 1978 paper [Compton, 1992]). She also said, following Ferenczi and Freud:

> To recognize and interpret this symbolism is of as little therapeutic value as is purely symbolic dream interpretation. Only the interpretation that the stubborn clinging to her agoraphobia simultaneously served as a safeguard against the dreaded re-displacement on to her infantile conflicts was therapeutically effective. The first interpretation explains only the contents of the anxiety, the second reveals its function and, in conjunction with the first, implements the therapeutic goal (p. 49).

Such insistence that the patient "do something" about her phobic symptoms amounts to what is currently called "exposure."[5]

Katan also, following Freud's idea that the central mechanism in phobia formation is displacement, attempted to augment understanding of agoraphobia at a theoretical level. She saw what we ordinarily think of as "transference," and also the formation of other adult relationships, as manifestations of the mechanism of displacement. The detachment of sexual desire from its infantile objects at puberty is accomplished by displacement, a defense mechanism. She saw the operation of displacement in that developmental circumstance as irreversible, because, she said, the transformation extends to the id, but otherwise is the same as other displacements. These ideas raise some difficult issues which will require discussion.

Fenichel (1944), apparently on the basis of the literature cited

[5] I. M. Marks (e.g., 1987) presents extensive evidence that exposure *by itself* causes agoraphobic symptoms to disappear, that the effect is lasting, and that no "symptom substitution" occurs.

here thus far, as well as his own work, differentiated agoraphobia from other phobias on the grounds that it is a projection of excitement, an externalization of an inner danger, rather than a substitution by displacement of one external object for another (p. 314). He recognized that the presence of a companion for relief of anxiety is not an invariable, and therefore not an essential, feature of agoraphobia (pp. 314-315). He also suggested that a specific conditioning may be (secondarily) involved in agoraphobias (p. 321).

It is not hard to see that different authors had clearly different and sometimes opposing views of the role of projection and/or externalization, apparently based on different concepts of anxiety and admixtures of hypotheses from the topographic and structural models of the mind.

Miller (1953) reported analytic data on a thirty-five-year-old woman with severe agoraphobia and attempted to synthesize earlier contributions to the clinical theory of the condition. This patient's mother apparently had an extended affair, with sexual liaisons taking place during the daytime at home. The patient's experience of these "primal scenes"—listening outside the bedroom door, with feelings of curiosity, envy, and isolation—provided the organizing theme of the analysis. The patient was prone to creating situations in which *someone else* was forced to experience those unpleasant feelings. This was manifested, for example, by provoking her husband's jealousy of the analyst. Her husband was maintained as a maternal transference figure. Curiosity (voyeurism) and warded-off exhibitionistic urges were very prominent features. Miller interpreted the street fear, following a suggestion by Deutsch (1928), as a manifestation of an infantile fantasy of giving birth. The strength of the erotic impulses in the analysis is especially noteworthy.

Passionate expression of sexual impulses in the analytic situation was also noted by Weiss (1935, 1964) and perhaps by Wangh (1959), who reported on a patient who had agoraphobia with panic attacks. He chose to de-emphasize anxiety and defense in favor of a focus on drive and object development and,

especially, on the superego—a "structural approach." He thought that his patient had tendencies toward impaired drive control that are shared by persons with "acting-out personalities." What seemed to promote the formation of the phobia *instead* of acting out were: (1) her mother re-enforced patterns of avoiding tension and substituting objects; (2) her reality sense was good; and (3) she had strong defenses against masochistic strivings.

Since the patient did not act upon her impulses, "passionate strivings" seems more appropriate to me than "impaired drive control."

Other analysts have taken a "structural approach" to agoraphobia, postulating defective superego formation (Ruddick, 1961) or "ego distortion" (Rhead, 1969).

By far the most extended psychoanalytic discussion of agoraphobia is Weiss's 1964 monograph, which he said was the first time that a series of analyzed cases had been presented in a single study. (In fact, it is the only such series to date.) Although four of the seven cases he described had been reported in 1935, his ideas on agoraphobia had changed significantly (see Weiss, 1953). He remained clearly aware of the necessity to find out what is specific about agoraphobia (e.g., 1964, p. 19). He took the position that persons with agoraphobia experience distressing sensations to which *they react* with anxiety—that is, he no longer saw anxiety as the primary event.[6] One of the ways Weiss differentiated agoraphobia from other phobias is that the fear is of an *internal danger* (p. 1). This internal danger, the paradigmatic experience which characterizes agoraphobia, is an "unbearable feeling of ill-being," including a profound sense of being ill, loss of feeling of identity (depersonalization, loss of "ego feeling"), derealization, dizziness, fainting sensations, loss of orientation—"To all of these internal experiences [the pa-

[6] This clearly resembles the current cognitive-behavioral theory of "catastrophic misinterpretation" of somatic sensations.

tient] reacts with unmasterable anxiety" (p. 3). He also recognized that distress at being confined, that is, claustrophobia, is typically part of agoraphobia.[7]

Weiss saw the agoraphobic as engaged in a struggle to remove her own repressive efforts—that is, engaged not only in an ego versus id conflict, but in an intra-ego conflict. Following Federn, he proposed that not only are drives repressed in the course of development, but "ego states" as well. "Oscillations of ego states and stimulation of blocked drives easily arouse the repressed, pertinent ego structures, thus threatening the ego's integration. Bodily and mental ego disturbances reduce the patient's confidence in his ability to act and behave properly. He is made to feel helpless and unable to function by himself. *These phenomena are precisely what constitute the frightening feeling of ill-being*" (p. 48)—that is, the feeling of ill-being seems to be a direct mental registration of structural disorganization, rather than representing a meaning. There then occurs a "regression to a dependent attachment to a mother-figure . . . [that is] the result, and not the cause, of the ego disturbance which increases the ego's need for security measures" (p. 49). But Weiss later said that agoraphobic anxiety is a reaction to the threat "of intrusion into [the patients'] conscious ego of a repressed ego stage of their childhoods which had contained the blocked sexual urges" (p. 50, n.). In this view the anxiety, too, must be secondary to the feeling of ill-being.

He mentions that in many cases "agoraphobic patients resort to enigmatic protective measures"[8] and cites examples from earlier reports (p. 52), suggesting that the canes, carts, kittens, and dark glasses, which many agoraphobics use to make going out possible or more bearable, have symbolic significance that relates to "ego feeling."

Weiss also appended to several of the case reports that the

[7] The term "agoraphobic syndrome" seems less restrictive.

[8] This is abundantly true and has been peculiarly neglected by psychoanalysts.

patients may have trouble dealing with their sexual impulses once they have been liberated from repression; in certain ways, agoraphobia is a protection against actual promiscuity. This is apparently, once again, the issue of "impaired drive control."

Weiss's cases are additionally notable in the following respects: fluctuating course of agoraphobic symptoms, remissions, and alternation with depressive states; variation from very rapid symptom resolution in treatment to very extended or multiple analyses before symptoms resolve; one failed case ("Michael") is reported (the only such case I have discovered). Not clear is whether Weiss saw some of this as specific to agoraphobia, or whether he would understand all phobias, and perhaps all neurotic symptoms, in terms of warded-off ego states.

Calef (1967) called attention to a connection between excessive alcohol intake and phobic symptoms in four cases. He linked this connection to a particular phobic content (birds) and saw the connection as stemming from a single unconscious equation.[9] Review of the material he briefly presented indicates that these women, in fact, had "agoraphobic syndrome."

Perhaps the most detailed and extensive case material is to be found in Wallerstein's (1986) monumental report on the Topeka Psychotherapy Research Project. No attempt is made there to contribute to the theory of agoraphobia. It is of interest that all seven patients with phobic diagnoses (of forty-two total patients in the study) were rated as having "very good" treatment outcomes—100%, as opposed to 40% for the whole study group, or 29% for the study group minus the phobic patients. Three of Wallerstein's patients were treated by psychoanalysis, four by psychoanalytic psychotherapy.

In a subsequent communication I shall take up current issues concerning the validity of agoraphobia as a diagnostic entity.

[9] Increased frequency of alcohol and drug use in the phobic population is now well documented in the psychiatric literature.

"*Panic Attacks*"

It was called to my attention by Austin Silber that the phenomenon so much depended upon in current psychiatric nomenclature, "panic attacks," is not, after all, foreign to analysts *in the analytic situation*. These episodes appear in the analytic literature under the rubric of "severe regressive states." These have been described by Silber (1989) as well as by Atkins (1967), Dickes (1967), and others. Probably all analysts have had experience in dealing with states of this kind, but have not thought of them as "panic attacks." Silber shows that the attacks of his patient meet DSM-III-R criteria for panic attack.

Other Types of Phobias in Adults

The agoraphobic syndrome often, or usually, includes fears that can just as well be labeled claustrophobic as noted by Weiss and others. Lewin (1935) suggested a strict definition of claustrophobia which would distinguish it from the agoraphobic syndrome descriptively: claustrophobia *if and only if* the reported experience is "a fear of being caught or crushed by a gradual closing in of the space about one. This definition . . . would exclude such fears as that of entering into a closed space . . ." (p. 48). He also suggested a set of unconscious fantasies which apply in this strictly defined form of claustrophobia: a fantasy of being disturbed while an embryo in the mother's body. The symptom choice is determined by the unconscious fantasy content. Later psychoanalytic authors did not consistently adhere to Lewin's definition. Lewin was suggesting for claustrophobia, as Calef did for "ornithophobia," that a specific unconscious fantasy might account for the specific phobic content.

Gehl (1964) and Asch (1966) asserted linkages between claustrophobia and depression. The central concepts in their work are Lewin's (1950) oral triad—to eat, to be eaten, and to sleep—

and the idea of depression, in the sense of depressive states or depressive illness, as a phenomenon based on oral-incorporative fantasies and narcissistic object relations, assumptions subsequently challenged by Brenner (e.g., 1982). Asch (1966, p. 728) saw an unconscious fantasy common to depressive illness and claustrophobia, a wishful fantasy he called "claustrophilia," and suggested that the phobia arises in someone who has that unconscious orientation and has "developed a propensity for displacement and avoidance." Gehl later (1973) extended the idea of claustrophobia to various kinds of feelings of being trapped—for example, being trapped by making a decision—and to a character type, the claustrophobic character.

While claustrophobia may or may not exist as a symptom complex distinct from the agoraphobic syndrome, erythrophobia appears to be something clearly different from agoraphobia and from the animal phobias of early and middle childhood. In Benedek's case (1925) the patient was socially inhibited because of a fear that other people were watching her and that she might blush. There is not enough clinical detail presented to discern whether the feelings of being watched were delusional. Bergler (1944) referred to a broad psychoanalytic literature (that is, not specific to erythrophobia) and stated that "those given to this kind of blushing are therapeutically difficult of access, narcissistic, and self-contained, and not infrequently express ideas that border on paranoia" (p. 43). The case he reported does not seem to fit this description. My own experience with one case (unreported), however, certainly does: the patient qualified as a borderline personality with quasi-delusional ideas of being observed. Exhibitionistic/voyeuristic conflicts activated in social situations were prominent in this case, as well as in those of Bergler and Benedek. Conscious experience of intense, focused anxiety was not a prominent feature in any of these cases.

Dosužkov (1975) reported the case of a young man with political aspirations who sought treatment because of pathological

sweating of his hands and face, and/or the fear thereof.[10] The content of the patient's fears and the situations he avoided were similar to those of reported erythrophobic patients. Both types would seem to fall into the DSM-III-R classification, "Social Phobias," without loss of psychoanalytic contribution.

Spider phobias, while they arise in infancy, appear to have a somewhat different significance than other infantile zoophobias. All of the reported cases involving spider symbolism and/or spider phobias have been severely ill, borderline, or schizophrenic adults, often with "psychosomatic" illnesses (Azima and Wittkower, 1957; Little, 1966, 1967, 1968; Newman and Stoller, 1969; Sperling, 1971). Sperling tried to address the factors involved in the specific choice of symbol. She saw the spider primarily as a representation of the "dangerous (orally devouring and anally castrating) mother" (p. 493) and believed that the phobias originate in the anal phase.

DISCUSSION

This discussion is about the agoraphobic syndrome except where other conditions are specifically indicated.

Descriptive Issues

The first problem is that of categorization of content. The patients in the psychoanalytic literature presented with a variety of fears. Sometimes there was no attempt to describe the content, designated, for example, only as "street fear." Other patients were said to be afraid of going crazy, of losing control, of wide streets, of narrow streets, of stores, of bridges, of tunnels, of open spaces, of closed spaces, of restrictive situations—and so

[10] There are categorical problems with these cases: Is the symptom the blushing or the sweating? Or is it the fear of the blushing or the sweating?

on. Others presented with much more localized fears—of birds, for example—but typical agoraphobic fears were recognized later on.

Before we can decide whether the dynamics of any syndrome show consistent features, we must have a clinical picture with reasonably well-defined boundaries; that is, we must know what the syndrome is that we are trying to investigate. The most natural boundaries, descriptively, here seem to me to include all of the above kinds of fears, since they tend to occur together in any event, even though not all may be present in any given instance. The name "agoraphobic syndrome," rather than "agoraphobia," then seems more appropriate. This agoraphobic cluster has been demonstrated by Marks (1987) and others by the technique of factor analysis.

A second descriptive issue concerns measures taken to prevent realization of the fears. These measures include both inhibitions and avoidances, on the one hand, and positive arrangements, on the other. Some of the patients were afraid to go out of the house at all; some could go out only with a particular companion, usually a parent or a spouse; some could go out with almost any well-known person. Sometimes certain limited distances from home were tolerated, or certain accoutrements made going out or entering some more specific feared situation possible. Again, this variety of protections, which includes more than avoidances, can be best encompassed by the term "agoraphobic syndrome."

Another descriptive matter is the position of anxiety attacks (or panic attacks or severe regressive episodes) in this syndrome. This has become a central controversy in current psychiatric formulations. Does the illness always or almost always or sometimes or only occasionally start with a panic attack? The question was, in fact, introduced by Freud in his early work, and his position on the matter was not clear later on. Several authors, including Freud and Weiss, have suggested that the illness begins with an anxiety attack and that what the patient is afraid of is the occurrence of another anxiety attack. This does not fit

with the cluster of fears listed above and does not provide any pathway to explanation of why the feared anxiety attack should so often start in one or another of the typical situations. It is necessary to ascertain the frequency with which the agoraphobic syndrome commences with an anxiety attack without conscious content. The issue of unconscious content is another matter, but not one about which there is agreement even among psychoanalysts.

The role of and types of "precipitating events" are also important. Freud's initial hypothesis was that the illness stemmed from impairments in current physical sexual life. Several authors more recently have suggested a background of some step into adult life—graduation, marriage, job promotion—as a category of event frequently associated with the onset of agoraphobic symptoms. This, even more clearly than the previously listed descriptive issues, is a matter for empirical investigation and statistical analysis, something for which the traditional methods of psychoanalysis are poorly suited.

The final descriptive consideration I will mention is nosologic. What is the relation of the agoraphobic syndrome to other psychopathological conditions? Other types of phobias, including infantile animal phobias and "social phobias," seem to be distinctly different, both descriptively and in terms of psychoanalytic impressions of important dynamics. Analysts have, on the other hand, repeatedly noted that depressive states may be related to, or alternate with, agoraphobic anxiety states. The regularity of this association needs investigation and, if confirmed, explanation. On the basis of the evidence in the psychoanalytic literature reviewed, plus my own experience (to be reported as part of this series of communications), alternation of depressive states with anxiety states is so regular that it should be included as a descriptor of the agoraphobic syndrome.

Certain aspects of obsessive-compulsive syndromes are often referred to as phobias—dirt phobia, germ phobia, for example. Wegrocki (1938) and Rangell (1952) presented interesting case material of this kind under the rubric of "phobia." Wegrocki's

patient was afraid of even numbers; Rangell's was afraid of dolls. Both were adult males and both were seen by the reporting author as having obsessive-compulsive neuroses. These patients appear to share little with those discussed as having infantile phobias, agoraphobic syndrome, erythrophobia, or social phobia except for elements of attempts to cope with anxiety by avoidance. Such symptoms are best studied in the framework of obsessional conditions. Even though they conform to most aspects of our descriptive definition, they are part of a more encompassing condition.

Is there a "character type" which is regularly associated with the development of agoraphobic syndrome? Psychoanalysts loosely refer to phobic or avoidant or counterphobic characters or character traits. The DSM-III-R entity, "avoidant personality," does not coincide or even overlap with these psychoanalytic usages. Because of the complexity and breadth of the nosologic issues involved, discussion is deferred to a subsequent communication.

Treatment Issues

What happens to patients with agoraphobic syndrome in and after analysis? Treatment outcomes will be studied in a subsequent communication. Here a few examples will serve to show the variety of patterns.

Deutsch's first reported case (1928) was referred to her by a male colleague when he left Vienna. The patient had already experienced considerable relief of agoraphobic symptoms in that previous treatment. With Deutsch, there was a period when the patient was anxiously concerned about the welfare of her previous analyst, followed by a resumption of her typical agoraphobic symptoms. Deutsch hypothesized, "The vivid, conscious phantasy about the analyst acted as a wish-fulfilment and served as a protection against anxiety and a substitute for a

companion. . . . the analyst's departure was felt by the patient as a disappointment in love and produced a sadistic reaction" warded off by reaction formation (pp. 55-56).

Miller's (1953) patient similarly experienced considerable relief of her anxiety with a previous analyst after that analyst gave up on the treatment and established a social relationship with her. When he died, her symptoms became worse than before the contact. After about two years of analysis with Miller, she was said to be symptom free, but she subsequently required at least one period of further treatment because of recurrent agoraphobic symptoms.

How might the fantasy of a fulfilled love with the analyst serve as a "protection against anxiety"? Some sort of less pathological compromise formation—less pathological in the sense that unpleasure affect is diminished—must have arisen. An agoraphobic patient whom I have had the opportunity to follow for eighteen years after the interruption of her analysis, always maintained the image of her analyst in her mind and, at a time when a series of untoward life events occurred, experienced an acute exacerbation, not of her agoraphobia, but of her transference love. The protection appears to be against further regression which may be a prerequisite for typical agoraphobic symptoms.

Some of the reported cases showed symptom relief after a few months, but others only after many years of analysis. Some developed other types of symptoms in the analytic sessions, such as hysterical seizures; others subsequently developed depressive or obsessional illnesses.

The general impression that one gains about treatment from the literature is that agoraphobic symptoms tend to improve in analysis, but over very variable time periods, and with a tendency to recur. Depressive states are often a problem before, during, and after treatment. The changes that occur during treatment, at least initially, seem to be related to alterations in the affective tone of the relationship to the analyst; that is, if the affect that arises is predominantly affectionate/erotic, a "trans-

ference cure" occurs temporarily. This may have more lasting significance, however, than the pejorative "transference cure" suggests, as indicated in the eighteen-year follow-up.

The role of exposure to the feared situation is mentioned only by Freud and Katan, but is taken as a treatment essential by both of them. Future case reports should try to clarify this issue. The burden of showing that psychoanalysis does as well as, or something more than, exposure therapy certainly rests upon psychoanalysts.

Psychoanalytic Clinical Issues

What is the role of traumatic experiences in the causation and precipitation of the agoraphobic syndrome? Deutsch's first patient revealed two traumatic experiences: (1) she recalled witnessing a "primal scene" in infancy; (2) at puberty she saw her father collapse in a seizure. The overt precipitating event for the onset of the agoraphobia was seeing a man on the street have a seizure; a covert precipitating event was that she had been "sexually attacked" by her boyfriend. In the other reports traumatic precipitating events are not prominent. On the contrary, successes, achievements—steps into adult life—may be a common precipitating event.

The idea of a "primal scene" is more problematic. What constitutes a primal scene? Must the child view parental sexual intercourse? Is only overhearing sufficient? Once or repeatedly? Up to what age? Is there *anything* that can characterize the actual parental behavior required, or are we talking only about reactions which can only retrospectively be judged to have been traumatic? We shall return to this problem in the discussion of anxiety.

What is the role of the companion? Deutsch hypothesized, again from her first case, that the presence of the patient's parents served as a protection against the fear of enacting forbidden sexual wishes, and also as reassurance that her parents were safe from her aggressive wishes. In the second case, Deutsch was

more specific about the dynamics of protection: the daughter became the companion of the agoraphobic mother, assuming the role of a forbidding superego acting benignly, therefore vitiating death wishes. She calls the companion "the protected protector." In other instances the accoutrements seem to serve the role of symbols of a companion. In the case followed for eighteen years, in which no actual companion was required, the image of the analyst became a sort of internal companion which served to avert agoraphobic symptoms, more or less permanently. It is not clear, however, that this mechanism is any different from that of the formation of mental structure in general.

Does the agoraphobic syndrome proceed from some particular developmental level? The literature on infantile phobias left us with a strong suggestion that events in the sadistic-anal, early genital phase form the materials from which infantile phobias are constituted. There is nothing in the agoraphobic literature which suggests a similar pattern or even any particular connection with infantile phobias. This would seem to remain a matter to be decided by long-term developmental studies. I have already indicated my views on the oedipal versus preoedipal debate.

Are there particular kinds of conflicts which are characteristic of the syndrome? Are there particular unconscious fantasies which are regularly represented in, and in some way causative of, the symptoms? Or, conversely, is the syndrome an inevitable by-product of abnormal "generation" of anxiety? The psychoanalytic literature seems divided in respect to these questions, and not much has been added to the proposals of Freud and Deutsch in regard to dynamic content.

Theoretical Issues

Review of the agoraphobic syndrome raises a number of fundamental psychoanalytic theoretical issues. (1) How do we account for the particular set of symptoms formed—the problem of "choice of neurosis"? Analysts have been aware of the neces-

sity to explain the specific symptom pattern, but have not obviously succeeded in doing so. (2) What are the nature and scope of the concepts of displacement and projection? Given modern formulations of anxiety and agoraphobia (so far as the latter exist), do we still see a central role for projection in phobia formation? (3) What is a "primal scene"? Are there descriptive boundaries to what counts as one? (4) Are there different kinds of regression, such that agoraphobics regress in a different way than do children with animal phobias—a "temporal regression," as Freud put it? (5) Are there significant psychodynamic and psychogenetic similarities between infantile animal phobias and agoraphobia?

All of these theoretical issues take us well beyond the scope of this part of the paper. The "problem of anxiety" is involved in all of them, however, and requires further comment here. Intense, overwhelming states of fear—panic—seem to have a substance of their own, to be "thing-like" in some way, such that the "spontaneous" appearance of such states challenges hypotheses of their occurrence on the basis of meaning alone. Freud's idea, or one of his ideas, for dealing with this problem was that of traumatic states in which anxiety is generated. The theory of the primal scene experience is a way to make concrete or to locate some event which has this traumatic quality and lends it a more or less specific content. Deutsch, in passing, used the phrase "predisposition to anxiety," in a way which suggests it as a substitute for the primal scene hypothesis. Later, Greenacre (1941, 1945) developed this idea: certain kinds of events in early life may result in a permanent "diathesis" to the development of states of intense anxiety and/or chronic anxiousness. If such traumatic states or predispositions to anxiety exist, this leaves us with a question concerning signal anxiety. If we adhere to Freud's 1926 formulation, fear is always inside and danger is always outside—at least in the realm of signal anxiety. But traumatic states raise the possibility of "internal danger," roughly the danger of disorganization of the mental apparatus. Anna Freud (1936) prominently included this possibility in her book.

Weiss's theory of agoraphobia is a variant of the same idea—the anxiety is a reaction to the perception of structural disorganization *and* a manifestation thereof.

Finally, are there important dynamic mechanisms common to infantile animal phobias and agoraphobia? How can we decide whether "projection" is an important factor? Is "displacement" a candidate for a, or the, central dynamic in agoraphobia?

On the basis of the literature reviewed, one cannot say very much in answer to any of these questions. Anxiety in the agoraphobic syndrome appears to be less focused than that in infantile phobias: I am not tempted to try to explain the syndrome by applying Anna Freud's hypothesis of a massive condensation of infantile conflicts onto one symbolic object. The same nonapplicability covers displacement as it is used in the literature on infantile phobias. Katan means something quite different from symbolic substitute formation. The question of projection or externalization brings us once again to the problem of anxiety. How one understands the position and role of anxiety in neurosogenesis is the crux of the matter for psychoanalysis, not just for biological psychiatry.

It seems to me that the agoraphobic syndrome, on a descriptive basis, constitutes an entity worth investigating as such. Further detailed case reports are required in order for us to formulate clearly the questions which need to be answered from a psychodynamic viewpoint.

SUMMARY

Accumulated psychoanalytic experience suggests the following hypotheses about the agoraphobic syndrome. Clusters of related fears tend to occur together. These include fear of open places, closed places, bridges, tunnels, elevators, restrictive situations, and some specific animal fears. Relief of the anxiety is often but not always provided by the presence of a companion who is emotionally important, and sometimes by wearing or carrying

or pushing various accoutrements. The great majority of the patients are female, with onset of the illness from late teens to early thirties. The illness tends to be chronic or recurrent and shows a strong association with depressive states or depressive illness. The conscious content of the fear is of going crazy, dying, or otherwise losing control *in the phobic situation*. Analysts are divided on whether the illness starts with a contentless anxiety attack or without such an attack, and even upon whether or not there is unconscious content or only "generated"—at this point we might just as well say "primary neurophysiologic"—anxiety. An event which has the significance of a step into adult life may be a common precipitating cause.

The results of psychoanalytic treatment are not well documented but appear to be variable. Symptom relief may occur within a few weeks or months, or may require many years. There are recurrences after analysis, and the position of depressive states has not been carefully considered. There may also be transitions to other types of symptom pictures, such as obsessional neurosis or social phobia. There are data suggesting that a positive relation to the analyst is important in symptom relief, at least temporarily ("transference cure"). Actual exposure to the feared situation may be an essential part of the treatment, though this does not appear to be true in all cases.

Psychodynamically, there have been repeated suggestions that fear of acting upon sexual temptation is a central issue. A number of authors have noted that the patients tend to be particularly passionate about their sexual impulses in analysis, but only one reported patient showed anything like promiscuity. The predilection for the illness in women has been related to pronounced exhibitionistic conflicts, to masochistic identification with a degraded object (mother), and to a strong feminine-masochistic cast to the sexual fantasies. The presence of a companion, if one is required, is thought to be related not only to protection by the companion from enactment of sexual fantasies (a prohibiting superego function) but also to protection of the companion from the enactment of aggressive fantasies.

Whether or not there are more specific types of unconscious fantasies underlying the agoraphobic syndrome is presently unclear.

There is no clear evidence that an independent syndrome of claustrophobia exists. On the other hand, social phobias of adults do appear to be different. The existence of erythrophobia as an entity is questionable. Spider phobias are an anomaly of unclear status. Use of the term phobia in relation to these conditions does not rest upon any significant similarity to infantile phobias or the agoraphobic syndrome beyond the presence of overt anxiety with some degree of focused quality.

No further modifications of our descriptive definition of phobia seem necessary on the basis of the agoraphobia literature, although some of what was added on the basis of infantile phobias seems only marginally applicable.

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BOOK REVIEWS

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THE PSYCHOANALYTIC CORE. ESSAYS IN HONOR OF LEO RANGELL, M.D. Edited by Harold P. Blum, M.D., Edward M. Weinshel, M.D., and F. Robert Rodman, M.D. Madison, CT: International Universities Press, Inc., 1989. 536 pp.

The essays in this volume, written to honor Dr. Leo Rangell, are a fitting tribute to the man and his important and unique contribution to psychoanalysis. They reflect his warmth and concern as a man and his curiosity, intelligence, and dedication as an investigator of the human psyche.

The first essay is a personal memoir by Jacob Arlow who nostalgically recounts experiences which he and Leo Rangell shared when they were house officers at the same hospital. Though they later settled on either coast of the United States, their friendship has persisted, cemented as it is by their devotion to psychoanalysis.

Robert Rodman presents a condensed overview of Rangell's work in an essay entitled "Leo Rangell and the Integrity of Psychoanalysis." The title is felicitous, as it characterizes Rangell's approach to his life and work and indicates his interest in the subject of integrity, about which he has written and spoken at length. Closely related to Rangell's interest in integrity is his concern with intrapsychic conflict. The resolution of intrapsychic conflict involves decision making and choice. To choose is to give up and lose the alternative. Inconsolability can be a response to loss. Edward Weinshel's article on inconsolability elucidates what is known of the subject and points to areas that require further exploration.

Charles Brenner points out that symptoms, like dreams, are compromise formations and require analysis. He rejects the idea, accepted by some analysts, that symptoms are unimportant. The dismissal of symptoms, Brenner believes, is an overreaction to an earlier excessive focus on symptoms that disregarded the dynamic and genetic issues behind them. Symptoms are compromise formations. Their analysis can yield valuable information.

Contrary to the belief of some analysts that preoedipal events contribute little of importance to therapeutic psychoanalysis, Marjorie Harley demonstrates the significance of the distorted ego and drive development which can result from excessive preoedipal

stimulation or deprivation. Preoedipal trauma can enhance the effects of oedipal trauma and can foster the denial and the interference with reality testing which result from such trauma.

In response to Rangell's contribution to the task of distinguishing between psychotherapy and psychoanalysis, Robert Wallerstein reviews the history of the subject, its present state, and the prospects for its future. According to Wallerstein, the differences between psychoanalysis and expressive psychotherapy and supportive psychotherapy are not clear-cut. Further study of the subject is essential.

Several papers pursue Rangell's interest in moral issues. Arlow dates the quest for morality to the very early desire of the child to please the primary caretaker. The young child responds to a variety of verbal and nonverbal cues that indicate pleasure or displeasure. With the development of language and the advent of separation, the child is guided by the mental representation of the caretaker rather than by his or her actual presence. Identifications and internalizations based on the complex interaction of drive derivatives and object relations are additional determinants of morality. They contribute to passing judgment, meting out punishment, and granting forgiveness.

The punitive parent, according to Harold Blum, has often, but not always, been subjected to excessive punishment in his or her childhood. Reports of severe punishment may or may not reflect actuality. They may reflect fantasies about "deserved" punishment for fantasied misdeeds perpetrated by the patient or others. So intricate may be the motivation of punishment that neither the recipient nor the punisher may understand the behavior. Severe, cruel, and exploitative behavior is often associated with what Leonard Shengold refers to as soul murder (i.e., the destruction of a person's identity, will, and emotional integrity by physical or psychological abuse). Autohypnosis, via denial and separation, can defend against the very painful memories of abuse, but the denial results in defective object relations and poor reality testing.

Janine Chasseguet-Smirgel believes that the development of a postoedipal superego is essential to the establishment of the boundaries of good and bad. In the absence of a sound superego, character disorder develops because of a failure to integrate parental

values, acknowledge differences, and accept a meaningful hierarchy of values.

Jules Glenn demonstrates, in a detailed case, that the superego is not a monolithic structure. The ideals, behaviors, and goals guided by the superego can vary and even be internally contradictory, as they are based on different experiences with different people or even experiences with the same persons under different circumstances. Otto Kernberg, in his study of sexual perversion, attempts an integration of personality organization, object relations, vicissitudes of aggression, narcissism, and superego formation.

The source of the data for Robert Stoller's article on sadomasochistic perversions is unusual. Stoller visited an establishment where such perversions were practiced, and he talked to some of the participants. He cataloged the techniques used, and noted that most of the scenarios enacted involved power and powerlessness. He observed many differences and recommended that more data be gathered from non-psychoanalytic treatment sources. Heiman Van Dam reports that actions are communications, the analysis of which can elucidate conflict and attempts at mastery. Conjoint therapy of mother and child is described by Eleanor Galenson and Barbara Fields. The child's mourning of the death of her father was inhibited by mother's attachment to the child, who was the focus of mother's unresolved mourning for her own father. As a result of treatment, mother and child were able to separate and resume mourning.

A series of papers address the conflicts and challenges which analysts face in the course of their work. Clifford Yorke pays tribute to Anna Freud's astute and wide-ranging contributions to psychoanalysis. He notes especially her addition of the diagnostic profile and developmental lines in the diagnosis and treatment of patients. On the basis of his long personal and professional relationship with her, Yorke details Anna Freud's skills and inventiveness as an administrator and clinician and her warmth and understanding as a human being and friend. Pearl King describes the many issues which occur in the course of being a psychoanalyst that test integrity. King views the pressures to which psychoanalysts are subject as similar to those experienced by the persons involved in the Watergate scandal that led to a compromise of integrity. She agrees with

Rangell that such compromise is the result of the triumph of narcissism over principles. A firm sense of identity counters narcissism. Being a psychoanalyst tests narcissism because of pressures from the group and competitiveness within the group around issues of status and productivity. The analyst's identity, according to Léon Grinberg, is based on integrity, ethics, and love of truth. These attributes are manifestations of the analyst's ego ideal and superego. The failure to abide by analytic principles harms patient and analyst. Re-analysis is recommended to deal with such failures.

The validity of an interpretation, according to Horacio Etchegoyen, is established by the analysand's response to it. An interpretation is the analyst's view of the analysand's thoughts in a given situation. It is not the analyst's opinion of the situation of the persons involved in the situation. In evaluating the analysand's response, the analyst must be mindful of the analysand's suggestibility.

The value referred to in Nikolaas Treurniet's paper, "Having and Giving Value," is truth. The capacity to accept the truth about oneself (i.e., the "good" and the "bad") is an important determinant of the value of the analyst, for it enables the analyst to help the analysand do the same. In this context "good" and "bad" are not moral judgments; they are characteristics which have been developed to cope adaptively or maladaptively with troublesome situations.

Serge Lebovici traces the formation of morality to the preoedipal struggle to assure parental love. The superego derives from the early attachment to the parental "good" and "bad." He alludes to Melanie Klein's theories of the split in the ego and the role of projection in the genesis of morality. Shame and moral masochism protect against guilt.

In his paper on aggression, sexuality, and the death instinct, Adam Limentani reiterates the close relationship between sexuality and aggression. He presents an illustrative case study and indicates the importance of theory in understanding clinical situations. He believes the notion of the death instinct is dispensable. He stresses the importance of the analysis of affects. The effects of major aggression are observed in studies of the Holocaust. In these studies, Milton Jucovy avers, controversies about pathogenesis and about understanding of symptomatology have emerged. However, there

is agreement about the importance of remembering, mourning, and coping with guilt.

Shame and entitlement, according to Rafael Moses, indicate discrepancies between the ego and the ego ideal. They are opposite sides of the same coin. They are important factors in persons engaged in the political process. These issues are central in Rangell's work on integrity.

The scope and quality of the papers in the volume attest to Rangell's outstanding contribution to psychoanalysis. Each paper, in an original and imaginative manner, addresses issues about which Rangell has declared himself. This collection is not only a celebration of Rangell, it is also a noteworthy contribution to the psychoanalytic literature.

REBECCA Z. SOLOMON (HARTFORD, CT)

FREUD REAPPRAISED. A FRESH LOOK AT PSYCHOANALYTIC THEORY. By Robert R. Holt. New York/London: The Guilford Press, 1989. 433 pp.

Robert Holt is sharing with his readers a most enjoyable personal, intellectual, and psychoanalytic journey in this collection of fourteen of his papers, which he has carefully reviewed and occasionally revised. There seem to be a number of motivations in his creating this book. First, it represents a recapitulation and integration of his own thinking, reviewing the passage he has made that has led him to his present stage of looking toward a new integrative world hypothesis, as he finds the current status of psychoanalytic theory unsatisfactory. Second, he expresses the hope—which I feel is quite justified—that in sharing some of his struggles in trying to understand Freud, he might be able to ease the way of those students and scholars who find themselves at an earlier point on the same journey. At the same time, he clearly states that a reading of this book will not substitute for a reading of Freud in the original, and that certainly is the case. However, I must say that there will be points when the reading of Freud for the first time or maybe for the second time can be aided by readers' having this Holt volume with them as a companion piece.

As Holt shares his own intellectual history with us, he is explicit in saying that he has in mind writing an intellectual history of

Freud. I find him well prepared for such an undertaking. In fact, he is already well on his way toward doing that; and I encourage him to move ahead with his enterprise. In the meantime, I think he has attained his goal of providing "a sort of Baedeker for a traveler into inviting but often difficult and puzzling intellectual territory" (p. v), the territory being that of moving toward an understanding of Freud's contributions.

One of the strongest points of the material reviewed by and written by Holt is his emphasis on uncovering the unconscious motives and fantasies or the unacknowledged assumptions Freud was using in taking some type of implied stand on such fundamental questions as: "what is real," "how is knowledge possible," "how are the mind and body related," "how can we find truth," etc. Freud rarely grappled directly with such issues, but his exposure to a variety of conflicting teachings and influences, which shaped his orientation, Holt believes, is an important source of subtle confusion and contradiction in his writings. Holt makes significant progress in this volume toward developing an intellectual history of Freud.

All but the first and the final chapters are papers which have been previously published. Each chapter has a significant foreword explaining Holt's thinking at the time the original paper was written and the individuals with whom the material was discussed and reviewed. This gives a context for the whole exposition, neatly laid out at the beginning of each chapter. It also orients the reader to what might be of interest in the material without the reader's having to review the whole chapter. In addition, there are extensive notes on various points in each chapter included in the appendix. I found these notes just as interesting and as enriching as the material in the chapters themselves. Finally, many of the chapters have an "Afterword." A few of these are quite extensive. Most of them summarize the change in Holt's thinking at the present time or describe more general developments in psychoanalytic theory or understanding which have taken place since the period when the paper was first written.

The time of writing ranges from 1962 thru 1985. The contents are organized in six parts. Part I, "Background," starts with a personal introduction that focuses on a history of Holt's exposure to psychology and psychoanalytic thinking and on the significant

scholars and clinicians with whom he had an opportunity to work and by whom he was influenced. The next paper discusses the manifest and latent meanings of metapsychology, how Freud defined and used metapsychology, and some intellectual antecedents of the term and concept. The final paper in this section, a most interesting one, is on Freud's cognitive style. It ends with a "decalogue for the reader of Freud"—a decalogue I had not previously seen. I recommend its use as the reading of Freud's contributions is initiated with such groups as residents, psychoanalytic candidates, and others.

Part II begins the meat of the book. It contains three papers discussing psychic energy and the economic point of view. In this work, Holt reviews his struggles to understand the concept of bound energy. At the end he tells us that he would have been better served if he had had his decalogue for reading Freud available when he first started out. "Like many another Freudian scholar, I assumed that Freud had something far more complex in mind than he probably did" (p. 108). Holt goes on to review the background for Freud's biological assumptions and the difficulties created in the development of psychoanalytic theory by those assumptions. He comments that Freud had hoped that by shifting to a kind of abstract brain model, he would be freed from the limitations of the biological disciplines within which he had labored for many years. But that very shift concealed the biological nature of his theoretical starting points. Holt is encouraged, as are many others, that the day is fast approaching, due to the very rapid advances in the neurosciences, when psychoanalysis may at least become the kind of productive science Freud wanted it to be through return to the disciplines in which he did his first scientific and professional work. Although Holt finds the assumptions used in these energic concepts erroneous and believes they need to be replaced, he cautions, "Theories are not dragons to be dispatched by a single stroke of a methodological sword; they are much more like social systems which can be overthrown only by being replaced by another, no matter how creaking and inadequate the other may be" (p. 165).

Part III contains Holt's major effort to critique instinct theory and to consider some alternative ideas. His conclusion is that Freud's concept of drive served a useful function in his own theoretical development, but for us, it is an anachronism beyond hope

of rehabilitation. With relatively few terminological changes, however, his earlier but never abandoned concept of *wish* can be made a clinically usable substitute.

Holt reviews his writing and thinking regarding the structural point of view in the four chapters contained in Part IV. In short, Holt feels that the fatal flaw in ego psychology proved to be its foundation in metapsychology. He says that

> in the long run I'm not even sure that psychoanalysis will have a general theory of its own—nor that there will be any valid scientific need for a recognizable psychoanalytic theory to replace metapsychology. As sciences mature, schools wither. We are not yet at a high enough level of scientific maturity that it is evident to all that there can and should be one general, all purpose theory of the human person. A necessary and absolutely indispensable prerequisite to any such theory is that it incorporates all of the clinical discoveries of psychoanalysis. . . . For the foreseeable future, psychoanalysis is in the awkward position of having to abandon metapsychology without having any equally comprehensive and more tenable substitute at hand (pp. 214-215).

Part V contains "Critical Reflections on Psychoanalytic Theory as a Whole." In two papers Holt presents a beginning for a new theory for psychoanalysis, the hoped-for alternative to metapsychology; he discovered, however, that he was not ready to present a new theory but instead needed to discuss fundamentals. He then makes this statement:

> If metapsychology is dying from impalpability and inconsistency, let it be reborn into a vital psychoanalytic science by the effort to account for our original and always most stimulating data, the transactions of the psychoanalytic hour. And, to the extent that it has been a model, let it be transfigured into an effort to achieve the kind of intermediation I have described between psychoanalysis and the biological sciences of the human organism (p. 323).

In his last chapter, "Freud and the Emergence of a New World Hypothesis," the only chapter in Part VI, Holt brings to a close his critique of metapsychology. He says that as he went through a study of his work on Freud, he found that Freud, much more than he had imagined, was a prisoner of his earlier assumptions—not only about methodological issues but about other metaphysical ones as well. Holt feels he should lay his own cards on the table by attempting to outline a systems metaphysics that appears to him to be a more adequate foundation for future psychoanalytic theory than the pragmatism that is so prevalent, especially among those who are drawn to hermeneutics. He bases much of his thinking on

the work of Stephen C. Pepper (1891-1972).[1] He states: "Repeatedly in the history of ideas, where competing but incompatible formulations have persisted, the outcome has not been the victory of one and rout of the other but a reorganization of the field, making it possible to transform and integrate what in untransformed guise had seemed irreconcilable" (p. 361). In Holt's more optimistic moments he feels that progress is being made toward such a synthesis. He is firmly convinced that metaphysics does matter, that huge benefits will accrue if satisfactory philosophical foundations can be laid for a true concert of the disciplines—the arts and humane letters alongside the sciences. Psychoanalysis will be an indispensable component.

Holt's reappraisal generously repays the considerable time and thought required to immerse oneself in the flow of the intellectual development and argument. The recent, more rapid development of new information in the biological sciences, especially the neurosciences, makes joining Holt on his retracing of his intellectual journey through the evolution of psychoanalytic theory especially timely and orienting.

JOHN A. MACLEOD (CINCINNATI, OH)

BETWEEN FREUD AND KLEIN. THE PSYCHOANALYTIC QUEST FOR KNOWLEDGE AND TRUTH. By Adam Limentani. London: Free Association Books, 1989. 281 pp.

Psychoanalytic wisdom and experience cannot adequately be summarized, and so it is with this gentle yet profound volume. Although Limentani states that years of practice guarantee experience but not wisdom, this collection of his papers makes it clear that he has acquired both. The author for many years has been a member of The Middle Group of the British Psycho-Analytical Society, hence the title of the book. From this position he modestly but firmly presents his synthesis of the classical Freudian and the Kleinian points of view. Free of jargon and metapsychological formulations, its wealth of clinical theory and practical suggestions most

[1] See Pepper, S. C. (1961): *World Hypotheses: A Study in Evidence*. Berkeley: Univ. of Calif. Press; (1972): Systems philosophy as world hypothesis. *Phenomenological Research*, 32:548-553.

often leans toward object relations, although instinctual factors are hardly neglected. The emphasis throughout is on the vicissitudes of affects in psychoanalytic work. While this area of our work is put foremost in much of the literature, it has often become secondarily lost in actual practice.

Limentani's remarkable openness to what he has seen and heard over many years transcends an attempt to merely fit the new into the accepted mold. He begins with a history of the controversy in the British Society during the early 1940's between the adherents of Anna Freud and of Melanie Klein. He further illuminates his discussion of conflict in other psychoanalytic societies along the lines of unresolved transferences toward Freud, psychoanalysis, and later psychoanalytic leaders.

In the discussion of acting out he stresses that such behavior in a transference inevitably leads to countertransference reactions. Nonetheless, in his patient and penetrating fashion, he sees acting out as an unconscious communication. It is not only resistance to abstinent technique, although that is also present. He views acting out in patients, as in social delinquents, as an expression of the individual's fantasy life, and as a means of relieving unbearable tension. But mainly it is to find a fresh solution. Such patients think they can control the real world, not just the unconscious world of fantasies. When no such outlet exists, psychosomatic illness may result. Repeated episodes are related to phases of interpretation in the process of working through. Limentani's approach is to tolerate acting out and allow for its gradual decrease.

In his useful comments on analyzability, the author notes that in the role of the assessor one should not assume a silent and inactive mode. He is concerned about the contrast between the widening scope of psychoanalysis in the general population and a narrowing one for candidates. We can easily err in our prediction of analyzability by too much or too little emphasis on either diagnosis or presenting symptoms. Since we have a significant rate of nonsuccess as a result of factors from both the analyst and the patient, it is unsafe to express definite views while the analysis is in process.

In another chapter dealing with training difficulties, Limentani examines the troublesome status of the candidate in what he views as a psychoanalytic family situation. Institutional training is seen as antithetical to an analysis because of the conflict between infan-

tilization and maturation and individuation. The neutrality of the training analyst is seen as nothing but a myth. And among the many difficulties for the candidate are the narcissistic problems arising from being a patient while aspiring to be an analyst.

A number of sections deal with the author's vast experience with patients with sexual perversions. In discussing bisexuality, he focuses on the significance of unbearable separation anxiety and a profound disturbance in interpersonal relations. He views protracted and recurrent bisexual behavior as a preoedipal problem rather than a result of unresolved oedipal conflicts. In general, he associates it with narcissistic and/or borderline states. When dealing with homosexuality he speaks of multifactorial causation, which cannot be predicted from the nature of early parenting. His overview is that the homosexual syndrome is part of a defensive movement directed at lessening anxiety, or at creating barriers against the eruption of unbearable conflicts—and quite often simply at ensuring survival. A useful classification of homosexuality is suggested. Group I consists of "latent heterosexuals" with severe oedipal conflicts and castration anxiety. Those in Group II have "true perversions," serving as defenses against overwhelming separation and psychotic anxieties. Group III includes patients whose perversions are related to periods of stress and special social surroundings. Prognoses and treatment modes obviously differ.

When dealing with transsexualism, Limentani views the idea of mind being alien to the body as central. Differentiating these cases from homosexuality or transvestitism, he notes the absence of castration anxiety or of any sign of sexual excitement. To deal with the most profound anxieties, the patient acts so as to deny being afraid of being separate: "I have mother with me—I am *really* her."

Perhaps the chapter most indicative of the author's empathic working mode is the one on affects. He tries to put affects back into the center of the analytic process. Among his many clinical observations and suggestions he stresses that patients do not always attempt to repeat past affective experiences in analysis; they sometimes try to avoid them. Along with many current writers, Limentani views countertransference as an instrument of understanding the patient. Although the analyst is very involved affectively in the treatment, he counsels against revealing the analyst's own affective states. He questions whether words are always all-important to the

psychoanalytic process. Since words are so difficult to connect to feelings, we must try to know nonverbally what a patient experiences. It is in this realm that he most forcefully views object relations as the best approach to a thorough analytic examination.

Limentani's lucid and direct mode of presentation is wonderfully presented in the chapter on the negative therapeutic reaction (NTR). For the patient the NTR reflects deep-seated fears about the meaning of health. An early NTR is worked with as a resistance or defense. If the NTR occurs later, it is viewed as an inadequate understanding of transference or countertransference. Recurrences are bad signs. Some patients prefer an NTR to a frank attack on the analyst, and hope that the analyst can contain it. They do not feel guilty, but "ill"; and unconsciously they want to make reparations to internalized objects. Although acknowledging the discouraging aspects of NTR, Limentani sees it as an opportunity to experience faulty development of detachment from a dyad. The patient can become more accepting of attack. "Guilt can be reduced without deflation by realizing that he doesn't menace the gods" (p. 162). In a view which parallels a central theme of the writer's thinking about psychopathology, he views the NTR as arising from the trauma of early separation from mother, which has caused unbearable pain and continued defense against it.

Other topics presented must be reviewed more sketchily. Delinquency is seen as "rooted in denial and a belief in the magical and omnipotent solutions of anxiety, conflicts, and particularly of the problems related to helplessness" (pp. 188-189). In a striking redress to our conventional skewed view of psychosexual states, he discusses the "vagina-man," the counterpart of the phallic woman. These are men who present with no awareness of sexual difficulties but have marked anxieties about their femininity and threatened homosexuality. The vagina-man uses his identification with the woman, his primal object, to escape from this threat. His femininity, almost entirely psychic, is equated with passivity in his defensive maneuver. Much concerned with psychological issues in their social context, Limentani views drug abuse as very much involved with ways of dealing with aggressiveness. Ambivalence and destruction in a background of primitive fantasies toward the mother result in attempts to externalize a desperate internal state.

The book is replete with case examples—of work that succeeded

and failures that enhanced understanding. To sketch in the topics covered is only an attempt to convey the richness of clinical observation and the empathic understanding which characterize Limentani's analytic career. They are presented in a setting of an outline of his psychoanalytic autobiography, which further enhances the rewards of the volume.

HAROLD R. GALEF (SCARSDALE, NY)

SEPARATION AND THE VERY YOUNG. By James and Joyce Robertson. London: Free Association Books, 1989. 242 pp.

This slim volume recounts in detail the clinical research conducted by James Robertson, the British psychiatric social worker and then psychoanalyst, and his wife Joyce on the effects of separation from the mother on the under three-year-old child. The bulk of the book was written during the last two years of James Robertson's life, prior to his death in 1988, with a few added articles written by Joyce Robertson concerning her research on parenting.

This is not at all a book about theory. It is a book about actual individual children, each suffering a significant separation from home and family. It is also a book about the Robertsons and their role in bringing about changes in the way children undergoing such separation are seen, understood, and helped. The Robertsons were activists and advocates, and the often strident resistance to their findings is recounted in detail, as are their eventual successes. This is an important historical document.

In 1948 Robertson joined John Bowlby at the Tavistock, where Bowlby was studying the reactions of children to separation from their mothers. Robertson was assigned the task of doing the necessary fieldwork to support Bowlby's hypothesis; indeed, it is as the source of much of Bowlby's clinical data that the Robertsons are best known to psychoanalysts.

Robertson first elected to observe and film children under three who were separated from their families during hospitalization for elective surgery. By way of contrast, he later observed and filmed children undergoing similar surgery in hospitals which allowed mothers to room in and remain with their children. Next, he and his wife filmed children placed temporarily in residential nurseries when their mothers were in hospital giving birth to siblings. Finally,

they filmed children placed in foster care—with the Robertsons themselves—in the same circumstances.

Their observations are a testimony both to how much one can learn about a child by looking and listening in a sensitive and receptive manner and also to how much one can fail to see if the largely nonverbal communications of small children are ignored by adults responsible for their care. The detailed descriptions of each individual child's day-by-day ordeal, with follow-up visits months after, make up the first fifteen chapters of the book. They are deeply moving not only because of the suffering they depict and the descriptions of the children's desperate and often heroic efforts at finding ways to cope and adapt, but also because of the extent to which the adult professionals involved—doctors, nurses, and social workers—so often failed to see or respond appropriately to the children's distress. In addition, when the films were shown publicly in an effort to educate doctors, nurses, and institutions, the Robertsons were personally attacked and their findings rejected. They did, however, eventually largely prevail. It is an affecting story.

For those who take to heart the abuse through neglect that children have suffered throughout history and still do all over the world, this book will touch them deeply; one is reminded of Freud's all too accurate observations that the oedipal child's neurotic symptoms are routinely dismissed as naughtiness—except that here instead of neurotic symptoms we are dealing with the consequences of the loss of the primary object prior to the establishment of object constancy. The films themselves are available through the New York University Film Library. It would have been better if, instead of sharing this information with us only through the appended bibliography, a special page had been set aside with detailed information about how to obtain copies of the films, especially about their availability on videotape.

The three chapters by Joyce Robertson concerning the emotional needs of the young relate to the topic of separation as she describes the effects upon the developing child of the emotional unavailability of the physically present but inadequate mother. The final five chapters of the book concern the Robertson Centre, set up in 1975 to "promote the understanding of the emotional needs of infants and young children." Their working definitions of bonding and attachment are given with a minimum of theoretical terminology,

and examples are given of their consultations with the courts on issues of adoption and child custody. Again, the theme is their historic role as advocates for children undergoing a variety of environmental stresses in which their unique needs are underrecognized.

This is a deeply moving and involving book, and as such, it would make a powerful teaching tool for the education of those who are or will be in positions of responsibility for children. This would include pediatricians, nurses, social workers, family court and divorce lawyers, judges, teachers, and day-care staff. As the book is graphically clinical and not at all technical in its writing, it is perhaps most ideal for a student population.

J. ALEXIS BURLAND (BALA-CYNWYD, PA)

THE LOST CHILDHOOD. By Yehuda Nir. New York: Harcourt, Brace, Jovanovich, 1989. 256 pp.

The account of every victim of the Holocaust is unique. To experience terror without end, to fear impending death without relief, must be almost too difficult to recollect, impossible to communicate. Within the barbed wire fences of the concentration camps, the borders of doom were unmistakably delineated. The enemy was ever-present and clearly visible. But there are other stories that some survivors have to tell, very different but in many ways very similar to the experience of the survivors of concentration camps. Such was the fate of a small number of Jews who, having obtained forged identity papers, passed to the outside world as non-Jews. They too lived in a concentration camp, a vast concentration camp without walls. Terror and the threat of death accompanied their every step. Who suspects? Who knows? Who will betray? These were the ever-present concerns that colored every human contact. Every human encounter demanded an immediate life-and-death decision.

Such is the story Yehuda Nir has to tell in his moving memoir, fittingly entitled *The Lost Childhood*. Son of a wealthy merchant in the Polish city of Lwow, Yehuda was almost ten and experiencing the first stirrings of romantic love when the Second World War changed the quality of his childhood forever. After his father was captured and killed, Yehuda, his mother, and his sister, with the

help of papers forged by an admirer of his attractive sister, decided to pass as Poles, first in Crakow and then in Warsaw. Every detail of the family's survival is harrowing in itself. To minimize the possibility of betrayal, this little family separated, but kept close enough to keep in touch with each other.

Every day, every moment, presented a new challenge and, although Yehuda recognized that he was powerless, he was by no means weak. Although with his papers he had changed his identity, he never surrendered his spirit or sense of self. While not yet in his teens, Yehuda joined the Polish underground resistance, serving as a courier and helping transport arms to places of crucial significance.

Even to his Polish comrades in arms, Yehuda did not reveal his true identity, and correctly so. When the Polish resistance rose up against the Nazis, while the Russian armies were just across the river facing Warsaw, Yehuda fought bravely with his compatriots. When the uprising was finally crushed, the Nazi generals, aware of their own precarious situation, made a truce with the Polish resistance. If they laid down their arms, they would not be executed but would be marched off instead to work in labor camps in Germany. Marching together off to Germany, the author reports hearing his erstwhile comrades in arms saying, "Well, one good thing about Hitler. At least he's killing the Jews."

The author gives us this harrowing account of his lost childhood in straightforward, narrative form. There is no sermonizing, but also no surrender to conventional piety. The story speaks for itself, as it does, I am sure, for countless others who could not command within themselves the resources needed to set down their accounts of survival at a time when decency, humanity, and civilization lost their meaning. It is Nir's essential objectivity that makes this book so compelling. We can feel the slush and smell the stench of the underground Warsaw sewers through which Nir and his comrades carried arms in their vain attempt to relieve a beleaguered outpost. Yet the account is not without its humor and irony. Small victories help enormously when one is faced by seemingly insuperable odds.

This is a book that should be widely read. It is a fragment of history that should never be forgotten.

JACOB A. ARLOW (NEW YORK)

THE SIGNIFICANCE OF INFANT OBSERVATIONAL RESEARCH FOR CLINICAL WORK WITH CHILDREN, ADOLESCENTS, AND ADULTS. (Workshop Series of the American Psychoanalytic Association, Monograph 5.) Edited by Scott Dowling, M.D. and Arnold Rothstein, M.D. Madison, CT: International Universities Press, Inc., 1989. 257 pp.

This timely monograph brings together a variety of opinions on a topic that infiltrates much of the current literature, either directly or by implication. Discussions about the meaning of psychoanalytic process, the role of developmental psychology within psychoanalytic theory, the nature of therapeutic action in psychoanalysis, the integration of self psychology and the conflict model, the interface of psychoanalysis and neurobiology, indeed, the very domain of the discipline, commonly include references to new knowledge of infancy and its impact on the way we think about human psychology. Remarkably, such discussions often appear to rest on the question of whether information about real infants holds any scientific interest for psychoanalysts, with lines drawn between the object relations/self psychology school (yes) and the conflict/compromise formation school (no).

For the burgeoning field of infant psychiatry to become allied with a particular theoretical viewpoint would be unfortunate in the extreme, despite the inevitable fact that much of the research is informed by the particular persuasion of the investigators. Many of these and related issues are addressed in this collection of papers, helping to orient the reader in what may often seem like the hostile crossfire of a heated polemic.

The Workshop Series format is well suited to the task, with the Workshop papers sandwiched between a historical review and five discussion papers. Phyllis Tyson's review confronts the "contention" in the field; she understands its origins in the two broadly defined avenues of approach to infancy within psychoanalysis, the clinical/naturalistic observational approach and the academic/laboratory research approach. She points out the potential for dialogue and mutual enrichment. She introduces her paper with a reference to Sir James Barrie's Peter Pan, the infant who escapes from humanity into the world of fairies at seven days of age and

who, given the opportunity to return to his mother, to give her the greatest joy and himself the human pleasure of infancy, elects to dawdle among the fairies until his chance is gone and his place is lost to another: "it is Lock-out Time. The iron bars are up for life" (p. 4). This allegorical tale, based on Barrie's own infant observation, serves Tyson's argument that far-reaching inferences about the inner world of neonates are problematic indeed; I think it also provides a whimsical and touching admonition to those who would view the therapeutic relationship as a renewed opportunity to experience the lost paradise of an attuned and loving mother-infant dyad and to recapture the infinite promise at the threshold of development. Differences over the degree to which one views expanding knowledge as applicable to *psychoanalytic* technique and contributory to therapeutic benefit may be a fundamental distinction between camps, a distinction that is usefully addressed in the papers that follow. However, to confine one's interest and education to only that which one can do something about at a given moment in the history of a scientific discipline would surely thwart every field of medicine; microanalyses of infant-mother interaction should be no less interesting to the practicing psychoanalyst than electron microscopic studies are to the practicing infectious disease specialist.

The Workshop papers set forth a rich selection of clinical material reviewed in the light of new information about infancy. While the authors certainly have their differences, especially around terminology (in some cases, seeming to replace familiar categories with unnecessary new designations), there is a consensus in this section about the enhancement of clinical work by a greater appreciation of the complex, marvelously endowed newborn and the subtlety and power of its interaction with the caregiver. The degree to which this is felt to add directly to the therapeutic armamentarium varies. For example, in Jack Novick's paper, he asserts that his therapeutic endpoint would have differed had he a better appreciation of the very early origins of his young patient's masochism, which he retrospectively understood to represent an "addiction to pain" rooted in an irreparable mismatch in the mother-infant dyad. From his description, he had actually achieved a remarkable outcome after seven years of heroic work with a severely disturbed boy.

It would seem an unfortunate "impact" if the revelation of infant research created a kind of therapeutic optimism that eclipsed realistic expectations. This may be especially true in cases such as this where severe breaches in ego integrity and unevenness in development strongly support the presence of unanalyzable "atypicality," i.e., ego deficiencies arising from the neurophysiological substrate. I believe, however, that the same cautionary note applies to a range of patients, all of whom might be greatly benefited by analytic treatment.

Melvin Scharfman addresses this issue in his comment: "In my view all of these approaches shift away from interpretation within the transference neurosis as the central factor in assessing the mode of therapeutic action. Their focus is essentially on an early disturbance in the object relationship, primarily with the mother. In that sense, they make a very real contribution to furthering our understanding of the origins of certain characterological disturbances" (p. 62). He goes on to say that this is one of the essential contributions: a background to understanding global patterns of moods and relating that are not accessible to change by interpretation.

Certainly, most clinicians would agree that they do not expect to transform their patients' *character*; they expect that the overall qualities that make their patients recognizable will at best be modified to permit greater freedom, but not obliterated. This ushers in the inevitable question of the potential impact contained within the real relationship with the analyst and the controversy about the possibility of new or liberated "development"; positions on that question tend to closely correspond to attitudes about direct applicability of infant research. Here the child analysts do form a bridge, however, since the assertion that the analyst is a new "real" object is part of the classical theory of child analytic technique: certainly the papers that describe work with very young children, such as Jules Glenn's, acknowledge the importance of Anna Freud's idea that analysis offers the child a smorgasbord of therapeutic possibilities and that some of these cannot be verbalized, even though they are understood by the analyst (p. 73).

Other facets of this debate are elucidated through these papers. Galenson and Fields's presentation, based on Galenson and Roiphe's research on the early genital phase, demonstrates the im-

mediate usefulness of this kind of naturalistic observation: their approach leads to a multimodal intervention to interrupt the pathogenic family dynamic *in statu nascendi*. Similarly, despite the regular debunking of Mahler among infant researchers, I would contend (as do others in this volume) that her observations and conceptualizations, apart from some unfortunate terminology, continue to have relevance. This is so not only for preventive interventions but also for understanding patients of all ages, very much along the lines of what Arnold Cooper refers to as the "actual plots of early interpersonal life . . . , the genetic narratives that can be reasonably entertained" (p. 84) and what Joseph Lichtenberg calls "model scenes closer to the lived experience of the child" (p. 91).

Martin Silverman's comment that "basic patterns of parent-child interaction observable in the course of infant observation are likely to persist or to recur repeatedly over the years thereafter" (p. 138) serves the important purpose of tempering an overenthusiastic embrace of these new "model scenes," since it is unlikely that a significantly pathogenic interaction will appear only in the preverbal period. Furthermore, he notes, subsequent versions, corrections, emendations, and elaboration will overlay the early residue, and inevitably the early disturbances will be recruited into neurotic conflict. I believe this would apply to the kinesthetic and gestural behaviors described in McLaughlin's original paper as well. As many of the adult case presentations suggest, the appreciation of the early roots of some of the "extra-conflictual" elements of character, such as tension regulation, affect tolerance, differential cognitive endowment, etc. (in addition, of course, to their recruitment in conflict), can offer an invaluable dimension to treatment.

In the discussion section, contributions by Morton Shane, Harold Blum, W. W. Meissner, Leo Rangell, and an Epilogue by Scott Dowling provide a range of viewpoints about the preceding work and help to clarify the complex history of ideas vis-à-vis development and its place in the psychoanalytic metapsychology and theory of technique. Dowling's closing comments are particularly helpful in demarcating some of the lines of dissent and delineating the specific challenges posed by infant research. It might have been helpful, especially for the reader unfamiliar with the preceding authors' viewpoints and with the controversy in general, had the

editors provided more ongoing orientation throughout the volume, even through the simple addition of introductory remarks to each paper. I believe this would broaden the appeal and the usefulness of this collection, making it serve the larger community with an interest in infant psychiatry and psychoanalysis. Nonetheless, this monograph is both rich and propitious, and I believe it will serve any reader well in enlarging awareness of a complex and important polemic in the field of psychoanalysis.

KAREN GILMORE (NEW YORK)

NEW ESSAYS ON NARCISSISM. By Béla Grunberger. Translated & edited by David Macey. London: Free Association Books, 1989. 205 pp.

The earliest of the essays in Béla Grunberger's *New Essays on Narcissism* seem, to this American analyst, to follow from his original volume,[1] suggesting a rich, leisurely sojourn through the French countryside. I recall vividly a visit to Burgundy, particularly to Vezelay; the town is dominated by its beautiful, towering cathedral, just as the core of all of Grunberger's writings reflects his vision of narcissism. Leading to the cathedral is an ancient stone road up a steep hill, lined by the enthralling edifices of medieval homes and shops. In the ascent to the cathedral, small streets and paths lead off to the side, sometimes bringing the stroller to enclosed courtyards which may contain lovely, well-tended gardens, or may as likely restrain small, rooting farm animals, not unlike the anality of drives which Grunberger perpetually contrasts with narcissism. Some of these paths suddenly open to beautiful, sun-drenched vistas of the green valleys and hills of the Burgundian summertime. These panoramas of the countryside inevitably relate, however, to glimpses of a spire or buttress of the cathedral, as each turn of Grunberger's interest is informed by his engagement with narcissism.

[1] Grunberger, B. (1971): *Narcissism: Psychoanalytic Essays*. Translated by J. S. Diamanti. New York: Int. Univ. Press, 1979.

These essays, so evocatively European in their perspective on the psychoanalytic endeavor, consistently derive from Grunberger's earlier *Narcissism: Psychoanalytic Essays* (1971). Most were previously published in French or Spanish psychoanalytic journals, and each represents an elaboration, emendation, or new application of his fundamental conceptualizations. The theses remain the same: that narcissism represents a memory trace of prenatal coenesthesis ("prenatal state of elation," 1971, p. 12); that this idyllic state of narcissistic bliss is always at dialectical odds with instinctual drives and reality; and that the task of maturation and development is to find a way to integrate narcissism with the demands of reality and libidinal (oedipal) and aggressive strivings.

Grunberger's description of narcissism and narcissistic phenomena evokes a dreamlike, wistful yearning for return to blissful reunion, to "*memory* of a unique and privileged state of elation" (1971, p. 20), when everything was given and nothing asked of the self. This state is characterized by the lack of libidinal challenge or the impositions of reality, an absence of the demands of oral or anal instincts for resolution of the oedipus or accommodation to expectations from objects. His view in this earlier volume is that, gradually, the instinctual and narcissistic accommodate to one another, as maturation proceeds with the enrichment of each element from input by the other. This process occurs through

> [the] *successful integration* of the narcissistic factor into the instinctual life through an evolutionary process of maturation as well as through various techniques for realizing narcissistic longings in a substitute and vicarious mode (p. 20).

Difficulties occur in attaining such "successful integration," with depression and shame reflecting inadequacy and insignificance, reminders of "paradise lost" (Chapter 8); and the narcissistic insistence on uniqueness, with concomitant refusal to identify with the "other," leading to avoidance of the oedipus complex (Chapter 11). However, these problems are essentially *intrapsychic*, causing subjective conflict and pain. Later essays in the current collection, however, turn more to the distinctly pathological ramifications of unintegrated narcissism, and to the havoc in individual lives and society caused by avoidance of the dialectic between narcissism and instinct.

Grunberger immediately expands the content of narcissism from a strictly prenatal state of bliss to the postnatal "monad," in which mother and neonate are one—"container and a content" (p. 63)—as for a while longer the infant is protected from the demands of reality and of drives. "Mother and child form a double unit which exists inside the monad" (p. 4). The monad represents "the ideal state [he] experienced in the womb and which, for a while and in a sense, he continued to experience . . ." (p. 12). Self and other are not differentiated; there is no desire, no frustration. Yet the monad prepares the infant for eventual monadic disintegration, for the introduction of drives and of reality (represented by the paternal). The analytic situation, as well as the "phallic" (differentiated from the penis) represent the regressive pull of the monad, out of which emerges the ever-dialectical relationship to reality, the paternal, and the oedipal.

Wonderfully French, impressionistic, and evanescent are Grunberger's expressions of narcissistic yearning. It seems to this reviewer, however, that there are many similarities between the monad and Kohut's description of the *selfobject* function, in which the "other" is experienced as part of the self, providing entirely for the self's needs. Grunberger notes that "the voice and gaze of the mother can also function as a monad" (p. 4), and he cites "the importance, for children of this age, of the *gaze* and of *reflection*" (p. 18). This is similar to Kohut's mirroring selfobject. And he states that the " 'basic trust' the child places in the monad is reproduced in the analytic situation when a narcissistic idealization is projected on to the analyst inside the monad" (p. 7), which is reminiscent of the idealizing selfobject transference. Within the transference, the ("asexual") mother is sometimes compared "to a *landscape* or a familiar *atmosphere* which can support primary narcissism" (p. 129)—again, the Burgundian countryside. But here the Kohutian analogy ends, for the maturational goal of the monad remains its own dissolution, with integration of narcissism into the drives, the oedipal, and the paternal function. Absent is Kohut's separate maturational line of narcissism, for the monad must ultimately be relinquished in favor of instinctual reality.

Grunberger struggles with the dialectical tension between narcissism and oedipal strivings in the next four chapters, with progressive emphasis on the pathology resulting from refusal to relin-

quish narcissistic goals, or the narcissistic ("maternal") ideal. "For the narcissist, all that exists is himself and language. . . . Anything that is not him does not exist . . ." (p. 27). Narcissism moves from its *dialectical* position to an *oppositional* one with regard to the oedipus. In discussing training analyses, for instance, Grunberger observes that "we suffer the pressure of the reigning narcissistic, anti-oedipal—*and therefore antianalytic*—collective superego and collective ego-ideal" (p. 35, italics added). Similarly, "The notion of maturation is essentially anti-narcissistic" (p. 45). In confronting the oedipus (reality; "the law of the father," p. 51), one is obligated to abandon narcissism. Finally, Grunberger argues that the monad is replaced by *perversion*—both dominated by the mother—in avoidance of the oedipus. Here, anality and purity may be one, as he demonstrates with his example of Hitler's perversities.

In subsequent papers, Grunberger descends into the pathological and antisocial, bringing us along in the compelling meanderings implicit in my Vezelay analogy. About the anti-Semite's avoidance of the oedipus, he writes of the unconscious equivalence "between the Jew and the witch, the phallic, all-powerful and dangerous mother" (p. 75). This is accomplished through projection of the anal, the impure: "The ego ideal is narcissistic, and the satisfaction is that of perfect narcissistic integrity recovered through the projection on to the Jew" (p. 77). About "purity," Grunberger suggests that it "can therefore be defined as a narcissistic ideal of omnipotence and absolute sovereignty (well-being) that is completely free from the instinctual dimension" (p. 91). Here are images of ecstasy, "beatific illumination," "pure radiance," brilliant light—the sunny Burgundian meadows beneath the cathedral town.

In later chapters, he differentiates the narcissistic ego ideal (with its insistence on absolute uniqueness and refusal to identify) from the oedipal superego; frames Don Quixote's fanciful quests as combats against reality, the oedipal, and causality; and outlines the fetish as representing a part-object which seeks to resolve the antagonism between anality and narcissism, between fantasy and the "real."

Thus, in these recent essays, Grunberger once more takes the reader through the fields and by-ways of his vision of narcissism—sometimes Elysian; more frequently, this time, anal and regressive.

He seems, over time, to focus more on the ugly, the mean, the pathological, viewed through his lens on the narcissistic. These essays make for wonderful, enchanting reading, but I would value further consideration of the positive, the *esteemable*, in the narcissistic (e.g., the role of narcissism in *creativity* as projection of the elational—the ideal— into a work of art). Perhaps my wish illustrates his point about the avoidance of the oedipal/real, but for me, Grunberger has become too either-or when he states:

> Either he inserts himself into the natural evolutionary process and attempts to realize his project through his instinctual life (a maturational development involving the Oedipus, the anal-sadistic component and reality), or he begins to look for a purely narcissistic solution by avoiding the Oedipus, by remaining within the imaginary rather than confronting the real, and, in a word, by circumventing the maturational process and living a marginal existence as though neither the father nor reality existed (p. 176).

No room, here, for the continued maturation of the narcissistic, independent of the oedipal, as suggested on this side of the Atlantic by Kohut. Grunberger seems to conclude that only the instinctual, the paternal, and the real represent maturation. But, we might ask, reality according to *whom*? Here, there is no room for intrapsychic reality, which is relegated to the fantasy of the destructive mother. Also, the good-bad distinctions between paternal-maternal certainly raise questions from the perspective of contemporary revisions of theories of female development and of the preoedipal. Grunberger's *renunciation* of the "purely" narcissistic in favor of "separateness" and object choice leaves no room for the development of "mature" self-selfobject relations—the healthy persistence of the "monad" into adult life—elaborated in contemporary contributions from self psychology.

These reservations emerge as questions stimulated by Grunberger's evocative, challenging, and important recent papers. He writes assertively from an explicit point of view, yet manages to express himself with softness and subtlety. These essays are a pleasure to read; no study of narcissism is complete without careful attention to Grunberger's thought.

ANDREW P. MORRISON (CAMBRIDGE, MA)

EFFECTIVE PSYCHOTHERAPY WITH BORDERLINE PATIENTS. CASE STUDIES. By Robert J. Waldinger, M.D. and John G. Gunderson, M.D. Washington, D.C.: American Psychiatric Press, Inc., 1989. 232 pp.

Five very disturbed patients were treated by five different therapists in psychoanalytic psychotherapies. The patients improved dramatically over a time span of about five years. The authors, who were two of the five therapists, have written this book to explain why.

The patients were chosen because they had done well, and because the therapists were willing to participate in the study. This included their willingness to contact their patients for permission to be used in the study, and for information about follow-up. The therapists met regularly to discuss the cases over a period of about a year, in preparation for this book.

Before they go into some depth about each of the five cases, the authors give an excellent, useful overview of the literature on intensive psychotherapy with borderline patients. In less than twenty pages, they review, compare, and critically evaluate work by many of the past and present major contributors to the field, including Gunderson, whom I have always thought of as sensible and down-to-earth: the kind of guide one should have available, along with others, on the difficult and often confusing journey that one takes with borderline patients. His theoretical positions have been derived from observable data, data that he shares with his readers. His review of the theoretical positions of others seems even-handed and accurate.

The following section is devoted to an in-depth description of the psychotherapies of the five patients used for this study. I read these case histories with much interest, and I applaud the authors for using this format to illustrate their points of view. I was able to see aspects of my patients in theirs, aspects of myself in the treating therapists. I had a chance to criticize some of the therapists' interventions, and to agree with others. I felt justified in my criticisms when what I felt were uncalled for parameters resulted in transient exacerbations of pathology, or non-productive periods of treatment. I was impressed that most of the therapists were able to shift

theoretical views about their patients during the course of the treatment—these shifts being the result of paying close attention to their patients' progress and to patterns of their own emotional responses. I was curious about patterns of intervening and general approaches that differed from my own (many of the therapists did not emphasize how the patient's past distorted and interfered with the patient's present) which resulted in successful outcomes.

Specific criteria were used, not only for establishing the diagnosis of borderline personality disorder and for assessing psychological characteristics of the patients, but also for assessing characteristics of the treatment process and for evaluating change during the treatment. The outcomes are significant:

> All five patients were working toward sustained vocational and personal goals by the fifth year of treatment. These goals clearly stretched their known capacities and reflected their ability to risk failure, as well as a sense of realistic hopefulness about their chances of success. . . . From an ego psychological point of view, this area of outcome is describable in terms of new capacities to plan, organize, and initiate, as well as to endure frustrations, failures, limits, and negative affects. From a public health point of view, it speaks most persuasively to the issue of the potential costs and benefits of psychotherapy for borderline patients. After five years of psychotherapy, all five of these patients were self-sufficient and productive members of their communities who were contributing to the welfare of society rather than absorbing its resources (pp. 210-211).

Lest the above sound too focused on signs of external change, I should add that there was evidence of significant internal change in all of these patients as well, which was a direct result of their therapies. However, while all the therapists were "psychoanalytically trained," none of these therapies were analyses, nor did any of them approach what I would define as an analytic process. While Wallerstein stresses similarities of change in psychotherapy and in psychoanalysis,[1] I have not been convinced of this. I think the change in a successful psychoanalysis can be a lot more profound. However, these authors are not claiming psychoanalytic successes, and the successful outcomes they do illustrate are instructive and impressive.

[1] Wallerstein, Robert S. (1986): *Forty-Two Lives in Treatment: A Study of Psychoanalysis and Psychotherapy*. New York: Guilford. Reviewed in this *Quarterly*, 1989, 58:643-647.

None of these patients seemed appropriate for analysis when they began their therapy. However, something the authors did not address is that for several of the patients, the therapies helped them become more appropriate for analysis. Herein lies one of my criticisms. There seemed to be a suggestion—not explicitly stated—that one aspect of the success of these cases was that the therapy lasted five years or less (one patient was continuing once a week treatment at the time of the writing). From my viewpoint, one aspect of a successful therapy can be that the patient is ready for and wants a psychoanalysis one, two, five, or ten years later if he or she finds that persistent symptoms and character traits significantly interfere with happiness and with functioning. I also feel that another acceptable outcome of successful or relatively successful treatments of borderline patients is that they can use the therapist on an infrequent regular or irregular basis for the rest of their lives. I would be curious to know how the authors feel about outcomes like these—whether they feel that such outcomes would still be consistent with their view of an "effective psychotherapy."

Another criticism is that while Gunderson has criticized Abend, Porder, and Willick for their "theoretically determined investment in identifying Oedipal elements in borderline psychopathology,"[2] I feel that the therapists in these cases often ignored or were unaware of oedipal elements. Regression was often seen as regression from preoedipal aggression rather than from the more complex and richer sexual and aggressive dynamics of the oedipal situation. Oedipal pathology is often fairly apparent in borderline patients. The question, as with every other question of technique, is when and how to deal with it. If it is not addressed when appropriate, my experience has been that this can lead to prolonged binds in the treatment and to infantilization. The patient, Ann, may be an example of someone who could have benefited more from a greater awareness on her therapist's part of the oedipal issues that were involved in her insistence on being part of his family at various times during the treatment process.

[2] Gunderson, J. G. (1985): Review of *Borderline Patients: Psychoanalytic Perspectives*. *Amer. J. Psychiat.*, 142:510.

The authors derive conclusions from their data that are useful for anyone working with borderline patients: 1) "Clinicians should expect to see at least a modest diminution in the severity of acting out generally and of self-destructive behavior specifically in the first two years of therapy. . . . Failure to show improvement in this area by 2 years probably indicates that a significant revision in the treatment program is needed." 2) ". . . explicit and positive dependency upon the therapist is an important stage that patients should be expected to enter. This reflects a shift away from the distrust, counterdependency, and denial that preceded this stage" and "sets the stage for more direct expressions of hostility toward the therapist and the development of a collaborative working alliance." Rather than representing an "addiction that cripples," this dependency "enables potential psychological growth." 3) ". . . the return to work seemed to have therapeutic merits and was a major source of support for the psychotherapeutic enterprise . . . role performance in the form of employment is probably both a cause and an effect of successful psychotherapy" (pp. 191-192).

Also, I found it helpful to know that in all five cases, the therapist met with one or more family members at some point during the first two years of treatment. This was done not as a matter of policy or for any reason other than to preserve the integrity of the treatment.

I heartily recommend this book. I very much hope that the authors continue to study this difficult group of patients so that we might all benefit more from their labor. I also hope that they continue follow-up studies of this particular group of patients, and let us know how they are doing, not only after five years, but after ten, fifteen, and twenty years as well.

ROBERT E. FISCHEL (NEW YORK)

LOVE AND SEX IN TWELVE CULTURES. By Robert Endleman. New York: Psyche Press, 1989. 141 pp.

In 1927, Bronislav Malinowski published his, at the time, sensational work, *Sex and Repression in Savage Society*. On the basis of years of fieldwork in the Trobriand Islands, he questioned the va-

lidity of the presence of the oedipus complex as far as matriarchal social organization is concerned. Eight years later, Margaret Mead's study of *Sex and Temperament in Three Primitive Societies* appeared. While Malinowski's response to psychoanalytic propositions was openly critical, leading to the well-known controversy between him and Ernest Jones, Mead treated her subject with greater finesse. Both authors dealt extensively with the natives' attitude toward sex activities and sexual relations.

Since then anthropologists working in the field, being aware of the causative connection between early development and the ensuing personality structure, have paid more attention and given more thought to patterns and details of sexual and emotional relationships in a great variety of native cultures. Biographies and culture-specific dimensions of interpersonal modalities have been the focus of a goodly number of field studies, some of them applying psychoanalytic considerations. One revealing aspect of these first-hand reports is the conspicuous absence of descriptions of love relationships beyond lusting or desiring, let alone stable, devout, post-ambivalent love as it is understood in more developed societies. Even the team of Swiss analysts, P. and G. Parin and Fritz Morgenthaler, studying some Dogon individuals in Mali and several Agni in the Ivory Coast in West Africa, have little to say about any notion corresponding to our idealization of the partner. In my own recent work in the Ivory Coast I had several days of interviews with one Baulé in his mid-thirties. People in his native village looked at him as an exception because he had learned French and had become a teacher. He had left the village, his wife, and children in order to pursue his studies at the University of Abidjan. There he met a young woman with whom he fell in love, a hitherto unknown sentiment, he volunteered. I replied to his revelation with a well-known Chinese axiom: "The first woman you marry for the family; the second one for love." His response was reminiscent of that of a patient after a fitting interpretation.

The title of the book under review underlines Endleman's focus. It is not a full-fledged study of these natives' erotic inclinations. It is simply meant to sketch a great variety of manifestations of the dynamics of physical attraction and carnal appetites among the people of the twelve cultures chosen. While we know that there is no imperative link between love and lust, familiarity with the mo-

dalities in the majority of preliterate communities provides a more contrasting scenario than the one we usually anticipate in a different social world.

It is a truism that the life conditions of more complex societies have influenced many psychoanalysts' "average" expectations, theoretically as well as clinically. Take as an example Freud's discussion of marital conditions (in the chapter, "Femininity," in his *New Introductory Lectures*). His viewpoint is prompted by the supposition of monogamy *and*, in Ernest Jones's word, of phallocentrism.

Marriage on the basis of choice, self-selection, and affective bonding is not part of the tradition in tribal society. On the other hand, there is a good deal of evidence for physical attraction, and there are many reports about short-lived infatuations, often preceded by employing love-magic, while legitimate bonding depends on socially regulated exchange rules.

The title of Endleman's work is slightly misleading because among preliterate people there is little indication of romantic idealization beyond capricious appetites and sexual desire. Familiarity with the prevalent sexual-emotional passion in tribal cultures gives a rather dissimilar picture from the ones in more differentiated environments. Endleman provides us with a brief sketch of each of twelve, in the main well-researched tribes, finding that "love is definitely not considered a prerequisite for marriage" (p. 7).

The first tribe he chooses as an example are the Northern Athabaskan Indians in Alaska, researched by the Boyers and Hippler. They gathered much evidence for these people's shallow (from our point of view!) object cathexes and, indeed, lack of affective reciprocity. There follow relatively condensed overviews of two Native American tribes, four South Seas ones, and three African societies. At the end of these descriptions Endleman correctly underlines that "something like our Western conception of love, though not entirely absent, seems to be rare in such tribal or transitional societies" (p. 83). The obvious question is *why*? It is precisely this aspect which needs further exploration in depth. In his final chapter, entitled "Comparisons with Our Own Society," the author touches upon the Western perspectives but his descriptions are far too cursory where they should have dealt with the intriguing divergence in norms, manifest behavior, maturational ideals, and affectivity.

The book calls attention to the causes of these salient differences

in deep and ideally lasting relationships, but it does not shed light on the germinal conditions which predispose the individual to the idealization of one's partner, to *falling* in love or *losing* one's heart, which stresses the loving person's intense affect bordering on a notion of helplessness. Endleman's survey demonstrates the substantial discrepancy of emotional climates, especially when applying our own maturational aims and moral guidelines. Here are criteria which have undoubtedly influenced normative psychoanalytic assumptions, possibly even diagnostic considerations. *Thus, this study is a timely reminder of the arbitrariness of certain psychoanalytic propositions rooted in our own sociocultural bias and scale of values.* Regretfully, the book does not point to the dominant preconditions such as the great variations in child-rearing practices; to the powerful effects of multiple mothering often customary in these cultures; to the consequences of the essential differences in socialization and social organization. Without question, our model of mother-child symbiosis is at variance with conditions prevailing in many Oriental as well as preliterate cultures. Or: types of separation-individuation as traditional in Western-type conjugal family organization are in no way compatible with growing up in tribal milieus that inevitably induce a different spectrum of affects and self experiences. These are some of the prerequisites effectively laying the groundwork for the kind and capacity of the eventual self-object rapport. There is strong evidence that the Western model of the psychic representation of introjects and the assimilation of narcissistic libido to object libido (as postulated by psychoanalytic theory), which effect a sense of selfhood and help create ego boundaries, is not consistent with growing up in tribal surroundings. As a result, certain components of early longing and idealization are, at best, incomplete (from our point of view) and reflected in an inability to establish, let alone sustain, the kind of impassioned closeness between the sexes we believe to be essential and a yardstick of sound emotional adaptability. The author is fully aware of the lasting impact of the specific ways of early care. But while the book is dealing with the absorbing issue of sex and the subjective experience of love, it does hardly pursue these culture-specific preconditions beyond their manifest content.

The intrinsic value of Endleman's study lies in the fact that it

reminds the reader of the extent to which societal criteria leave their mark on the subtleties of individuation and the ensuing nature of interindividual responsiveness.

The book is in need of thorough editorial scrutiny for typographical errata and stylistic anomalies.

WERNER MUENSTERBERGER (NEW YORK)

OEDIPUS IN THE STONE AGE. A PSYCHOANALYTIC STUDY OF MASCULINIZATION IN PAPUA, NEW GUINEA. By Theodore Lidz and Ruth Wilmanns Lidz. Madison, CT: International Universities Press, Inc., 1989. 228 pp.

This is a gem of a book. Brilliantly researched and organized, it distills for the practicing psychoanalyst the evolving anthropology of the tribes of the remote regions of Papua, New Guinea. Concentrating on the *pre*pubertal initiation rites practiced by these tribal peoples, the authors consider the ethnographic data they so evocatively present within the context of our current theories of male development. The results are illuminating. Not only do they make the Western reader privy to the rituals and myths of these simple societies, but, in so doing, the Lidzes further entreat culture-bound readers to reassess their notions about the critical ingredients of the early evolution of masculinity.

Oedipus in the Stone Age may be seen as a state-of-the-art position paper in a tradition in applied psychoanalysis that began in 1954 with Bruno Bettelheim's *Symbolic Wounds*.[1] In this first contribution, surveying the field data then available to him from societies like those reviewed by the Lidzes, Bettelheim argued that psychoanalysts had been too preoccupied with the castration threat on the part of the collective fatherhood toward their initiates which seems evident in their bloody rites of passage. Rather than simply reminding these boys that their mothers and sisters were off limits, these

[1] Bettelheim, B. (1954): *Symbolic Wounds: Puberty Rites and the Envious Male*. New York: Free Press.

"symbolic wounds" served to help the tribe's young men-to-be to come to terms with the last vestiges of their bedrock feminine or, better, ambisexual identifications and with their envy of woman's reproductive power. For example, in societies where the father's procreative function remained unknown, the penis was subincised and thereafter dubbed a penis-womb. In those where the fecund phallus was worshipped, Bettelheim continued, the foreskin was lopped off to rid the youthful warrior of his labia-like flesh and of his longing to be a woman.[2] Bettelheim's notions, however, were based on scanty data pertaining only to pubertal initiation rites.

Over the years, numbers of other analysts, notably Robert Stoller[3] and the Lidzes themselves[4] drew from the discoveries of Herdt,[5] Poole,[6] and other ethnographers about rituals at earlier stages of development. Against this backdrop, they elaborated on the essential fragility of a boy's male identity and the need to shore it up through acts of extraordinary aggression on the part of the fathers and father figures in these social groups. These contributions to applied analysis were paralleled by a trend within the psychoanalytic mainstream in which oedipal-age conflict and castration anxiety were juxtaposed to the father's earlier developmental function in forcefully helping a boy disidentify from his mother.

[2] See also, Nunberg, H. (1947): Circumcision and the problems of bisexuality. *Int. J. Psychoanal.*, 28:145-179.

[3] Stoller, R. J. (1968): *Sex and Gender: On the Development of Masculinity and Femininity*. New York: Science House.

[4] Lidz, R. W. & Lidz, T. (1977): Male menstruation: a ritual alternative to the oedipal transition. *Int. J. Psychoanal.*, 58:17-31.

Lidz, T. (1963): *The Family and Human Adaptation: Three Lectures*. New York: Int. Univ. Press; (1968): *The Person: His Development throughout the Life Cycle*. New York: Basic Books; (1988): The riddle of the riddle of the Sphinx. *Psychoanal. Rev.*, 75: 35-49.

[5] Herdt, G. H., Editor (1982): *Rituals of Manhood*. Berkeley: Univ. of Calif. Press.

Herdt, G. H. (1987): *The Sambia: Ritual and Gender in New Guinea*. New York: CBS College Publishing.

[6] Poole, F. J. P. (1982): The ritual forging of identity: aspects of person and self in Bimin-Kuskusmin male initiation. In *Rituals of Manhood*, ed. G. H. Herdt. Berkeley: Univ. of Calif. Press.

This would include the work of Abelin,[7] Greenacre,[8] Greenson,[9] Herzog,[10] Mahler, Pine, and Bergman,[11] and Ross.[12] Even the paternal castration threat in Loewald's[13] conceptualization might be seen as a safeguard against regression to a boy's structureless beginnings in his mother's orbit. Now the Lidzes have brought these lines of inquiry together in a new synthesis of clinical anthropological and developmental perspectives on male psychology.

The authors stress the absence of the father in the New Guinea nuclear family (he lives in a male hut in order to remain uncontaminated by women). They then detail a series of initiation rites, which begin in latency and unfold in stages over as many as ten to fifteen years (in contrast both to the oedipal period proper and to the pubertal passage in which its conflicts are recapitulated). They concede that the boy's "erotic tie to the mother and potential intense rivalry between father and son are important in Papua, New Guinea" (p. 13), yet note that the repression and resolution occur later in childhood partly because the child has had so little contact

[7] Abelin, E. L. (1971): The role of the father in the separation-individuation process. In *Separation-Individuation: Essays in Honor of Margaret S. Mahler*, ed. J. B. McDevitt & C. F. Settlage. New York: Int. Univ. Press, pp. 229-252; (1975): Some further observations and comments on the earliest role of the father. *Int. J. Psychoanal.*, 56:293-302.

[8] Greenacre, P. (1966): Problems of overidealization of the analyst and analysis: their manifestations in the transference and countertransference relationship. In *Emotional Growth: Psychoanalytic Studies of the Gifted and a Great Variety of Other Individuals*. New York: Int. Univ. Press, pp. 743-761.

[9] Greenson, R. R. (1968): Dis-identifying from mother: its special importance for the boy. *Int. J. Psychoanal.*, 49:370-374.

[10] Herzog, J. M. (1980): Sleep disturbance and father hunger in 18- to 28-month-old boys: the Erlkönig syndrome. *Psychoanal. Study Child*, 35:219-233.

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

[12] Ross, J. M. (1975): The development of paternal identity: a critical review of the literature on nurturance and generativity in boys and men. *J. Amer. Psychoanal. Assn.*, 23:783-817; (1979): Fathering: a review of some psychoanalytic contributions on paternity. *Int. J. Psychoanal.*, 60:317-327; (1982): From mother to father: the boy's search for a generative identity and the oedipal era. In *Father and Child: Developmental and Clinical Perspectives*, ed. S. H. Cath, A. R. Gurwitt & J. M. Ross. Boston: Little Brown, pp. 189-204.

[13] Loewald, H. W. (1951): Ego and reality. *Int. J. Psychoanal.*, 32:10-18.

with the male parent. Moreover, father absence and a boy's consequent primal immersion in the world of women promote a particularly intense "core identification with the mother" and require harsh measures to ensure the "attainment of a firm masculine identity" (p. 14). The brutal violence inflicted on a boy during these rituals (nose bleeding, rubbing the body and genitals with stinging nettles, emotional terrorism, etc.) and homosexual or specifically pederastic behavior (fellatio, ingesting semen, etc.) do function both to warn the initiates off incestuous objects and to provide same-sex substitutes to gratify the mounting libidinal impulses of adolescence. However, they also represent efforts to bleed away, as it were, the womanliness associated with his mother's menstrual flow and its imprint on him—and the ingesting of masculinity through acts of homosexual submission and incorporation in the manner of the Greek gymnasium. (See the work of Licht,[14] Liebert,[15] and Slater.[16]) These practices are justified by the secret myths of the men's hut in which heroic ancestors are held to begin life as hermaphrodites and in which matriarchal rule is believed to predate later patriarchal practices (again as in ancient Greece). And the sudden male domination of younger boys is reinforced by the degradation of women, various injunctions about the dangers that emanate from women and their sexuality, and women's isolation before marriage and during their menses (as among orthodox Jews) (p. 15). Longing to return to his mother's protective care and to reunite with her relatively late in life, the New Guinea male is catapulted into the status and mindset of the fierce warrior he will need to become if he is to guard his tribe's territory from outside invaders and maintain the society's internal integrity. The price for this stability is the abrogation of intimacy between the sexes and the placing of a premium on aggressive displays to the detriment of sensuality and libidinal indulgence.

Having posited this central thesis, *Oedipus in the Stone Age* then

[14] Licht, H. I. (1969): *Sexual Life in Ancient Greece*. London: Abbey Library.

[15] Liebert, R. S. (1986): The history of male homosexuality from ancient Greece through the Renaissance: implications for psychoanalytic theory. In *The Psychology of Men*, ed. G. I. Fogel, F. M. Lane & R. S. Liebert. New York: Basic Books, pp. 181-210.

[16] Slater, P. (1971): *The Glory of Hera*. Boston: Beacon Press.

briefly reviews basic anthropological theory, emphasizing the functions of rituals and myths as forms of causal explanation and magical modes of thinking. The book subsequently surveys the ethnography itself, starting with Read's[17] early description of the Gahuka-Gama rituals and proceeding to the later studies of Herdt of the Sambia and to Poole's work with the Bimin-Kuskusmin. Without underestimating the differences among these groups and their rituals, the authors stress certain commonalities of practice and purpose (p. 50). These include the threats, beatings, bleeding, and forced vomiting, all aimed at expelling "womb-blood" (p. 58); sustained homoerotic activity between boys of different age-sets; the fact that these rites typically begin before puberty and last for years, unfolding in as many as six stages; the explicit effort to dislodge the boys from the mother's household and dominion over them, a rupture of bonds to which mothers respond with manifest hostility (p. 53); and a plethora of prohibitions regarding the commingling of bodily fluids between the sexes.

The descriptions of the rites are both horrifying and riveting. They seem alien, yet personally forbidding. They derive, the Lidzes imply, from universal unconscious fantasies about the origins and fitful differentiation of the sexes yet stand in some contrast to our own mythological heritage, in which sex differences have generally been taken more for granted (with exceptions, of course). Analysts have had a sampling of this ethnography in earlier contributions, but never before has this field of study been brought together in such a cohesive, readable, and succinct series of narrative and interpretive reflections.

For those of us who have labored for some time to demonstrate the power of early maternal identifications in contemporary Western boys and the conflicts these give rise to later in their life when as men they must function as workers, lovers, and fathers, *Oedipus in the Stone Age* comes as a welcome testimonial to the truth of our assertions. Where in our Western patients the rumblings of pre-oedipal and ambisexual individual pasts must be exhumed from beneath the surface of awareness, and indeed from beneath the oedipus complex itself, in societies like those of New Guinea, the

[17] Read, K. E. (1952): Nama cult of the central highlands, New Guinea. *Oceania*, 23:1-25.

theme of sexual ambiguity and paradox is to be found in the foreground of cultural experience and psychological motivation. Works like this one demonstrate that elsewhere in the world and in human consciousness, men are at least as uncertain about their sexual identity as are women—if not more so. And they tell us, both as analysts and civilized Western men and women, that there is more to the life of the mind than is dreamt of in our psychology. An essay on applied psychoanalysis, Ruth and Theodore Lidz's *Oedipus in the Stone Age* should thus prove an invaluable addition to the library of the clinical psychoanalyst.

JOHN MUNDER ROSS (NEW YORK)

TOO LONG A CHILD. THE MOTHER-DAUGHTER DYAD. By Nini Herman. London: Free Association Books, 1989. 358 pp.

For Nini Herman, the most significant factor in the psychic development of women is the unique quality of the relationship between mothers and daughters. She believes that psychoanalytic theory has failed to recognize just how crucial is the issue of separation within the mother-daughter dyad. From her therapeutic work with women, Herman has concluded that what holds women back in their effort to achieve equality with men lies in inner conflicts over separation which are at the core of the mother-daughter dyad. In *Too Long A Child*, the author traces the relationships of mothers and daughters through the ages. The book is a very scholarly and detailed history covering over ten thousand years of mother-daughter relationships as depicted in myth, fiction, letters, diaries, and case histories of women from Persephone to Sylvia Plath.

Before beginning her historical journey, Herman points out that while it has been a century since Freud introduced psychoanalytic principles, female sexuality remains a controversial, unresolved area. Freud, she says, pondered time and time again the question, "What *is* it that woman wants?" Herman states that the answer which emerges in the majority of cases of long-term psychotherapy is: "to be myself, to live my life as I desire, by my own personal design—without offending my mother, without antagonizing her or hurting her own views or feelings; without thereby having to make an enemy of her, because I need her as a friend, a comrade and beloved sister, as a lifelong all-in-all" (p. 6). The author also

feels that she is able to demonstrate that each successive generation of women contributes to the independence of future women. No clinical data are given, and the book's failure lies in the fact that the reader is unable to discern how Herman's view of the psychic development of women can be used in the psychotherapeutic setting, and, therefore, whether or not it is helpful or even valid.

Herman feels that Melanie Klein partly clarified the anxieties which draw the girl back into the maternal orbit, but did not explain the forces which lure her away. The author raises many questions about current psychoanalytic thinking on female development, such as the transfer from the mother to the father as the primary love-object. However, the basic unanswered question for her remains: "Is there or is there not in the experience of women, however buried and obscured by cultural and other factors, a concept of primary femininity, present from infancy to slowly ripen and mature to full exultation of its potency in time?" (p. 18).

The author feels it is "patently absurd" that the sense of femininity should develop as a response to feelings of disappointment and castration fantasies caused by lack of a penis. She reminds the reader that psychoanalytic theories were based on the findings in "ailing women." Then, drawing on poetry from the Greeks, especially Sappho, whose love-poems were addressed to women, Herman claims that there has been a "conspiracy of silence." She states: "That one of her own sex, in the person of her mother, may, from the very first to the last and final breath, marriage and childbearing notwithstanding, remain the object of her deepest passion, is still one of our best-kept secrets and constantly subverted truths" (p. 35). It is only in those situations where the father closely shared in the early parenting that the author feels there can be a truly acceptable transfer of primary love feelings to the male.

Herman turns to Greek mythology to aid in the elucidation of her understanding of how and why the girl resolves her attachment to her mother. Myths, she says, can be an attempt to "come to terms with change at times of crucial transition linked to growing consciousness in our human evolution" (p. 50). Zeus, we are reminded, made the famous pact with Hades allowing Persephone to divide her time between her husband and her mother. When the mother and daughter were reunited, Demeter was upset to learn that her child had eaten pomegranate seeds which her husband had offered

her. She felt her daughter would never belong to her as before. During the time they were together the vegetation would thrive, but it would die back every year during their separation. Using the "Homeric Hymn to Demeter," Herman examines the details of the story to try to understand why it is that the girl leaves her mother. This explication is a literary exercise which becomes tedious and does little to advance our theory.

Still dealing with the ancient world, Herman takes up the "case-history" of Clytemnestra. While the three dramatists Aeschylus, Sophocles, and Euripides have provided three versions, none has overlooked the fact that Clytemnestra was simply not a good enough mother. Herman believes that it was the "fury and despair of early infantile frustration . . . that drove the sword into the maternal breast" (p. 73). She also claims that Electra's lamentations over her father's death are not genuine because "where a girl turns to her father in full flight from a frustrating mother, the feelings lack true loving depth, the grace of sincerity" (p. 83).

Part II of the book starts with the beginnings of Christianity and the story of Mary. It is here that the author loses any semblance of objectivity and becomes a voice for feminism. Herman believes that the contradictory views of women which are found in the New Testament cannot be resolved in psychological isolation. Furthermore, she feels that they continue to control the female psyche where social conditions have remained unchanged and that they are active even in emancipated women. She asks, "How many of us suffer guilt if we exercise our right to a fuller life than the measured formula which exclusive motherhood provides?" Resolution, she feels, lies in the realm of "wider change in the socioeconomic sphere" (p. 103). The book goes on to show how privileged groups of women seize every opportunity to try to make a richer life for themselves.

Herman proceeds to follow the paths of women through the Middle Ages and into the Renaissance where it seems that learned women were encouraged by their fathers to take the opportunities that the era offered them. The publication of the pamphlet, "The Countess Lincoln's Nurseries," in 1622 is felt, by the author, to be a particularly significant milestone. "It conveys a change in woman's self-image: her willingness to speak up, to promulgate what she believes in with growing conviction that her views *can* make an

impact" (p. 143). Elizabeth Lincoln was taking up her conviction that it was a mother's duty to nurse her babies, thereby confronting deep-seated prejudices and beliefs. It was the dogma of the day that "sexual intercourse would corrupt the milk," meaning that "conjugal debt had priority above the welfare of the infant."[1] Herman comments on the split between the sexual and the feeding mother which is reflected in society between the upper classes and working women of the day. She also states that the attitude of men played a crucial part, as it does today, in establishing norms of society (p. 153).

The eighteenth century produced a line of impressive forerunners in women's "quest for an integral identity." The point is made of how much a woman's life responds to the sort of mothering she has received. Of course, no one would argue otherwise, and, indeed, the quality of mothering is crucial for the male sex as well. Herman writes about the lives of Mary Wollstonecraft and her daughter Mary Shelley. The author makes the point that "the emotional deprivation" of Wollstonecraft's "earliest years continued to eat away at her zest for love and life, to undermine her belief in herself at that elemental level where each of us must depend on that wellspring in our life" (p. 165). Since Mary Shelley lost her mother in infancy, Herman feels she did not believe she was able to keep anyone she loved alive and hence was unable to prevent Shelley from going sailing on the day he drowned.

Part of a chapter is devoted to Florence Nightingale and her turbulent relationship with her controlling mother Fanny. She details Florence's emotional difficulties, including a serious depression which Herman believes stemmed from a sense of guilt "that she had failed her mother by being different and insisting on her right to live that difference to the full, even if she had to forfeit the reward and reassurance of the soothing certainty of having been a good daughter" (p. 200). Herman then brings up how, in the therapeutic situation, it is not easy to buy women their freedom. "It seems that a daughter cannot win the moment she ceases to be a faithful replica" (p. 210).

With the example of George Sand and her daughter Solange,

[1] Prior, M., Editor (1985): *Women in English Society 1500-1800.* New York: Methuen, Inc., p. 27.

Herman shows that the daughter's mobility, either up or down, was experienced by the mother as *away from* and therefore not tolerable. Chodorow has pointed out that mothers of daughters tend not to experience their infant daughters as separate from themselves. "Primary identification and symbiosis with daughters tend to be stronger and cathexis of daughters is more likely to retain and emphasize narcissistic elements, that is, to be based on experiencing a daughter as an extension or double of a mother herself. . . ."[2] Herman gives examples of women who tried to get out of the "symbiotic net." A poignant one is Louisa May Alcott, who was unable to survive too long after her parents' death. The author also shows how difficult it is for women to take full credit for their achievements outside of the domestic sphere. She attributes this difficulty in part to the indistinct boundaries between their mothers and themselves.

Continuing on her historical journey, Herman takes up the life of Sylvia Plath as an example of a psychotic interaction between a daughter and her mother. She demonstrates Aurelia Plath's need for a genius of a daughter and how Sylvia intuited that need. More important, Herman finds in the poetry of Plath what she believes is the reason why so much creative talent in women is aborted. "The terror is that it will be used to murderous advantage in oedipal wars" (p. 258). Though the boy's castration anxiety is powerful, it is confined more closely to the purely sexual drive and spills over less into the wider creative sphere.

Herman has an interesting chapter, entitled "The Emergence of Guilt," in which she discusses the need to differentiate the guilt of the mother from that which afflicts the daughter within their relationship. The latter, she feels, has its origin in the depressive position, where attacks are made in fantasy against the primary caretaker. Today's mother is torn between repressing her daughter's individual personality and supporting her bid for a free, creative life. Florence Nightingale fell ill precipitously and "had to pay the heavy price for having bulldozed her passage to such premature success, without true separation at a deeper psychic level . . ." (p. 307). In this chapter Herman also points out that interpretations

[2] Chodorow, N. (1978): *The Reproduction of Mothering. Psychoanalysis and the Sociology of Gender*. Berkeley: Univ. of Calif. Press, p. 109.

along the lines of stealing the mother's penis do little but accentuate guilt. She discusses the idea that for a woman to believe she can conceive and rear a baby successfully, she must have had the experience of being loved in her own infancy. Herman states that a common observation is "that girls appear more vulnerable to maternal deprivation and carry their resentfulness to greater lengths than their brothers, who can make it up in mothering from their wives" (p. 311).

Herman sums up her book herself. She says, "We have travelled a great distance, and done so inconclusively" (p. 328). She points out the two threads which are discernible in this exploration of the mother-daughter dyad. The first is the theme of separation, and the second is the legitimacy of woman as a sentient being. Herman feels that both issues are gender-specific with respect to the "range and extent, the content and velocity of projective identification which is found to operate in" the mother-daughter dyad (p. 329). Why does separation pose such an impasse to daughters? Stating that unresolved grievances provide a potent glue, the author presents a list of answers from the daughter's and the mother's points of view. Factors which have facilitated a separation of the dyad include the role of the father and the growing prospects for women in the wider world, which offer creative roles beyond the domestic sphere. Herman discusses the "sexual bigotry" which Dinnerstein felt was built into the Freudian perspective[3] and warns every woman who enters psychotherapy to give "careful thought to her choice of her therapist" lest she be considered "suspect goods, still burdened with a legacy she is unlikely to shake off conclusively on the couch" (p. 343).

Too Long a Child is an ambitious book which is actually a history of women. It might be of interest to those involved in Women's Studies, but it does not seem particularly useful for the psychoanalyst. While the author offers some interesting opinions about women and their particular difficulties with mothers, she unfortunately does not back them up with any clinical data. We are left to rely on Herman's interpretation of historical and literary data which seem to be reflections of her own opinions and gut feelings.

[3] Dinnerstein, D. (1987): *The Rocking of the Cradle and the Ruling of the World.* Concord, MA: Souvenir Press, The Women's Press, p. xxiii.

The book takes a strongly feminist position and thereby sacrifices any claim to scientific objectivity.

RUTH K. KARUSH (NEW YORK)

MYTHS AND MYSTERIES OF SAME-SEX LOVE. By Christine Downing. New York: Continuum Publishing Co., 1989. 317 pp.

Homosexuality is written about by individuals from a wide variety of disciplines. Christine Downing, a professor of religious studies at San Diego State University and faculty member of the California School of Professional Psychology, discusses a specific aspect of the subject, same-sex love, from the perspectives of depth psychology and mythology. Her purpose is to enrich our understanding of homosexual love by discussing its conceptualizations by Freud and Jung, and its meanings as communicated in ancient myths, and by poets and philosophers such as Sappho and Plato. She approaches the subject from a deeply felt personal perspective: "I am a lesbian. Many of my closest male friends are homosexual. Some have AIDS. Some have died" (Prologue, p. xvii). She goes on to express the hope that searching after "an understanding of the soul meaning of same-sex love" will help both heterosexuals and homosexuals understand themselves better, but help the former in particular to "explore the roots of their denigration and fear of homosexuality." One notes that "denigration and fear of homosexuality" is also unfortunately common among homosexuals in contemporary society. The book is written from a subjective, evocative, expressive point of view. It makes no claim to be the work of a scientist or a clinician, although some discussion of Freud's and Jung's cases is provided.

The sections on Freud and Jung are divided into "The Personal Dimension," "The Theory," and "The Classical Cases." In addition, a discussion is provided of Freud's models of female homosexuality. On the one hand, Downing covers ground that is quite familiar to psychoanalytic scholars. Freud's theories about homosexuality have been, by this time, extensively discussed in the psychoanalytic literature. This qualification notwithstanding, Downing provides an interesting slant by reminding us that Freud's ideas about homosexuality were at the very center of his model of psychological

development and of psychopathology. She also notes that psychoanalysis was born in the context of the intensely eroticized relationship between Freud and Fliess, a relationship that was followed by the troubled, but also eroticized, relationship between Freud and Jung. Freud's theory of bisexuality was influenced by his own bisexual fantasies mobilized by these intense relationships. Downing's psychohistorical writing is lucid and much of it rings true.

Downing's decision to devote the same kind of attention to Jung as to Freud is puzzling, since Jung's treatment of homosexuality was scant and often misleading. Jung stated, for example: "The more homosexual a man is the more prone he is to disloyalty and to the seduction of boys. . . . A friendship of this kind naturally involves a special cult of feeling, of the feminine element in a man. He becomes soulful, aesthetic, . . . in a word effeminate, and this womanish behavior is detrimental to his character" (p. 115). Downing argues that Jung's thoughts about gender psychology and his ideas about the collective unconscious and about mythology add an important dimension to the study of homosexuality. This is unconvincing, and the section on Jung is of interest largely because of the relationship between Jung and Freud.

The half of Downing's book devoted to classical Greece is not particularly well integrated with the earlier sections on Freud and Jung. Downing suggests that Freud and Jung, both influenced by Greek thought, provide ideas about love and death that have unique relevance in this, the age of AIDS. She also argues that the images and ideas of the Greeks are particularly salient in modern times because of AIDS, and are illuminated by Freudian and Jungian depth psychology. The argument is a loose one, justified more by personal associations in the mind of the writer than by scholarship. Even so, sections of the part of the book on Greece make interesting reading. The nine pages in which she describes *paiderastia* provide a good introduction to the subject, for those not familiar with homosexuality in ancient Greece. A specific type of stylized homosexual activity between males was not only accepted, but was assigned important social functions. This occurred between an *eremenos*, an adult, and an *erastes*, a youth. The adult courted the youth, and if accepted, assumed a role which might best be described in our own terms as a romantic mentor. The erotic relationship, based on mutual choice, usually ended when the youth

reached the age when he began to shave. Sexual practice was closely regulated. The older man had face-to-face intercrural intercourse with the younger. The *erastes* was not penetrated, was not supposed to experience sexual arousal, and was expected to gratify the older man's sexual need out of a sense of affection and gratitude. The idealized relationship between *eremenos* and *erastes* occurred concurrently with the older partner's participation in marriage and parenting. Since men were not particularly emotionally involved with their families, the intense relationship with the *erastes* served as an outlet for feelings which in our own culture are generally directed to wives, lovers, and (to some extent) children. Interestingly, anal intercourse, in contrast to intercrural intercourse, did involve people of the same age group. Greek society tended to depict the person who was penetrated in contemptuous terms since, in this male-dominated culture, men who were perceived as being feminized were devalued. The *erastes* was not so conceptualized. The role he occupied was a masculine one, without parallel in our society. Homosexual pair bonding as it exists in our culture, between individuals of the same age and social standing, occurred infrequently, if at all, in ancient Greece, and was not socially sanctioned.

The section of Downing's book on Greece also contains sections on homosexual love among the gods. Downing makes the interesting observation that except for Ares, the god of war, and Hades, the god of the underworld, all of the major Greek gods are depicted in mythology as being erotically involved with men. She discusses homosexual love in women and devotes a particularly interesting chapter to the poetry of Sappho. Following chapters on Plato's *Symposium* and *Phaedrus*, the book closes with discussions of sexuality and AIDS, love and death.

Myths and Mysteries of Same-Sex Love seeks to cover old intellectual territory in a new way. It is partially successful. Each of its sections is well written, but few contain new ideas. The material on Greece is too scant for the book to stand as an important contribution to Greek scholarship. The same is true regarding the material dealing with Freud and Jung. The author's deeply experienced sense of personal mission is expressed in a poetic way. This provides an additional reward to readers.

RICHARD C. FRIEDMAN (NEW YORK)

PANIC. THE COURSE OF A PSYCHOANALYSIS. By Thorkil Vanggaard. New York/London: W. W. Norton & Co., Inc., 1989. 144 pp.

Thorkil Vanggaard is not likely to be a name familiar to most American psychoanalysts, even though he is a foremost senior psychiatrist in Copenhagen; he spent part of his long career in this country while doing psychoanalytic training at the New York Psychoanalytic Institute. In this slim volume, he presents the clinical record of an old case and proffers an argument for the psychotherapeutic approach to a clinical entity which is now regarded in this country in general psychiatric circles as an almost purely biological phenomenon, the treatment of which requires primarily pharmacological intervention—so-called "panic disorder."

It is not clear whether Vanggaard intended this report more for a psychoanalytic or for a psychiatric audience. The former group will likely find this effort to be an enjoyable, though not profound, clinical account, which raises indirectly some fascinating questions, albeit without really tackling the theoretical issues involved. They are not trivial matters at all; for instance, Vanggaard's insistence that this five-and-a-half-month, three-times-a-week treatment should be regarded as an "analysis." (Most analytic readers will probably conclude that this case represents a very successful psychoanalytically oriented psychotherapy, and a brief psychotherapy at that.) However, the most enduring value of this case report, one which may, in fact, make it one of the most important psychoanalytic publications in recent years, concerns issues of diagnosis and treatment which Vanggaard addresses to psychiatrists as a whole in a direct, accessible, and convincing manner. Of particular relevance to American psychiatry is the implicit critique of DSM-III and DSM-III-R regarding the politically determined expunging of the term and concept of "neurosis" from the official nosological lexicon.

Even this evaluation of the book does not diminish its potential interest for the psychoanalytic clinician. In spite of the recent trend toward more complete reporting and publishing of clinical process, it is all too rare that we have the opportunity to gain access to the relatively unexpurgated, daily material of a treatment from beginning to end. Add to that the even rarer inclusion of a seventeen-year follow-up on a case, with statements by both patient and ther-

apist, and one has an interesting document indeed! This is exactly what Vanggaard has provided us.

His patient was a forty-four-year-old, highly successful, academic physician who presented with a sudden onset of cardiac palpitations and overwhelming panic resulting in a hospitalization and unremarkable work-up, after which he was referred for psychiatric consultation. There is no doubt from what Vanggaard describes of the initial consultations that if this man had landed in one of the offices of most American psychiatrists in the past decade, he would have departed with a prescription for a tricyclic antidepressant, or benzodiazapine, or one of the other commonly used medications for "panic disorder." But, Vanggaard put his patient on the couch and within five and a half months discharged him from his care with symptom relief that proved permanent. The patient's difficulties included, beyond his expressed symptom, an ambivalent marital relationship, especially manifest in sexual relations, and a variety of inhibitions and anxieties vis-à-vis his colleagues and superiors at work. Much of the interpretative work focused on this man's conflicts over aggression, the resulting guilt, and several of the derivatives of his relationship and identification with his father. All of this comes through clearly as Vanggaard reports succinctly on the progress of the work on the patient's symptoms, extensive dreams, and some character elements.

What is particularly intriguing, even a bit vexing, is that here is a wonderfully successful therapeutic result, derived from interpretative work that appears to have been solid, but which does not impress the experienced analytic clinician as anywhere near complete. In the present age of our discipline, we expect the adequate working through of the analysis of character, transference, and the reconstruction of the primary fixations to require more time and intensity of contact with even the most talented of analysands. Psychoanalysis generally aims at more than symptom relief. Nonetheless, it is quite instructive to see how another analyst works, especially one from another culture. In this respect, Vanggaard's tone, both in speaking to his patient and in his writing, has a kind of European formality and intellectualism that has a resonance reminiscent of Freud's case histories. Of more clinical and theoretical interest is that Vanggaard apparently includes didactic and philosophical interchanges with his analysand in his technique. There is

throughout a kind of benevolent, paternal, authoritative attitude that Vanggaard conveys, qualities that are not analyzed as countertransference but may well have exerted a beneficial, suggestive effect, especially for this patient.

Be this as it may, one is nonetheless challenged to explain how the result could have been so effective without more extensive and thorough analytic work. There is hardly a question that a transference neurosis, however one defines that term, ever emerged; it was not necessary in this case. What, then, are the implications of this fact, of the less-than-usual frequency of sessions, and of the unusual brevity of the treatment for our theory of technique?

Unfortunately, for the more advanced psychoanalytic reader, Vanggaard does not deal with such issues. Instead, his discussion after the case report is a rather elementary presentation of such concepts as resistance and transference. However, for *other* readers—medical and psychology students, residents, and other psychiatrists—the level at which his discussion is pitched may be the most useful and cogent. In the end, psychoanalysts would do well to be aware of this book and perhaps to refer colleagues, students, and even the general public to it for a persuasive demonstration that not all the answers to the riddles and problems of emotional life reside in the realm of neurotransmitters.

ERIK GANN (SAN FRANCISCO)

THE ABILITY TO MOURN. DISILLUSIONMENT AND THE SOCIAL ORIGINS OF PSYCHOANALYSIS. By Peter Homans. Chicago/London: University of Chicago Press, 1989. 390 pp.

This book is frequently intriguing in its elaboration and integration of ideas, but exasperating in its turgidity of style and, at times, in its content. This reader tended to reread the introduction periodically as he read the text in order to anchor himself in the basic intellectual structure of the book.

Although admiring of Freud as an innovative genius and creative thinker, Homans does to Freud what Freud did to humankind. He deposes the founder of psychoanalysis from the center of the psychoanalytic universe in its broadest sense and sees the roots of psychoanalysis as originating in the breakdown of the medieval

Christian ethos. With the development of Puritanism and its associated individuality, and the development of physical science in the seventeenth century, began the long process of the breakdown of cultural values that led to psychoanalysis. Homans integrates his thinking about the repudiation of the past by linking Kohut's de-idealization, Winnicott's disillusionment, and Klein's pining with Weber's disenchantment and Durkheim's anomie. The author emphasizes that he agrees with Rieff and Ricoeur that Freud did indeed create a total break with the (his) Western past, but, unlike them, goes on to claim that his theory was a creative response to this break.

Homans's view is that the process of mourning that resulted from this breakdown led to individuation and the creation of meaning with the development of new symbols and values, i.e., "the science of psychoanalysis." This affirmative statement of a break is contradicted as the author recognizes that the new has its origins in the old. In his discussion of individuation as a response to mourning, he refers to individuation "as the way . . . the self can remain integrated and psychological while also appropriating meanings from the past in the form of cultural symbols which infuse it" (p. 9). In this respect the development of psychoanalysis would be more readily seen as a transformation of Western values and meanings rather than as a repudiation of them.

It is in another sense as well that Homans emphasizes Freud's role as one of the participants in the development of a new *Weltanschauung* rather than as the central and only one. This has to do with the idea of Freud's self-analysis. Here the author evokes Ellenberger's idea of creative illness. He points out that a number of the main figures in psychoanalysis (and indeed in areas other than psychoanalysis) experienced a period of psychological disorganization that impelled them to an introspective self-scrutiny that in many respects resembled Freud's experience in the late nineteenth century. He points out that the major figures in the early history of psychoanalysis, such as Jung, Rank, and Jones, all experienced personal crises in their lives, in which they were compelled to challenge their value systems, in particular, religious ones. In these crises they evolved new perceptions of the world and developed changed self-representations. Weber, too, had such an experience, involving the de-idealization of his previous religious beliefs. What Homans fails

to acknowledge is that Freud transformed this experience into the theoretical structure and therapeutic technique called psychoanalysis that has formed the basis of an extremely influential psychotherapy. Moreover, Freud's theoretical model of the mind and his theory of behavior had a much more significant influence on Western thought than did the work of any of the other actors.

Homans describes the social circumstances of creativity. He emphasizes individual self-definition as dominated in traditional societies by the internalization of societal values. In the modern world individuals may, under certain circumstances, change their self-definition by an introspective re-examination of their inner world (one that parallels the experience of psychoanalysis) in the process of mourning for lost values. This may create new values in what Homans calls "transitional space," a psychological state that is intermediate between connection and separation, a concept derived from Winnicott.

Homans's discussion of the evolution of the development of the relations between Freud and his followers is of particular interest. Unlike previous authors who focused on the centrality of Freud's self-analysis as the most influential period for psychoanalytic creativity, Homans focuses on Freud's relationship with Jung and the upheaval that followed the dissolution of that relationship. Freud's initial optimism as a young man had been fractured by his recognition of the failure of liberalism, manifested in part by the anti-Semitism of the time. This coincided with his self-analysis and early work on psychoanalysis and led to his attachment to B'nai B'rith in 1897 and his relationships with Breuer and Fliess. This was a period of splendid isolation, and it led to a gradual de-idealization of his Jewish roots and to the first creative psychoanalytic period, which culminated in early psychoanalytic theory, in particular, in *The Interpretation of Dreams*. The appearance of Jung, who was himself searching for a new value system in the context of his repudiation of his religious past, led to an intense connection between Freud and Jung, partially solidified, in Homans's view, by Freud's need for mirroring. Freud hoped that Jung would assume psychoanalytic leadership after his own death and that this would facilitate the acceptance of psychoanalysis by the Christian world.

Homans attributes the conflict with Jung to Freud's view that Jung was making psychoanalysis a religion. This ignores the im-

portant theoretical difference that resided in Freud's perception that Jung's changing view of libido diluted basic theory. Homans states that the rupture with Jung led to persecutory anxiety in the analytic group and to the formation of a closed society, the Wednesday group. This disruption was extremely distressing to Freud and led to a second "creative illness" and to the works, "On Narcissism" and "Mourning and Melancholia." Freud's disappointment in his expectation that Jung would be the vehicle for the extension of psychoanalysis to the broader Christian world is viewed by the author as a stimulus for the cultural texts (in *Moses and Monotheism*), in which Moses vents his narcissistic rage against the followers who have betrayed him. Moreover, the writing of the metapsychological papers after the rupture reflected Freud's effort to underline the scientific, as opposed to the religious, nature of psychoanalysis. This view adds a new dimension to very complex events.

Homans finishes his work with an extensive discussion of sociological theorists and the relationship of mourning to society as a whole. He offers an interesting analysis of Weber's life as it related to the development of his theory. Unfortunately, much of this section, as well as the last part of the book, is very heavy going and often incomprehensible.

One of the main problems is the book's organization and Homans's writing style, which is tedious, long, disorganized, and frequently redundant. It would be a better book if it were rewritten at half its length, with clear lines of argument and avoidance of constant digressions. Throughout, there is a constant interweaving of descriptions of culture, autobiographical fragments, social and psychoanalytic theory, and interpretation, both cultural and analytic. This creates a text that is difficult to penetrate, although the author has a rich and scholarly knowledge of culture, history, philosophy, and psychoanalysis. His awareness of his own difficulty with writing is apparent in the frequency with which he offers summary comments of previous statements, sometimes in the middle of a chapter. Unfortunately, even this summary often seems to move in all directions and is difficult to follow. For example, after a very long chapter, his second essay, he states his intent to represent concisely two major conclusions and to generate a fresh set of

problems, all of which leads to eight further pages. The reader is left unclear as to which conclusions the author was addressing.

There are also difficulties and a lack of clarity in the author's use of terminology. He speaks of the impossibility of the modern self to exist "apart from the appropriation of the cultural worlds of the past." He states that it is possible for the ego to do so, but not for the self. What this means remains unclear. This is a major problem with this book. There are rich and creative ideas, but one is often left with the sense of vagueness about many of them, and there is a tendency to overinterpret on the basis of limited evidence.

MILTON VIEDERMAN (NEW YORK)

SUICIDE. UNDERSTANDING AND RESPONDING. HARVARD MEDICAL SCHOOL PERSPECTIVES. Edited by Douglas Jacobs and Herbert N. Brown. Madison, CT: International Universities Press, Inc., 1989. 505 pp.

This volume is a selection of papers presented at the series of suicide symposia that began under the auspices of the Cambridge Hospital Psychiatry Department. These symposia began in 1981 and extended over several years. Most of the participants are or were affiliated with the Harvard Medical School.

Individual papers deal with a broad spectrum of the issues pertaining to suicide, its causes, meaning, and treatment. The book presents an effort to articulate a broad, encompassing perspective on the nature and treatment of suicide worthy of carrying the Harvard good healthkeeping seal of approval. Some chapters are devoted to various aspects of the problem of suicide, including public health, epidemiology, psychological vulnerability, biological determinants, social relations, and risk management. Others focus on issues met with in specific categories: personality disorders, affective disorders, schizophrenia, children, adolescents, the elderly, and women. Discussions deal with the therapeutic management of suicidal cases in a variety of settings, such as in psychotherapy, in the emergency room, and in the hospital in both inpatient and outpatient situations. Finally, several contributions take up moral and legal questions. There is even reflection on nuclear war and collective suicide. The coverage seems quite complete, touching all the

bases and presenting a relatively up-to-date summary of contemporary views and information about suicide as a clinical problem.

Much of the content would not be of great interest to psychoanalytic clinicians, but several papers are worthy of note. Edwin Schneidman's introductory overview restates his well-known views on multiple causality and aspects of suicide phenomenology, especially the mind-set of the suicidal patient. His cubic spatial model of pain, perturbation, and "press" is a true help to assessment. Dan Buie and J. T. Maltsberger's view of psychological vulnerability tends to espouse a Kohutian view of the suicidal patient's psychic stance and intense dependence on selfobjects. The emphasis falls on an important aspect of the patient's state of mind, at least in a fair number of cases; but the discussion strikes this reader as relatively nonspecific and as yielding less clinical fruit than some of the other contributions of these authors. Their second paper in this volume, on common errors in the management of suicidal patients, has a good deal more clinical application that is astute and helpful.

John Mack adds an interesting reflection on his experience with suicidal adolescents. Norman Zinberg's long chapter on psychotherapy takes an inordinate amount of space, rehearsing ego psychological ideas, particularly Rapaport's view of autonomy, before getting down to clinical brass tacks. Even so, the treatment remains rather general. The section on moral and legal issues was somewhat disappointing. There is another rehashing of Thomas Szasz's views advocating a strong libertarian stance in favor of the right to kill oneself; attempts to forestall or treat the suicidal patient then become forms of coercion. Ronald Maris's essay on existential and biomedical forms of intervention has the twofold merit of being brief and of nicely focusing the relevant questions.

In general, the essays in this collection remain on a relatively superficial level, without much attempt to probe the deeper motivational levels of the suicidal experience. To the psychoanalytic reader, there is little in the way of new ground broken. Or, as Dr. Johnson would have it, there is much here that seems new and useful—but what is useful is not new, and what is new is not useful. Despite the title, the clinical discussions tend toward the theoretical rather than the practical. Some clinical material is cited, but it tends to be sparse and merely illustrative. The level of discourse is cast at the PGY II or III level; for trainees or inexperienced clinicians

many of the ideas and formulations will prove useful. There is little, however, for analysts to chew on. The volume suffers from the lack of a strong editorial hand; the quality of many of the papers might have benefited from more stringent reworking.

One final comment: the book is printed in a miniscule type that strains this poor reader's eyes and patience, and unfortunately, unlike the two-volume *Oxford English Dictionary*, it does not come with its own magnifying glass.

W. W. MEISSNER (CAMBRIDGE, MA)

DIRTY WORDS: PSYCHOANALYTIC INSIGHTS. By Ariel C. Arango, M.D. Northvale, NJ/London: Jason Aronson, Inc., 1989. 232 pp.

The focus of this relatively unsophisticated book is that "dirty" or obscene words are taboo because they evoke the sensual, incestuous, and bodily pleasures of childhood. Arango asserts that it is the moral repugnance regarding those pleasures that leads to repression and hence to neurosis. That same repugnance is felt toward the obscene words that have the power to evoke visual imagery, memories, and affects related to childhood wishes. With that in mind, Arango advocates the public acceptance of obscene words as an ally to a greater acceptance of culturally warded-off incestuous wishes. He further notes that a patient's use of obscene words to describe excretory and sexual functioning is an indispensable part of every analysis.

The book is divided into chapters each of which is on the "dirty" word for: genitals, intercourse, masturbation, excretory functions, etc. In each chapter, the author documents the import of the denied pleasures, with references to art, literature, and history. The chapter on feces and urine, for example, addresses the coprophagic practices of various religious sects, the powers ascribed to the diapers of the Christ child, and the anal erotism depicted by the Marquis de Sade. The author's goal is to underscore how our present-day "adult" aversion to anality is cultural and moral—not natural. (There is also a general implication that earlier civilizations, especially pre-Judeo-Christian antiquity, were, rightly, more tolerant of the sensual pleasures of childhood.)

The chapter, "The Voluptuous Mother," is a discussion of the curse, "son of a whore." On the one hand, Arango considers the

mythological and religious tradition of the virgin birth; and on the other, he documents the long history and often respectable social role of prostitution. Prostitutes, in reality, and virgins, in mythology, both have had sons. The myth of the virgin birth expresses the need of the helplessly yearning and jealous son to deny his mother's sexuality. "Son of a whore," according to Arango, would not be a curse if the culture fostered the child's acceptance of the sexuality of the mother. "Only an internal well-established image of the *whore* mother ensures a healthy love life in the male" (p. 179). (Arango does not address the possible pathogenic consequences of the child's perception of the joyfully sexually active mother, such as overstimulation, intensified guilt, and narcissistic mortification.)

I find Arango's views on neurosogenesis a little narrow. He seems to be saying that if a greater adult tolerance for children's incestuous and other sensual wishes were transmitted to children, they would have less need for repression and hence fewer neuroses. This explanation omits the powerful intrapsychic sources of conflict, and also does not accord a role for the fantasies, defenses, and regressions in a specific child's struggle with the fantasied elaboration of specific wishes within the context of the child's own family.

I would also disagree with Arango's technical advice regarding the indispensable role of obscene words in analysis. Obscene words can serve a myriad of functions in analysis, including, paradoxically, patients' attempts to desexualize the analytic setting and defensively denigrate their sexuality. It is true that euphemistic language may serve resistance, but the analyst's tactless encouragement of more graphic language may be experienced as a seduction, assault, or evidence of the patient's seductiveness. It is important to know what words are especially evocative for a patient; if the "correct" word for an anatomic part is more evocative than the obscene word, the latter serves resistance.

While this book contains some interesting quotations and historical oddities, I do not think that psychoanalysts will be informed by its focus on the well-known warded-off wishes of childhood. It takes an unsophisticated, somewhat utopian view that is reminiscent of prior attempts to prevent neurosis by redressing the frustrations of childhood.

RICHARD W. WEISS (NEW YORK)

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Lee Grossman

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ABSTRACTS

Journal of the American Academy of Psychoanalysis. XIX, 1991.

Abstracted by Lee Grossman.

A Developmental Perspective on Analytic Empathy: A Case Study. J. L. Trop and R. D. Stolorow. Pp. 31-46.

Writing in the self psychology idiom, Trop and Stolorow use an extensive clinical example to illustrate their views on analytic empathy. They make clear that the analyst's empathic inquiry does not mean the uncritical acceptance of the patient's conscious experience, but that the analysis of defenses had to await the consolidation of certain developmental prerequisites. In the case under discussion, they saw the patient as requiring a period of "experiencing the analyst's self-delineating selfobject function," in which the analyst helps the patient trust his own subjective reality (apparently by demonstrating that he understands the patient's conscious experience). Premature defense analysis "abruptly ruptured the selfobject transference tie . . . leading to fragmentation of [the patient's] sense of self . . . ." Once the patient's trust in his own subjective reality was consolidated, analysis of defenses was not only nondisruptive, it was experienced as meeting the patient's idealizing longings. It is not empathic to fail to analyze defense when the patient is ready for it. The authors conclude that interpretations should be guided by the developmental needs organizing the patient's experience in the transference.

Patients' Reactions to the Birth of a Male Analyst's Child. R. M. Waugaman. Pp. 47-66.

Waugaman reviews the literature on reactions to pregnancy in the analyst. He then presents vignettes from four patients, illustrating their reactions to the brief interruption of treatment occasioned by the birth of their male analyst's child. He found that the two women reacted more negatively, which he understood in terms of both positive and negative oedipal defeats; whereas the men tended to identify with the analyst's paternity.

Experiential Psychoanalysis and the Engagement of Selves: Ferenczi's Vision and the Psychoanalytic Present. I. S. Miller. Pp. 67-83.

Miller describes the evolution of Ferenczi's experiential psychoanalysis, and briefly notes his influence on modern analysts. Miller views the classical tradition as using the idea of neutrality to sidestep the issue of the analyst's subjective participation, and the Sullivanian tradition as using objectivity and the privacy of experience toward the same end. Neither recognizes the importance of the subjectively felt experience of interrelatedness. Ferenczi focused on the affective quality of the engagement for each participant. He reflected on his own participation in the process. Gill, Levenson, Racker, Sandler, and Searles follow his lead in seeing the analyst's participation as "a real response within a genuine transferential-countertransferential enactment." Transference was not simply a repetition of the past, but a directly enacted present experience.

The Creative Person as Maverick. P. L. Giovacchini. Pp. 174-188.

Giovacchini opines that the innate talents that are the essence of creativity are associated with the particular character structure of the maverick. They bend rules but do not break them; they are nonconformists but not rebels. These character traits are independent of pathology. Giovacchini uses brief examples, both from history and from clinical experience, to illustrate his thesis. He believes that the early environment provided considerable gratification, which made it possible for the creative person to rely on inner resources, rather than the outer world, both for stimulation and for security.

Sandor Ferenczi on Female Sexuality. J. E. Vida. Pp. 271-281.

Vida uses extensive quotations of Ferenczi's writings on female sexuality to demonstrate his attempts to appreciate the experience of women. The passages illustrate Ferenczi's sensitivity to the role of the environment in shaping women sexually, and the neglect of those considerations by Freud, in his male-centered approach to understanding sexuality. One of several passages from Ferenczi's *Clinical Diary* anticipates Horney's view that it makes no sense to think of the vagina as "undiscovered" by the psyche in childhood; another passage proposes that Freud's blindness to female sexuality had its origins in his need to ignore it in his mother. Ferenczi believed that "normal" development of children is so routinely disturbed by adults' insensitive or traumatizing behavior that healthy development cannot yet be described.

Freud and the Mighty Warrior. S. L. Warner. Pp. 282-293.

In this biographical speculation, Warner describes the development of an aspect of Freud's character which he calls the "mighty warrior." He describes this as beginning with Freud's relationship with his nephew, who was one year older. Throughout his life Freud identified with heroes, from the military realm in childhood, to Goethe, Shakespeare, and finally Moses. Warner explains this development as a "reaction formation" against his father, about whose stature he felt disillusioned, and an identification with the aggressor with respect to his mother's demands for achievement.

The Role of the Transference in the Wolf Man Case. H. L. Muslin. Pp. 294-306.

Muslin looks at the Wolf Man case in order to spell out Freud's 1914 view of the curative factors in analysis, especially with respect to the role of the transference. He describes how Freud used the transference attachment (i.e., the threat of termination) to facilitate recall of memories. Memory retrieval and reconstruction, rather than awareness and resolution of the transference neurosis, were seen as curative. Muslin cites several extracts from Freud's description which show his apparent use of transference leverage without exploration, or outright neglect of the transference. In Brunswick's re-analysis, the unresolved masochistic transference to Freud was noted, but the new treatment also neglected awareness of the transference, examples of which were abundant. Muslin suggests that Brunswick's "attack" on the Wolf Man's favorite son posture with respect to Freud was experienced as similar to

Freud's command to terminate. This allowed a transference cure by re-establishing the passive masochistic position that gave him peace. Muslin concludes that Freud's 1914 view of the role of the transference was that it was leverage to facilitate the recall of childhood memories and reconstruction.

How Analytic is Psychoanalytic Psychotherapy? R. M. Richard-Jodoin. Pp. 339-351.

The author argues that psychotherapy and psychoanalysis are fundamentally different. She sees psychotherapy as a reality-oriented process which seeks to integrate dissociated but conscious aspects of the self and object, and does not seek to uncover the unconscious. The failure to observe this distinction has led either to an attempt to reduce psychoanalysis to psychoanalytic psychotherapy, or to view therapy as an approximation of analysis.

Psychoanalytic Inquiry. IX, 1989.

Abstracted by James R. Edgar.

Below are abstracts of a series of papers presented at the 25th Annual Scientific Day Program of Sheppard Pratt Hospital with the theme "Psychoanalytic Perspectives on the Borderline Patient." The program consisted of a case presentation by Dr. Susan Pearson and individual discussions of the case which encompassed the classic, object relations, self psychology, Kleinian, and developmental perspectives of psychoanalytic thinking, followed by a summary by Dr. Joseph D. Lichtenberg.

Velvet Bricks: The Long-Term Inpatient Treatment of a Borderline Patient. Susan Kaye Leavitt Pearson. Pp. 487-516.

Dr. Pearson was a resident in psychiatry when she treated Mrs. X, a fifty-year-old married mother of two teenage children, for one year in an inpatient setting. This was Mrs. X's first hospitalization and came after ten years of psychotherapy with Dr. Z. Mrs. X, although externally accomplished, experienced an overwhelming sense of emptiness, had chaotic interpersonal relationships, and engaged in secret, self-mutilating behavior. She first came to Dr. Z after ending a dependent relationship with a nun, which caused longstanding difficulties to flare up. She became very dependent on Dr. Z over the course of ten years treatment. She hid the depths of her involvement for six years, which Dr. Z overlooked because of Dr. Z's own needs. When Dr. Z tried to work on the problem, Mrs. X became anxious and fragmented. She revealed other secrets, including an image of herself as split between a helpless undernourished infant who was slowly dying (the "real self") and an outwardly capable, dependable, but punitive gorilla (the "false self"). The gorilla self included behaviors such as abuse of alcohol and medications, self-mutilation with cigarettes and sharp objects, and ingestion of insecticides.

Dr. Pearson documents this same "split" in the patient's early life: an externally successful, wealthy family and the dependable structure of Catholic schools covering a chaotic family life and an alcoholic, impulse-ridden, sexually provocative father. Mrs. X found refuge in the church, in her intellect, in her identity as a teacher, and

in an older husband she described as "reliable, predictable, strong, and very blocked emotionally. Perfect for me."

She was admitted after consultation and medication had failed to resolve the impasse with Dr. Z. Dr. Pearson describes in detail the one-year course of treatment in the hospital, coordinated to encompass all aspects of the patient's life: the transference relationship, the continuing relationship with Dr. Z, and the problems caused by it. She describes the family therapy and how this was integrated with the individual therapy, psychopharmacology, and art therapy. Work was also done with the nursing staff to contain Mrs. X's tendency to split.

Discussion: The Classical Position. Jacob A. Arlow. Pp. 517-527.

Arlow states his misgivings about having been labeled the "classical" discussant because of the lack of consensus in defining this term, and because of his own criticism of many early ideas. Using structural theory and ideas about intrapsychic conflict to organize the material, he feels the patient's central conflict is murderous rage stimulated by a chaotic, abusive childhood and her guilt about the rage. She has attempted to "solve" this conflict by identifying with the aggressor, turning aggression against the self, and engaging in criminality out of a sense of guilt. Arlow then shows how the issue of rage and guilt is worked with during the hospitalization, providing her the structure she so desperately needs to allow a more functional "resolution."

Discussion: Self Psychology and Mrs. X. Ernest S. Wolf. Pp. 528-538.

Wolf uses the psychology of the self to organize his discussion of the case. He points out the early excessive idealization of others (in particular, Dr. Z) coupled with an apparent abnegation of the patient's own self. When Dr. Z interferes with these idealizations and merger fantasies, Mrs. X becomes frantic and fears she will die. Wolf sees the "so-called self-destructive behavior" as attempts to reassure herself that she is alive and to define her boundaries. He speculates that her earlier roles as mother and teacher had provided her with needed merger fantasies and selfobject experiences that staved off fragmentation. Wolf feels that the therapy moves forward because of a process of "disruptive-restorative events" that involve Dr. Pearson's having *done something* that interfered with Mrs. X's needs for an idealizable, perfect selfobject and the subsequent discussion of the disruption between patient and therapist. He sees her anger and fear as secondary to those disruptions of the idealized selfobject.

Discussion from an Object Relations View: A Resilient Fist in a Velvet Glove. Clarence G. Schulz. Pp. 539-553.

Schulz approaches the case from the perspective of the patient's "internal object world," using concepts such as self-transference, self-representation, object representation, self-constancy, and splitting. He defines projective identification and shows how it is useful in understanding the transference relationship between Dr. Pearson and Mrs. X. He also sees the "self-destructive behavior" more as attempts to define the self, acknowledging it could also represent turning the anger on herself.

Her relationship with Dr. Z may have provided the necessary symbiosis that made the later therapeutic gains possible.

Discussion: A Kleinian Perspective. Murray Jackson. Pp. 554-569.

Jackson discusses the current conceptual confusion about the diagnosis of borderline personality organization and its relationship to Klein's concept of the paranoid-schizoid position. Although acknowledging the reality of the early chaotic and provocative environment, he speculates that the cause of Mrs. X's problems is her own difficulty in containing destructive feelings of envy and jealousy in the early relationship with mother. This caused an early split in her personality and failure of the split-off part to progress beyond a paranoid-schizoid position. In spite of significant pathology, he sees in Mrs. X evidence of a strong reparative drive. Jackson clarifies the importance of her Roman Catholic background in providing her with structure in the midst of an otherwise chaotic life. He traces the "self-destructive behavior" throughout her development, pointing out its preoedipal origins and its usefulness in dealing with separation-individuation anxiety. He then examines the oedipal meanings of the behavior, her identification with the suffering Christ, and her persistent sadomasochistic fantasies. He points out the necessity of dealing with the fundamental distrust in the transference relationship because of the split-off part of the personality that is fixated in the paranoid-schizoid position. He uses that Kleinian concept to explain the relationship with Dr. Z, the transference relationship to Dr. Pearson, the dreams, and the artwork. However, he is careful to point out that he would not attempt direct interpretation of any primitive content; rather, he would patiently work through Mrs. X's defenses with an empathic awareness of her condition at the time.

Discussion. Howard F. Searles. Pp. 570-585.

Searles discusses the tendency to present Dr. Pearson as the "good mother" and Dr. Z as the "bad mother." He points out the advantages of working with such a patient in the contained atmosphere of an inpatient unit, and the difficulties inherent in the outpatient setting. Even if the previous therapist has been scrupulous in breaking off contact, the patient may feel abandoned. Searles, believing countertransference responses to a patient like Mrs. X to be inevitable, points out how Dr. Pearson lets herself be drawn into behaviors similar to those she condemns in Dr. Z. He speculates that the fear this will happen causes Dr. Pearson to avoid the transference relationship with Mrs. X early on, and thus to allow the relationship with Dr. Z to continue. Negative transference was displaced or acted out with the ward nursing staff, Dr. Pearson's supervisors, and in the patient's artwork. After tracing the oedipal themes in the transference, Searles turns to his and Melanie Klein's work on early ego development and the differentiation between the human self and the surrounding nonhuman environment. He uses these concepts to explicate the relationship between Mrs. X and the hospital itself. Returning to the countertransference, he sees the use of medication during the termination of hospitalization as the inability of the therapist to tolerate the attendant sadness, murderous rage, envy, and relief.

Psychoanalytic Theory is a Many Splendored Thing: A Discussion of the Discussions. Joseph D. Lichtenberg. Pp. 586-603.

Lichtenberg outlines Dr. Pearson's theories of psychopathology and treatment, as well as each case discussion. Identifying himself as a "developmentalist," he organizes the material around five motivational systems: psychic regulation of physiological requirement, attachment and affiliation, exploration and assertion, assertiveness through antagonism and/or withdrawal, sensual enjoyment and sexual excitement.

Contemporary Psychoanalysis. XXVII, 1991

Abstracted by Sybil A. Y. Ginsburg.

A Philosophy for the Embedded Analyst: Gadamer's Hermeneutics and the Social Paradigm of Psychoanalysis. Donnel B. Stern. Pp. 51-80.

Stern states that "analyst and patient are both participants" in the analytic process. How, then, does one "know" truths about an analysand? What is the nature of clinical understanding? The author turns to the work of Gadamer, a philosopher who studied hermeneutics (defined as "the study of the process of understanding"). According to Gadamer, "meaning" is dependent upon linguistic expression, and "prejudice" is the source of new experience. (Stern likens "prejudice" to the clinical concept of "countertransference.") Gadamer believes that language gains meaning only through being spoken, and Stern believes that clinical understanding occurs only in the context of an interactive therapeutic relationship. We must always approach the analytic relationship as an uncertainty, a hypothesis. As the relationship develops and traditions (i.e., prejudices) are shared, analysis takes place "at the edge of what the participants know." The author believes, though Gadamer would not agree, that empathy happens when "a preconception and its alternative can be differentiated." Stern also discusses the work of two other hermeneuticists, Habermas and Schafer.

Working through the Past, Working towards the Future. Lewis Aron. Pp. 81-109.

Freud envisioned working through as a type of battle, gradually won as an ego strengthened by analytic work overcomes the pressure of id impulses. Among later classical analysts, Fenichel, a representative of ego psychology, thought of working through in terms of defense and resistance interpretations, and Greenacre stressed the importance of reconstruction. These theoretical frameworks all consider id impulses to be immutable, and, therefore, the therapeutic process based upon them stresses renunciation and loss. Aron prefers the term "working toward"; he believes that id drives can develop and mature toward "new and better gratifications." The therapeutic relationship is a collaborative venture with the aim "of transforming the analysand's inner representational world." Piaget's work is noted for its understanding of how the inner world may change through adaptation, assimilation, and accommodation. Loewald is a classical analyst who has described a relational model of working through. Bowlby is a relational theorist noted for having contributed significantly to the concept of internal object relations. Aron also discusses the per-

spectives of other schools: British object relations, American interpersonal, and Kohutian self psychology.

Idealization and the Holding of Ideals. Anna M. Antonovsky. Pp. 389-404.

Idealization is different from, though under optimal conditions it may lead to, the holding of ideals. The latter implies a capability for "delay, control, neutralization, symbolization and sublimation." In "On Narcissism," Freud stated that the ego ideal develops as a result of the frustration that leads to the awakening of the reality principle. He added that the existence of the ego ideal may, but does not always, lead to such structure-building psychic work as sublimation.

Edith Jacobson and Melanie Klein, each from her own theoretical perspective, described the maturation process that may set the stage for the holding of ideals. Jacobson conceptualized a "disillusionment crisis"; its positive resolution is crucial for further development—helplessness and yearning for fusion gradually giving way to mature object relations and ego defenses. These, in turn, provide the capability for the development of ideals. Klein, in her elaboration of Freud's concept of the death instinct, theorized how idealization may be utilized as a defense against aggression. This defense may be resolved through traversing the "depressive position." The resolution provides the groundwork for the holding of ideals.

Freud's *Moses and Monotheism* is used as a metaphoric clinical example to show the "going from idealization to the holding of ideals, mediated by ego development and the depressive position." Freud hypothesized that Moses was a follower of the monotheist Akhenaten and that he kept the latter's ideals even though most of his countrymen abandoned them. Moses then left Egypt with a band of followers. However, even though their narcissism was flattered by being chosen by the nobleman Moses, his followers could not live up to his ideals and eventually rebelled. Over the generations after Moses, however, they developed further, and their descendants integrated "elements of Mosaic religion into" their primitive beliefs.

The Impact of the Therapist's Life Threatening Illness on the Therapeutic Situation. Gloria Friedman. Pp. 405-421.

The author examines her experience as a therapist during, as well as in the years following, her bout with cancer. She has remained well since the initial episode. The paper is of note, both because it discusses a topic about which there is little literature, and because it raises complex ethical and countertransferential issues. At the time of the illness, patients were told only that there was "a family emergency," and none ever became aware of her condition. Friedman concludes that she was not "in collusion" with her patients to deny the cancer, but rather that she had managed "effective and unambivalent compartmentalization." She contrasts her reaction of increased satisfaction with her work, with those of others who have reported resentment of patients' dependency or envy of their good health. Within the next few years after her illness, the author saw three new patients who had had recent losses due to cancer. One remained in successful treatment. The second had lost several relatives to cancer and was facing the imminent loss of yet another; Friedman felt unable to tolerate the prospect of hearing about all these ongoing tragedies, and

declined to work with the patient. The third patient fled treatment after being informed of the author's illness.

Three patients in ongoing therapy discovered the existence of the author's cancer, two accidentally from outside sources, and a third because Friedman appeared to the patient to know so much about cancer. For all these it seemed to be "grist for the mill," and led to transference analysis. The author intends to inform all future patients "who have experienced the death of an important person through cancer," because "to have them face the same possibility with me is more than I can be a witness to or partner of."

Discussion includes the differences between the classical analytic and interpersonal traditions. As a representative of the latter, the author believes that insuring the continuity of the analysis is more pertinent than concern for interfering with it by veering from neutrality and abstinence. She concludes that the coping skills of the therapist will set "the stage for what will or can transpire in the analytic situation."

Biblical Job: Changing the Helper's Mind. Jeffry J. Andresen. Pp. 454-481.

The fifth century B.C.E. poem of Job shows his transformation from "unknowing" suffering to an understanding of "God's view of creation." God caused Job numerous losses as a test of his devotion. His friends insisted that he must have sinned, but Job disagreed, and kept searching for meaning. He assessed his friends as having false sympathy and empty words, telling them to stop giving speeches, because if they were "at a loss for words" they might come upon truths. Eventually, God appeared to Job and directed him to become attuned to the majesty of creation, whereupon Job finally achieved peace through the "experience of awe."

The transformation of Job's world view is compared with the process of psychoanalysis, as well as with the dawning of consciousness in the infant and the development of the reality principle. The author discusses Winnicott's model of development via optimal frustration, as well as Klein's "depressive position." He also describes the formulations of Wilfred Bion, including his concepts of the "container-contained functions of the mind" and of maternal "reverie." Bion's theory of how the "suffering" of "not knowing" precedes a rewarding "transforming of awareness" is related to Job, as well as to the psychoanalytic situation. The ideas of the poet and philosopher Schiller concerning the relationship between sensations and significance are seen as concordant with those of Bion.

The Psychohistory Review: Studies of Motivation in History and Culture. XIX, 1990/91.

Abstracted by Thomas Acklin.

The entire fall 1990 issue is dedicated to the Menninger School of Psychiatry in memory of Karl A. Menninger. Of special interest for the psychoanalytically oriented reader are comments by Lawrence J. Friedman that the Menninger School of Psychiatry succeeded in transmitting Freud's ideas on the human psyche to a larger proportion of American medical professionals than has occurred at any time before or since. He comments on the psychodynamics of students of Karl Menninger in

their relation to such a powerful father figure. He discusses the broader issues of power relationships within psychoanalytic institutes, the political connection between the training analyst and his or her analysands, the nature of confidentiality in the analytic relationship and the consequences of violating it, as well as the very utility of psychoanalytically informed therapy and its balance with organic aspects of treatment. James Carney, in his contribution, shows the influence of Smith Ely Jelliffe on Menninger: in his movement away from nineteenth century descriptive psychiatry to psychoanalysis, in his understanding of psychoanalytic technique and procedure, and in his stance against lay analysis.

The Truths of *Frankenstein*: Technologism and Images of Destruction. Gordon Fellman. Pp. 177-231.

Fellman considers the cultural meaning of Mary Shelley's *Frankenstein*, its images of destruction and helplessness, not only as evoked in the present nuclear threat, but in all science, technology, economics, psychology, and politics—in short, in all endeavors to reach beyond human limits to attain extraordinary power. Fellman refers to *Civilization and its Discontents*, noting that Victor Frankenstein's horror at his own creation reflects what Freud describes as our fear of upsetting inner equilibrium in exploring the unknown in human personality. The novel examines the power and destructiveness of the strange and fearful dimensions of human sexuality, particularly in their oedipal intensity, reflected in attempts at resolution, such as the way in which Frankenstein goes away with his mother and comes back with the wished-for baby of his own creation.

Woman and sexual activity are not involved in his creation; Victor's monster represents the male child's narcissistic fantasy which refuses to accept that children come only from women's bodies. Fellman suggests that Frankenstein is ultimately trying to become far more than a woman bearing life or a father contributing to the conception of a child; indeed Frankenstein is rivaling God. The murderous offspring of all these conflicted wishes is named Monster, Demon, Fiend, Devil, or simply "He." The demon represents both Victor's own anger and the anger he expects his father to unleash against him in retribution for his autonomy and ambition. Fellman recognizes in the monster the same danger that Freud described in fundamental aggressive and sexual impulses becoming destructive if not acknowledged and allowed expression. The author identifies the struggle between Frankenstein and the monster as the struggle between ego and id. Moreover, Victor's monster is seen as a masturbatory fantasy, a failed attempt to prove the anal theory of birth, as well as an attempt to at once subsume the capacity to bear a child and to hold onto the departed mother by internalizing her. In all this Victor struggles to liberate himself from constricting oedipal bonds.

Fellman concludes by wondering whether the nuclear threat is determined more by confused male strivings, such as those found in Victor Frankenstein, than by historical circumstances. According to the author, repressed longing in the original constellation of the family is transformed into economic and political struggle and imperialism. The recognition of denial opens the pathway for sublimation and, according to the author, the sublimation of such destructive energy allows it to merge with what Freud identified as eros. Forms of domination are for Fellman

ultimately an interplay between the inner and the outer. He feels that social critics who ignore internal dynamics make the same blunder as psychoanalysts who ignore history and institutional dynamics in their description of reality.

Nietzsche and Freud: Two Voices from the Underground. Paul Roazen. Pp. 327-349.

Besides exploring the close affinity between Nietzsche and Freud—"these two voices from the underground"—Roazen raises the stimulating question of the past tendency to "prettify" Freud. He notes not only a paucity of studies regarding the possible association between Nietzsche and Freud, but also the tendency to ignore such aspects of Freud's thinking as the death instinct, his suspicion of the ideal of altruism, and his cynicism about human rationality and morality. Not only is Freud's indebtedness to Nietzsche far more direct than has been recognized, but his own pessimistic thinking has been covered over by a tendency to highlight the more positive aspects of psychotherapy and psychoanalysis. Says Roazen, "We must take the savage side of Freud along with the rest of him."

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Meeting of the Psychoanalytic Association of New York

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NOTES

MEETING OF THE PSYCHOANALYTIC ASSOCIATION OF NEW YORK

January 28, 1991. "LAZARUS STAND FORTH"—H.D. ENCOUNTERS FREUD. William D. Jeffrey, M.D.

H.D. (Hilda Doolittle), well known in literary circles as a member of the Imagist School, wrote three different accounts of her first analytic session with Freud, which took place on March 1, 1933. Her impressions were captured in a letter, a diary, and articles written between 1933 and 1948. She originally began psychoanalytic treatment in 1931 with her friend, the analyst Mary Chadwick. Shortly afterward she consulted Hanns Sachs and was referred to Freud. She came to Freud for help in dealing with a series of losses, including a miscarriage, the deaths of her brother and father, and her divorce. She was in treatment with Freud from March through June 1933 and in November 1934. Using H.D.'s accounts of her first session, Dr. William Jeffrey has examined the patient's underlying conflicts and her treatment experience with Freud. He has done so with an awareness of the distortions to be expected in a subjective account of a therapeutic encounter.

Immediately after meeting Freud for the first time, H.D. wrote to her friend and lover, Winifred Ellerman ("Bryher"). (The letter is part of a complete unpublished set contained in the Beinecke Library at Yale University.) Her first impressions of Freud were as a seducer: she must take off her coat, she is led around the room in order to admire antiquities, there are "dim lights, like an opium den," and she is asked to lie on the couch. Her description of Freud as a "little white ghost" reveals her ambivalence and her concerns about death. As Dr. Jeffrey noted, "A ghost has succumbed to death; a ghost has overcome death." Freud was old, small, and handicapped by a jaw prosthesis at the time H.D. met him. She recalled Freud's making the following statement: "Now although it is against the rules, I will tell you something: you are disappointed in me." According to Dr. Jeffrey, Freud correctly interpreted H.D.'s intense preformed transference—her wish for a special relationship with an idealized, vital analyst and her disappointment when faced with a frail, elderly man. She then attempted to deny her negative feelings by stating, "You are everything, you are priest, you are magician." H.D. further avoided her conflict by suggesting that if Freud's dog, Jo-fi, showed her affection, then the analyst must feel this way too. As Dr. Jeffrey pointed out, H.D. emphasized her need for Freud to love her rather than focusing on her fear of loving a less than ideal Freud. Dr. Jeffrey sees the patient's yearning for the analyst as primarily preoedipal. The "opium den" and the reference to magic evoke issues of altered states of consciousness and loss of ego boundaries. In her letter H.D. described Freud as "growling"

and "purring." Dr. Jeffrey noted that Jo-fi was used interchangeably with Freud and that "Cat" was a nickname for the patient. That H.D. had difficulty maintaining a mental representation of Freud is made clear by her statement, "He is not there at all, is simply a ghost and I simply shake all over and cry." Dr. Jeffrey speculated that Freud's speech impediment and German accent may have reminded the patient of a "dying stranger" when she "howls" that Freud is "not a person but a voice." In their first meeting H.D. tried her best to hide her fear that this new relationship would end: "I shall never get over oedipus and I go tomorrow and on and on." The letter rambles on as if the patient were not able to stop, and ends with the sentence, "Long live Oedipus." Dr. Jeffrey noted that "to love Freud was to love a person who soon might die" and that H.D. would thus risk losing an idealized object, which would continue a series of losses and deaths.

H.D.'s second account of the March 1st meeting is based on her memory of the session. It was first published in a British magazine in 1944, then again in 1956 as a book, *Tribute to Freud*. H.D. had completed a therapy with Walter Schmideberg (from 1935 to 1937) and was a follower of Lord Hugh Dowding, who believed in communication with the dead. Dr. Jeffrey believes that *Tribute* was H.D.'s attempt to preserve and bolster her image of Freud five years after his death. Her greatest fear, present at her first session, became a reality with Freud's demise. In *Tribute*, less interaction with Freud is reported for the first session; e.g., H.D. was greeted silently, rather than with "Enter, fair madame," as described in the letter. The letter had mentioned Freud's "hammering" the couch for emphasis during the session. In *Tribute*, she identified the action as emanating from an "enraged" analyst, coinciding with Freud's saying, "The trouble is—I am an old man—you do not think it worth your while to love me." After the original draft of *Tribute* was completed, H.D. revised it. She added to the hammering scene that Freud "beat that way with his fist, like a child hammering a porridge-spoon on the table." In *Tribute*, H.D. projected her unacceptable feelings; in her letter, she had denied them. She also increased the mystical, unspoken communication and reconciliation with Freud through Jo-fi. Dr. Jeffrey thought these additions represented a failure to re-establish a fading representation of Freud by means of writing a book dedicated to "the blameless physician."

In 1946 H.D. spent six months in a Swiss sanatorium and probably received convulsive therapy. This followed Lord Dowding's criticism of her faith in the occult. During this time, she wrote *The Sword Went Out to Sea*, an unpublished, autobiographical novel. The story included "dogs . . . bred with lions," used to "rescue individuals and parties of displaced persons"—an image that harks back to the merger of Jo-fi Freud and Cat-H.D.

In 1948 H.D. wrote her third account of the March 1st meeting. Although she had diary notes from the time of her analysis, this account of the first session seems to have been based on memory. "Advent" was published in 1974 as part of a new edition of *Tribute*. Significantly, maternal issues dominate this version of the first session. H.D. represented Freud in an integrated fashion; he is now gentle and omnipotent: he is "Lazarus come forth." Factors that may have led H.D. to return to this positive representation of Freud include her recovery from her psychosis and the benefits of further therapy. That H.D. had developed some insight into her

conflicts is evidenced by her retrospective statement, "I cannot be disappointed with Sigmund Freud only; I have this constant obsession that the analysis will be broken by death." H.D. was closely involved with the analyst, Erich Heydt, from 1953 until her death in 1961. During these years, she wrote *Helen in Egypt*. This book included a Theseus and a Helen who represented Freud and H.D. Dr. Jeffrey ended his paper with these lines spoken by Theseus-Freud to Helen-H.D.: "It is one thing, Helen, to slay death, / it is another thing to come back / through the intricate windings of the labyrinth; / beloved Child, we are together, / weary of War, / only the Quest remains."

DISCUSSION: Dr. Arlene Kramer Richards suggested that Dr. Jeffrey used H.D.'s first session as some analysts employ the first dream—as a "Rosetta Stone" that "contains all that will ever be known or needs to be known." She cautioned that this represents a "static" view of psychoanalysis which does not fully take into account the unfolding nature of diagnosis and treatment. She took issue with what she saw as Dr. Jeffrey's belief that H.D.'s analysis was unsuccessful because Freud did not deal with the preoedipal merger transference. Dr. Richards quoted from a letter written by H.D. on March 23, 1933: "F[reud] says mine is the absolutely FIRST layer. I got stuck at the earliest pre-OE stage and 'back to the womb' seems to be my only solution." Dr. Richards also pointed out that the predominance of issues of closeness and distance is expected in the beginning of any therapy and therefore does not necessarily prove that preoedipal themes dominated throughout the analysis. She suggested that analysis enabled H.D. to resolve oedipal issues of sexual identity and object choice. H.D.'s acceptance of her bisexuality was not her only great achievement. But because of this acceptance she was able to overcome a severe writer's block and go on to become the first woman elected to the American Academy of Arts and Letters. This accomplishment could have been a direct result of work with Freud. "The Poet" and "The Dancer," both written in 1934, were cited in support of the idea that H.D. was able to achieve insight into and sublimation of her bisexual tendencies. " The Poet" is heterosexual; "The Dancer" is Lesbian in the first six stanzas, then bisexual in the second half. The use of arrows as a symbol for women and "mer-men" for men are examples of H.D.'s integration of men and women into the "simply human." Dr. Robert Fischel said that Dr. Jeffrey's methodology is well suited to psychobiographical studies. He pointed out that the recent publication of three versions of Anne Frank's diary (original, revised by Anne, and edited by Anne's father) might be used in a similar way. Dr. Harold Blum stated that H.D.'s analysis was extremely short by modern standards. He suggested caution in attempting to state the nature or success of the treatment. That Freud's methods differed in this case compared with other of his cases was explained by the observation that his theory of technique was evolving and that there were always "many different Freuds" exploring analytic theory and technique. Dr. Jeffrey closed the meeting with several responses. He agreed that the initial session did not represent H.D. fully but was more an example of her potential for regression. He also concurred with Dr. Richard's belief that H.D.'s analysis had accomplished much. Dr. Jeffrey added his observation that H.D. may have had lifelong problems in main-

taining object representations and had surrounded herself with strong personalities, such as Bryher, Freud, Dowding, and Heydt.

JOSHUA I. DORSKY

The 11th INTERNATIONAL CONGRESS ON CRIMINOLOGY will be held August 22-27, 1993, in Budapest, Hungary. The general theme will be "Socio-Political Change and Crime—A Challenge of the 21st Century." For further information, contact: H. J. Kerner, Head, NKG-Bureau, Correnssstr. 34, D-7400 Tubingen, Germany. Telephone: 0049-7071-292931.

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