Modern Psychoanalysis

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Contents

Editorial Introduction

The most recent scientific conference of the National Association for the Advancement of Psychoanalysis was held in April of 1984. These annual events, though they vary slightly in format, have come to take a consistent general shape: Representatives of several schools of thought present talks that in some way represent the speakers' respective approaches to a particular problem or question of psychoanalytic practice. These talks have been, and were in the 1984 session, variable in their formality but scarcely at all in their penetration and in their value. Participants—and all who attend can be considered participants, since questioning from the floor is welcomed and is generally lively—often come away feeling significantly enriched by the cross-pollination that results. Similarities are discovered lurking beneath terminological variants; differences often seem surprisingly bridgeable, or tolerable. These conferences are, in short, an ongoing triumph of NAAP; if they were its only product they would constitute ample justification for its existence. This journal, then, considers it an honor to publish these papers along with the discussions they engender.

The subject for this year's conference was the uses of interpretation. It was addressed by Arthur Robbins, John Beebe, Harold H. Mosak, and Herbert Holt. Discussions are sometimes built into the program, with formal discussants assigned, and sometimes not. In this session one respondent commented on all four presentations—and, as usual, many more volunteered responses from the floor. The respondent on the platform was Phyllis W. Meadow, Dean of the Center for Modern Psychoanalytic Studies. Participants were welcomed byBeverley D. Zabriskie, President

of the National Association for the Advancement of Psychoanalysis.

Robbins is an object relations theorist who has lectured and written extensively on art therapy. He presents an anecdotal case history illuminated by an interpretation in the form of a vivid, powerful graphic image. Beebe, of the C. G. Jung Institute of San Francisco, credits his present understanding of the place of interpretation in therapy to a dream interpretation. Mosak, Chairman of the Alfred Adler Institute of Chicago, advocates exposure in training to many schools of thought, and gearing interpretative style to the patient. In his talk Holt, director of the New York Institute of Existential Analysis, presents and embodies the existential concern with things as they are, and its initial focus on the personality of Freud and of other analysts, including himself.

The Editors

Opening Remarks

BEVERLEY ZABRISKIE

On behalf of NAAP, its Board of Trustees, its committees and staff, I'd like to welcome you here. NAAP has been quite effective in the last year on several fronts, particularly in political and legislative efforts. Thanks to the petition that was signed by many of you, we were able to send in 1400 signatures and fend off an attempt in the District of Columbia to have psychoanalysis limited to practice by physicians. Thanks to your signatures psychoanalysis has been taken out of that constraint in that district. Also, in New York State, Mark Siegel has recently issued his proposal for the governance of the practice of mental health professions in which he has made psychoanalysis a separate profession and NAAP a certifying body for psychoanalysis. Now that means that all those other organizations who would prefer not to have NAAP in existence will be mobilized. So we're going to have a very serious and significant year. We'll be calling on you in the year to come for more help, and particularly to tell your friends and colleagues whose lives, beliefs and professions may be affected by legislation, to join NAAP and give us their support as well. I'd like to pause for a moment before we go on to our program to say that I'm here this year not by right but rather by sad necessity, occasioned by the fact that the woman who was supposed to have been president this year, and who was so briefly, Ethel Clevans, died this year. I knew her only for a short time but I was very much impressed by her. She was a modern analyst and a teacher and lecturer, and I gather quite a wonderful and magnetic person. So I'd just like to pause for a moment in memory of Ethel.

In my mind the best praise for NAAP is that it exists at all. Just

being a member and being here today is an admission of humanity, and of limitation; that we all have something to learn from others who are not part of our own belief system. And so we gather here today to learn from our very distinguished panel of speakers: Dr. Arthur Robbins, who is an object relations theorist; John Beebe, a Jungian analyst; Harold Mosak, who is an Adlerian and Herbert Holt, an Existential analyst. Phyllis Meadow, who is a modern Freudian analyst, will respond, not by giving a formal paper, but by a statement which will help clarify how a modern analyst would see some of the issues brought up by the speakers.

Interpretation as a Means of Organizing Psychological Space Within the Transference/ Countertransference Relationship

ARTHUR ROBBINS

MRS. ZABRISKIE: Dr. Robbins is co-chairman of the art therapy department at Pratt Institute. He is president of the Institute for Expressive Analysis. He is on the editorial board of the *Journal for Art Psychotherapy and the Arts in Psychotherapy*. Dr. Robbins was trained at NPAP. He has had many publications, mostly on the relationship between creativity and psychoanalysis.

In preparing this talk on the use of interpretation, a memory intruded into my consciousness which I'd like to share with you. I remember vividly making my first speech, at my confirmation. I recall all my 13-year-old discomfort as I stood at the pulpit with my legs quaking and my voice rather tense. Then I spotted my mother in the audience. There she was looking down with her hand on her head, and I knew she was thinking, "Oh, is he going to make a fool of me today?"

I responded to this challenge with some arrogance and a degree of provocation. I was torn by fear of having to prove myself and not wanting to have to assert my worth.

The relationship of my internal representations of the arrogant, frightened boy and his mother often has made itself felt in the psychological space between myself and others. This dyad projected outward acquired its own energy, intensity, sensibility, coloration. It also had a volume and rhythm. I still see, at times, in my professional interactions with patients, students, and audiences, the presence of that child as I again become somewhat arrogant, provocative, frightened. Perhaps you can detect a bit of

that today as I look out at you all in the audience and think how very mature and grownup you look!

I brought this type of relationship to my analyst almost from the very first day of treatment, as I said to him rather provocatively: "I'm entering analytic training and I think I should withdraw. I don't believe I have the stuff to be an analyst. I frankly think I should be in marketing research. That's something I can hold onto that's clear, specific, statistical, and can make me money."

I confessed readily that I wasn't quite sure whether I could make a living as an analyst. The frightened, arrogant boy within me nagged that it was such a grownup world: Who would want to see *me?*

My analyst's response was surprising. He replied that he saw no reason why I couldn't be an analyst. Very strange, indeed. Here I thought an analyst was supposed to be neutral and to analyze my defenses, and he was encouraging me. I walked out of that session feeling a tremendous sense of relief.

At a much later date, I acquired a more cognitive sense of this interaction. His response was quite clearly an interpretive intervention designed to differentiate the past relationship, regenerated in the transference, from the real present. His manner, attitude, and presence supported rather than undermined the little boy who was both trying to prove himself and wanting to withdraw from it all.

Interpretation, as I utilize it in my clinical practice, directly reflects my theoretical roots, which are in object relations theory. Within this context, I, as a therapist, work first to build integration and cohesiveness in a patient's sense of "self" suffering from deficits in early nurturing, and then to promote separation and individuation. Interpretations, then, spring from a strong sense of where the client is developmentally, transferentially, emotionally, etc., and they involve an organizing response on my part on both verbal and non-verbal levels. My goal is to take the germ of an awareness floating between us and to mold it into a communication that makes the intangible explicit. In working this way, I move between primary and secondary processes, using image, metaphor, and linear description. I remain open, but controlled; spontaneous, but not wild. Clearly, interpretation, in this sense, involves more than making the unconscious conscious, or connecting past and present. It gives shape and form to the myriad relationships being played out in the psychological space between

therapist and patient as their internalized objects make contact and react to one another.

To give you a better sense of what this actually looks like, I'd like to invite you into my office to meet a 25-year-old woman who has been in analysis for five years. As in most of our sessions, she barely looks at me as she moves to the couch with her face tight and drawn. Her averted gaze seems to cry out, "Don't look at me, I'm in too much pain and feel too vulnerable."

There's an explosive quality to the way she laments about first one person in her life, then another. She complains of her husband: "Why can't he listen to me; he seems so preoccupied with himself," then turns her attention to her sister, who makes her feel angry and unwanted. "Cant't she ever pick up the phone and speak to me? Of course, she doesn't want anything to do with me!" Again the focus shifts, this time to herself as she proclaims, "I can't stand to hear my voice. How can *anyone* listen to me?" The fury, pain, and bitterness that tellingly betray how unlovable she feels are reflected in the rigidity and tautness of her whole body. She looks as though she could explode.

Her associations take another turn and she remembers when she was 10 years old. She recalls walking on stage as an extra in a local opera company, and says, nostalgically, "What fun it was to dress up in costume, to be on stage, to play in the world of make believe!" She doesn't know why she thinks of this, and goes back to complaining about her husband: "Why doesn't he listen to me? Yet why should anyone listen to me?"

Now I receive her attention and she says: "You must be very bored hearing this over and over again. I know I'm tiresome, and you are probably just waiting for the session to be over."

As I consider how best to respond to this tirade, I recall that my past attempts to be empathic have not always been successful. Although this patient has come to feel better about herself, she still is overcome by waves of self-derision. As much as the hurt child in her wants desperately to be held and touched, her intense bond with the unloving mother of her past undermines her ability to let the craving for closeness be satisfied in the present. As though she is reading my mind she cries out: "I don't trust your attempts to be caring. They're phony. *I* don't matter, you're just doing a job."

I can almost see her mother standing between us, denying my patient's existence. Bored and preoccupied by herself, this mother plants the seeds in her child of negligible self-worth as the baby's

impotent screams go unanswered. It is the specter of this mother that has cut off my attempts at empathy.

Reinforcing this, however, is a father who basically feels contempt for women. As his presence permeates the room, I can hear him grumbling to my patient to get married and have children. "Forget a career," he says, "that's for men."

My patient's fury and envy of men screams out at me as she spits: "You have it all, Robbins: a practice, reputation, money. You can afford to be tolerant of me, but I know I'm really just like all the other patients, and I doubt if you ever think of me once the session's over."

Rather than answering immediately, I decide to let the atmosphere in the room invade my being. Something entirely new enters my consciousness. A graphic image emerges: Powerful red and black rays, vibrating with energy, fill my awareness as they radiate from the core of my patient. Reminiscent of a psychedelic experience, intense and vivid colors bleed into one another and shoot in all directions. Deep inside the body of this image I see a small pink ray.

With this picture, a new understanding of my patient strikes me. In the past, I've had little trouble being sensitive to her impotence and feelings of neglect, but the sheer intensity and force of this woman's internal world had been lost in the process.

I decide to share this image with my patient after considering the possibility that I may be acting out a countertransference seduction. My concern is that my difficulty in tolerating the strong sense of aloneness and futility this patient induces in me is provoking a desperate attempt to connect via the sharing of my image. The profundity of my patient's reaction, however, confirms the appropriateness of my decision. For the first time, all sound ceases and the remainder of the session is filled with a gentle, meditative silence. There has been some transformation in how my patient sees and experiences herself that is visible in the quiet way she walks out of the office.

When I see her again, it takes some time for her to get back to the previous session, but she finally tells me that she has felt peculiar. "I couldn't believe what was happening to me," she says. "I've often thought of myself as having so much in me, and yet I've heard people like myself described as being empty. I know I'm not empty, and your description touched and moved me. I don't quite understand it. I know that I created this response in you, but I still find it hard to believe . . . it's so very full. . . ."

In this brief encounter, we can observe the subtle merger of psychodynamics and aesthetic principles of form and energy shaping psychological space into a new dimension. My patient and I had done endless work on penis envy, castration anxiety, resistances, hostility, dependency, but interpretations of this nature, though accurate enough, merely served to accentuate and reinforce my patient's sense of powerlessness.

In this episode, a shift occurs in figure and ground. The patient's sense of strength, power, worth is affirmed. The impotent, castrated girl discovers power, while the father/therapist responds and is affected by the strength and intensity of her pain, rage, despair. The patient feels in charge of her life, and for a moment, can move the unmovable. She needs this experience of having the energy and force that come from a sense of self-worth and power before she can have the strength to look at underlying issues and make further connections. Here image and words, mediated by a merger of primary and secondary processes, form a continuous frame of subjective and objective reality which reflects the transference/countertransference relationship and the psychological space between patient and therapist.

Implicit in these ideas is the notion that relationships are characterized by different energy systems which shape and form the space around us. Within each system, there are different degrees of openness or closure, completeness or incompleteness. In terms of primitive mental states, the psychoanalyst offers a piece of himself or herself to help move the energy system from one level of differentiation to another.

I'd like to spend a moment, here, clarifying what I mean by the term "psychological space." This "space," as I see it, is the product of complex interactions on objective and subjective levels that occur the moment a patient and therapist begin to work together. Past and present merge to create a mood and atmosphere unique to a particular dyad. The inner representations of past relationships are the stuff of this interaction, as they speak of the me and you within each person that create individual perceptions of the world, and consequently, also shape the surrounding social world's response to the individual. Multiple levels of consciousness are at work.

Art psychoanalysis, then, offers the possibility for psychological space, or that which is created through the interactions of two individuals, to be reorganized by mirroring or complementarity (offering opposites). This space has much in common with what

Winnicott (1971) calls transitional space. It is an intermediate area that is neither inside nor outside, but makes a bridge between subjective and objective reality. By extension, dead or "pathological space" can also be created in the relationship when expression is weighed down by oppressive defenses. Here, relationships are experienced and programmed to recreate sterile childhood interactions.

In order to recreate the transitional space so necessary to bridge inner and outer realities, both patient and therapist must be prepared to play. In fact, Winnicott describes treatment as play, or in some cases, as helping the patient to move toward being able to play. If psychoanalysts are to serve this role, they, likewise, must be ready to play. Play as described by Winnicott, is not aimless activity or simply having fun, although fun may be one of the ingredients. The essence of play in therapy involves the capacity to lose intellectual controls and to become non-goal-oriented and open-ended in experiencing and working with the psychological space of patients. Here images and symbols move into consciousness with their own logic and organization regarding time and place. In symbolic play, form and content become one through a synthesis of primary and secondary processes, also allowing the merging of bound and unbound energy and a balancing between fusion and separateness, organization, and loss of control.

Therapeutic play, then, becomes a means by which we create a holding environment of resonance and relatedness with our patients. Like a child and mother, each type of resonance has its own aesthetic form: some being very gentle, some containing much space, some demanding close holding. Within each holding pattern, we, as analysts, find the appropriate rhythm of our child/patient to create the space and a subtle balance between our energy and that of our patient.

The challenge for the psychoanalyst is to provide an experience that keeps therapeutic space alive. What is called upon is the psychoanalyst's artistry in using his or her conscious symbolic awareness of the patient's communications along with play to keep the therapeutic process moving.

Likewise, each patient-analyst dyad creates its own use of artistry. For instance, with some patients I find myself receding into the background as they seemingly fill the room with bright colors and energy. Here, I become the container for their communications. With other patients, whose presences are so faint and ten-

uous that I can barely see them, I try to reverse the flow of energy in the attempt to organize and solidify the vague nuances floating about us. In all cases, the dimensions between analyst and patient have their own particular volume, rhythm, and energy, as well as a continuum of distance and closeness. Words are used to structure the energy and images generated.

Potentially, either participant can become the organizer, or artist, shaping and mirroring the essence of the other. In the best of circumstances, the analyst is both one with his patient and separate, organizing primary and secondary process communications into a broadened statement of meaning and self-cohesion. Although this is likewise true for the patient, it is presumed that the analyst's mastery and control of this process will be somewhat ahead of the patient's. In the clinical example I gave, my inability to allow primary process material to enter conscious awareness was masked by detached empathic relatedness. Perhaps there was also an arrogant little boy needing to prove himself. Ironically, the patient's sheer force and intensity most likely enhanced this.

The concepts of artist and artistry used in describing this interaction bring to mind the analogy of a diptych painting. Two art objects are separate yet interconnected, each enhancing the other, giving strength and power to one another, while still maintaining separateness. In the analytic interchange of my example, my response recognizes the patient's power as well as her soft, vulnerable part, giving new organization to our mutual awareness of one another. Here, each of us gives something different in psychic essence to the other. By contrast, my past interventions and reflections of her pain and despair augmented feelings of impotence. In these instances, neither of our pictures added to the other. At last, impotence and pain are transformed into power; softness and vulnerability are surrounded by force and direction. I, in turn, am awed by her intensity and strength.

Within this context, then, interpretation becomes a dynamic intervention in which the therapist utilizes himself or herself completely. Parallels with my experience as a sculptor come to mind. Here I sometimes find myself on what feels like an endless plateau. At times I turn my stone upside down so I can acquire a new perspective. In other instances, I walk away from my work and give myself a break. In general, I keep my perceptions open and try to avoid premature closure or facile solutions to the problems. There is much hard work and an enormous amount of trial and error involved. So it is, too, with patients. As in a fine work of art,

an interpretation that truly opens up new areas of the self is infrequent and is preceded by much preparation.

A great deal of this preparation has to do with the sensitive balancing of space, energy, and opposites of all sorts. Also involved in this process is a familiarity with the psychic territory so that we can move with comfort. Each patient and therapist grapples, one with the other, to find appropriate cues and responses to facilitate the verbal and non-verbal dialogue. As a therapist, I must create the holding environment which best releases the pent-up patient. The maintenance of this environment may require simple mirroring, confrontation, or reflection, but it always assumes an awareness of the energy moving the dialogue. Energy, in this sense, has both force and direction, and can either be invested or withdrawn. What we strive to do is to get our patients to release the energy invested in old objects and to help them to reinvest in new, fulfilling relationships and pursuits.

In conclusion, interpretations combine affective, perceptual, and cognitive responses on the part of the analyst to reorganize a patient's use of psychological space. Each therapist, I believe, must develop his or her own unique style to capture the aesthetic form of the therapeutic dialogue. Furthermore, within the limits of each analyst's style, interpretive efforts give form and organization to the transference/countertransference relationship. It is our ability to tap both primary and secondary processes that makes our interpretations effective. As with any artist, our freedom to use this dual level of consciousness will be largely determined by the depth, breadth, and firmness of our grounding in theory as well as the freedom we have to utilize our inner representational worlds in maintaining a holding environment for our patients.

If we are then able to take the emotional risk of being vulnerable with our patients, perhaps for a brief moment there can be a touch of poetry, an experience of artistry, as each participant approaches a sense of transcendence.

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DISCUSSION following Dr. Robbins' Address

Question: Dr. Robbins, how did you share that image with the patient?

Dr. Robbins: I described my experience word for word as I just stated it to you. I think every patient needs a different kind of interpretive intervention. For some patients sharing an image becomes a form of intrusion—it is experienced as an invasion. With others it is experienced as a form of empathy. When and how we share and our style of sharing depend on the nuances and sensibilities of that relationship. And certainly not in all relationships would I be so frontal and open in sharing images. In this patient it aided and facilitated a sense of equality which was so important for her to strive towards. The problem in the transference/countertransference relationship is that we have a patient who is hungry and needy for contact and yet as we give contact it is often experienced as a form of patronizing. So that how I could offer contact with her that was respectful seemed to be organized in this sharing of the image.

Question: I feel your feelings about risk taking and I like the idea of taking a risk. I wonder whether you would call it a parameter rather than an interpretation, in terms of giving what you saw in terms of visual image rather than an unconscious interpretation.

Dr. Robbins: My use of the term interpretation is fairly broad. I don't see interpretation limited to making the unconscious conscious, in the more classical form, although at times I work very classically with patients who fit that mode. The notion of parameter is one of taking a deviation from the classical position of maintaining a neutral stance and offering what you are seeing in the relationship in a direct fashion. Each patient requires a different interpretive style, and there are many ways to get insight to our patients. Sometimes by sharing what is going on inside of us, insight from past to present occurs so that the notion of parameter is not part of my language. I know it is part of the language of a more classical point of view. My idea of working with resistance or with process is that any interpretive intervention that facilitates the process is indeed an interpretive mode and that interpretive modes are acts rather than simply "giving cognitive insight."

Question: You talked about the interchange between taking on the pathology of the patient and the patient taking on some of your strengths. I got the feeling that up until the time of that interpretation you had some feelings of helplessness in relation to the patient. Would that be what you meant by taking on the pathology of the patient?

Dr. Robbins: I'm referring to a broad group of patients exhibiting what are commonly called primitive mental states—schizoid, borderline or narcissistic disorders. The whole treatment is played out of a mingling of subjective and objective reality. What happens, in the best of circumstances, is that we struggle as analysts with our ability to take in that patient and yet be in charge of taking that patient in. We have pieces of ourselves that are resonant with all areas of our patients. The ability to allow patient's self and objects to make resonant contact with that piece inside of us has much to do with our own working-through and openness to being comfortable with that type of touching and openness. My problem was not so much helplessness, although that may well have been the underlying dynamic; it was a detached, empathic relatedness, and that detached empathic relatedness was something I had to struggle with. All too often I find myself with my patients saying the same thing, saying I think I'm doing the right thing, and having finally to recognize I am not letting something touch me. It is in part taking on their pathology but you are still to some degree in charge of yourself as you let it touch; there are many different levels of consciousness going on: of father and child, of my father and her child making contact with each other, of her father making contact with my father. All those particular kinds of self and object plays that go on imply a degree of openness and a receptivity not so much to pathology, whatever that may mean, but to the various representations that she wants me to experience so that I can reorganize and feed them back in a more digestible fashion.

Mrs. Zabriskie: Do you see any affinity between the response that you give and Shamanistic techniques? That's a different kind of healing profession but do you see a connection?

Dr. Robbins: In an analytic audience I suspect that some of the Jungians may be sympathetic to my response. I see a continuum in energy. Energy that comes from the inside, which could be called libidinal energy, and energy that is on the outside. One's ability to be in touch with both the inside energy and the outside energy has a good deal to do with one's openness to all types of symbolic

material. I believe that there is not only personal symbolism that we need to be in touch with but indeed, archetypal symbolism. Even though I see myself as coming from an object relations framework and basically a Freudian one, I see no inconsistency with being open not only with the energy from the intrapsychic issues but also with the energy that surrounds us and our ability to be in touch with it and to mobilize it as a healing response to our patients. That implies creating a healing climate with our patients which is part of a holding environment. Thus, I see a merger of paranormal phenomena and intrapsychic process rather than a convergence or opposition between the two.

A Jungian Perspective on Interpretation

JOHN BEEBE

MRS. ZABRISKIE: I am delighted to introduce John Beebe. Personally, because he's an old friend; professionally because he's been a wonderful member of NAAP and I think he will present the Jungian point of view to us in a very approachable form. He's a member of the C.G. Jung Institute in San Francisco, and an editor of their Institute Library Journal, which covers topics that usually deal with the interface between psychology and culture. He is a lecturer, not only on clinical topics but also on the relationship between psychology and forms of art. He's written a book called, *Psychiatric Treatment; Crisis, Clinic and Consultation*. On another end of the spectrum he's edited a book on money, food, drink, fashion and analytic training.

When I entered analytic training, I imagined that I would learn to dispense analysis as I had already learned to dispense other medicines—I had no doubt that analysis was something that an analyst dispensed. My picture of the way that the unconscious was made conscious involved the patient's progressive assimilation of bits of truth that the analyst made available by means of well-timed, accurate interpretations. I was of course aware that material the analyst hadn't anticipated could be made accessible through interpretations of the defenses against facing such material, but this fact only reinforced my view that the analyst's interpretations were essential. As I saw it, the analyst was in control of the entire process: if the analyst did not do his work properly, the analysis could not proceed.

I felt supported in this view by the exceptionally conscientious example of my own analyst, who finally, after much reflection on

the process between us, suggested that it might be time for me to see an analyst of the opposite sex. My psyche was in accord, and this shift seemed to go well until some months into the new work, when I began to be aware of something unresolved in the previous analytic relationship. I returned for a visit to check this out, a return visit that I expected would be in the spirit of the earlier work, in which all feelings that had arisen between us had been thoroughly and conscientiously discussed. I said that I had come to sense a certain reservation in my former analyst's attitude toward me, which I had not been aware of during the time of our formal work together. The analyst replied that I had come to seem, in retrospect, as someone who needed to do everything perfectly, "almost a Christ." At first I was pleased by the openness with which my perception of a change in attitude toward me had been confirmed, even if the new characterization annoyed me, but as time passed I began to feel undermined whenever I tried to do my interpretive work with my customary care. The characterization now seemed to violate the very core of my analytic identity, both as a patient and as a therapist, and the more I thought about it the more outrage I felt. I thought I had learned such interpretive conscientiousness from this very analyst, and I had made it the cornerstone of my development as an analyst. Now the validity of this attempt at better empathy had been called into question, and the cornerstone was cracked. My sense of outrage grew.

At the time, it did not seem pleasing to me to consider another visit to reconsider these issues. Would such a visit not play into the hands of the very interpretation I was trying to resist? Had not the analyst indicated that my previous attempt to work everything out was a subtle form of inflation (the name Jungian analysts give to a puffed-up identification with godlike prerogatives)? Would not the best way to get my own back and prove the analyst wrong be to hold onto my anger, unforgivingly—a most unChristlike thing to do? After a period of time had passed, I told the former analyst by telephone that I was angry, but would work this anger out as part of my new analysis.

Analytic training is of course a time of exquisite vulnerability. I worried that harboring so strong a resistance toward my former analyst might have dire consequences for my future within my institute, but my honest feeling demanded that I hold onto my anger and not take the one-down position of accepting the analyst's immediate offer of another session. Not accepting that offer was a surprising decision for me. I am usually conciliatory, know-

ing the damage unresolved bitterness can do, but this time I was prepared to accept even the permanent scar of some cynicism within my analytic personality rather than cheat myself of what seemed an essential experience. My own obstinacy amazed me, and I wondered if it was masochistic. My life as an analysand and developing analyst seemed now to be divided into the time before and the time after my decision not to work out this misunderstanding. If at the time I wondered why I found this bitter duty necessary, I see it now as a consequence of having been placed, unintentionally I think, in a therapeutic double bind by the former analyst's new interpretation of my approach to analysis. In the light of this new interpretation there was no way I could have returned to work things out without entering the role of the perfect patient, the very role the interpretation had challenged. The only way left me not to appear neurotic was not to be a good patient, and I took it. This forced choice was therapeutic in that in time it would free me from excessive dependence on the interpretive opinions of the former analyst, but for now it meant a protracted struggle with a narcissistic rage, rage which continued in response to an uncorrected failure of empathy.

For the new analyst, whose duty it had become to hear my endless complaint, I was in the habit of typing up my dreams, of which there were many. Since the urgency of the affect I was expressing precluded as much work as either of us would have liked with its imagery, I often left dreams behind undiscussed for the analyst to read after I left. I arrived to one session to learn, to my surprise, that in one of these a baby had been born. Shocked to be told that I had skipped past so obviously important an inner event, I returned to the typed copy to reread the dream

In this dream, a dark, difficult woman my own age, a friend from college whose personality had been marked by spite, presents me with a baby, a boy born prematurely. Somehow it is understood that the baby is mine, although I find it hard to believe that I could ever have tolerated physical intimacy with this woman. As I take the infant into my arms, my eye catches the distinctive outline of one of his feet, and I am suddenly filled with fatherly feelings. I know that he is mine.

This dream really provided me with the solution to my rage at the former analyst, for it soon brought with it a new attitude toward the role of any analyst within the analytic process and a new perspective on interpretation. Looking at the dream, it was not hard to recognize in the dark difficult woman the spiteful re-

sentment that had been triggered by my former analyst's interpretation of me. The woman chosen was as unattractive to me as the sullen uncooperativeness I had felt myself to be indulging. She came as no surprise: what was surprising was that anything worth having had come of her. I had seen the sort of resistance she imaged as a block to the emergence of insight, as a spiteful defeat of one analyst's efforts in my behalf; yet according to this dream this very resentment had become the mother of something I could value, a new standpoint imaged in the dream by the distinctive profile of the baby's foot. This new standpoint marked the autonomy I had achieved from my previous analyst, with whom I had become overidentified. If my new-won independence of vision might seem premature, like the baby, in one who had not yet finished his analytic training, it was definitely mine, and, I thought, viable. In reality, I was beginning to formulate my own interpretive style.

As I pondered the unexpected outcome of living resistance I did not want to give up, I came upon these passages in Jung's seminar on the interpretation of visions:

> *Question:* Will you please say a word about the intensification of consciousness that you call individuation?
>
> *Dr. Jung:* First of all, individuation is not an intensification of consciousness, it is very much more. You must have the consciousness of something before it can be interpreted, and that means experience, life lived. You can only be really conscious of things which you have experienced, so individuation must be understood as life. Only life integrates, only life and what we do in life brings out the individual. You cannot individuate, for instance, by locking yourself up in a cell, you can individuate only in your concrete life, you appear in your deed, nowhere else. Real consciousness has to be based upon life experienced, just talking about things is not enough. It provides a sort of conscious understanding, but that is not individuation. Individuation is accomplishment through life. When, for instance, a cell divides and differentiates and develops itself into a certain kind of plant or animal, that is a process of individuation. Individuation means that one becomes what one is, that one accomplishes one's destiny, fulfills all the determinants given in the germ . . . becomes the primitive pattern that one was born with.
>
> *Question:* Does not individuation, in the sense that we are

using the word, mean living life consciously? Yet a plant individuates although it lives unconsciously.

Dr. Jung: Living consciously is *our* form of individuation. A plant that is meant to produce a flower is not individuated if it does not produce it, and the man who does not develop consciousness is not individuated, because consciousness is his flower, it is his life . . . All that a man does, whatever he attempts, means his individuation; it is the accomplishment, the fulfillment of his possibilities; and one of his foremost possibilities is the attainment of consciousness, that really makes him man; so to man [and in 1984 I must add, and to woman] life should be conscious.*

It was these passages that gave words to my changed perspective on the role of interpretation within the analytic endeavor. I saw that Jung meant that the development of consciousness is a natural process, and that the artificial attempt to cultivate it by living one's psychological development entirely under the umbrella of the analyst's watchful interpretive efforts is to shut oneself off from the sun, to lock oneself up in a cell, and to avoid consciousness. By insisting on living an angry resistance, I had indeed left such a cell. In resisting an analyst, I had found the point of analysis. It was a triumph of the living attitude toward analysis over the obedient attitude, and I really suspect that the unconscious arranged the entire unsettling experience to release both my analyst and myself from the symbiosis I had set up under the umbrella of conscientious analytic work. The rejecting interpretation, and my rejection of that, were needed to release me from my view of analysis as the dispensation of the analyst and of consciousness as a byproduct of interpretation. And yet I cannot deny that it was something my analyst said that set the whole unsettling process in motion.

I had therefore to rethink what I was doing with my own patients. I had formerly seen myself as the center of my patients' efforts at consciousness, and it was still hard to believe otherwise, given the central role their transferences granted me. But I realized after my own experience that I needed to be less literal in accepting their transference ideal of an analyst who could maintain the frame, orient them to what needed to be confronted, clarify what was really going on between us, point out the obstacles in the way

*C. G. Jung, *The Visions Seminars*, Book Two, Spring Publications 1976, pp. 296–7.

of their understanding, and indicate to them that he grasped the essence of their struggles. These were the essential functions of interpretations, which I had heretofore offered as if they were the meat and potatoes of the analytic enterprise.

It occurred to me now that interpretations, important as they were, were not the literal fuel of the analytic process but a way of recognizing that the particular process of individuation, using the analysis, was one that required an organic energy, for which the food of interpretation was a sort of stand-in. The interpretive meals I continued to prepare (as before with care, but with a certain playfulness now, as well) seemed to me less like literal food and more like the food symbolically placed by the Egyptians beside their dead at the moment of their individuation journey into the beyond. Placing interpretations alongside patients undergoing the mortification of analysis was a way of saying that the journey was to a new life, and of recognizing that this journey was arduous, requiring of comfort, attention, and energy.

The main function of interpretation, I decided, was to bring life to the process of dying that is part of any real analysis. Consciousness, as Jung taught, can only happen in a living context, even if it demands the death of former attitudes. It was entirely appropriate to try to make the analytic space itself alive, even if death was occurring there. The work of interpretation was the most welcome form of life I could bring, especially when it was shared, a true breaking of symbolic bread with the analysand that did not break the all-important container of the work, the analytic relationship.

Many analysts, upon coming to a similar realization that consciousness comes out of the life of the analytic process rather than out of the direct effect of interpretations, have chosen to abandon interpretation altogether in favor of other ways of being with their patients. After all, if people are able to come to consciousness on their own as natural individuation, why bother with explanations? And if life is the catalyst for the natural process that will produce consciousness, why not live with the patient in other ways?

I have not joined those analysts. I haven't traded interpretation for some other sort of therapeutic play, because I feel that interpretation is the therapeutic activity *par excellence,* that puts its questions directly to the unconscious itself. I don't feel we can expect the unconscious to answer questions that have been begged. If I no longer feel that interpretation gives answers, I do most certainly believe that it poses questions, creating the work-

ing hypotheses that challenge the unconscious to respond with its own interpretive efforts.

Jung spoke about this subtle dialectic late in his life, to a group of students. One had asked, "What is man to do with his passionate, primitive chthonic [demonic] nature?" This is one of those questions that come knocking at an analyst's door for an answer. This was Jung's answer:

> Go to bed. Think of your problem. See what you dream. Perhaps the Great Man, the two million-year-old man will speak . . .

(Jung had been talking earlier about the Naskapi Indians of Labrador, who believe that certain dreams put them in touch with the Great Man, an inner companion whose counsel is prized by these solitary hunters.) He went on:

> Analysis is a long discussion with the Great Man—an unintelligent attempt to understand him. Nevertheless it is an attempt, as both patient and analyst understand it . . . (The Naskapi would have an advantage because he would realize that it is a discussion with the Great Man.) Work until the patient can see this. It (the Great Man) can at one stroke put an entirely different face on the thing—or *anything* can happen. In that way you learn about the peculiar intelligence of the background; you learn the nature of the Great Man. You learn about yourself against the Great Man—against his postulates. This is the way through things, things that look desperate and unanswerable. The point is *how are you going individually to answer this?* . . .
>
> Never say no or yes on principle. Say it only when you *feel* it is really *yes*. If it is really *no*, it is no. If you say yes for any outer reason you are sunk.

Jung was then asked, "What is the result of an attitude of free decision?" I would phrase the question differently: why is the honest interpretive activity fostered by the analytic ritual necessary, if the unconscious, the Great Man, has all the answers? This was Jung's reply:

> The result is that you are always in the game; you are included, you are taken for real. If you are dishonest, you are excluded from the individuation process. If you are dishonest, you are *nothing* for

> your unconscious. The Great Man will spit on you, and you will be left far behind in your muddle—stuck, stupid, and idiotic.*

I take Jung to mean that the unconscious interpretive process will work, the answers of the Great Man will come, only if they are subjected to constant interpretive scrutiny at the conscious level. The analyst's interpretive activity is a model for the honesty required, and in time will be met by a similar honesty on the part of the analysand, if the analysand does not possess it at the start of the work. Only then can the unconscious create its own interpretations that, in time, will provide a kind of answer to the questions posed by the analytic enterprise. The psyche's own answers take the form of symbols, which are found not only in dreams but in meaningful outer events, which can sometimes be grist for the analytic mill. Once Jung had grasped the uncanny objectivity of the unconscious, he spoke of it no more as the "collective" unconscious, but rather as the "objective psyche."

For Jung, it was less that man interprets his nature than that he is interpreted by it. Jung located the ultimate source of interpretive activity in an autonomous Self beyond any possible control by the conscious ego, and this view has made it seem to many analysts as if Jung had traded the way of scientific understanding for a new version of the cure by faith. Among some of Jung's followers, an overdependence on the unconscious has been fostered, as unhealthy as overdependence on any human analyst.

But I don't think that either the scientistic or the pietistic reaction does justice to Jung's position on interpretation. If I hear rightly what he said to his students in this talk at the end of his life, he was really urging them to stick with the conscious interpretive activity that is psychoanalysis's ongoing legacy. This meant to him, and it means to us, going through unconscious material feeling by feeling, image by image, demanding honest reactions from ourselves and from our patients, those honest reactions that are the basis of honest interpretations. This kind of interpretive effort must always be understood as an effort at inquiry, not a way of giving answers but a dialogue with an unconscious capable of generating its own unexpected answers.

The ethical inquiry of analytical interpretation is an activity that the psychoanalysis of individuals has fostered. Interpretation conducted in this spirit has become a conscious art of psychologi-

*C. G. Jung, "Fragments from a talk with students, May, 1958," *Spring 1970*, pp. 177-181.

cal living which continues to develop as analytic techniques and perspectives broaden. Analysts need not apologize for the fact that their daily interpretive efforts are destined to be outgrown in their content and in their style by developments within this field, nor for the fact that so many working hypotheses turn out to be incomplete or wrong. The important thing is to stay with the game. We practice the long discussion with the Great Man by taking the way of interpretation, a way that reacts to solutions posed by the unconscious with an attitude of free decision. We take this long, laborious route of conscious interpretation so that the unconscious will not spit on us, so that it will continue to grace us with its spontaneous interpretive capacity.

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DISCUSSION Following Dr. Beebe's Address

Mrs. Zabriskie: Now I would like to welcome Phyllis Meadow. She is the founder and Chair of the Board of Trustees of the Center for Modern Psychoanalytic Studies and the Boston Center for Modern Psychoanalytic Studies. Formerly she was on the Board of Directors and Membership Director of NPAP, and an adjunct associate professor of Long Island University. Her publications include the *Treatment of the Narcissistic Neuroses,* "Drive Theory and Diagnosis in Treatment" and "The Treatment of Marital Problems" as well as many other papers. While no longer the president of NAAP, Dr. Meadow has continued to be a major inspirational and energetic force.

Dr. Meadow: I was surprised at how close we are in our views on treatment and interpretation. But I made note of some possible variances in our approach. Dr. Robbins, I thought, was describing an ideal human relationship between two adults, and certainly if we could maintain that level of contact with the patient it would be very satisfying. The good interpretation, "I don't see why you can't be an analyst," that his analyst gave to him was a symbolic communication. It was made person to person, and when we can do this it is very satisfying.

One of the possible differences in our approach would be that the problem in pathology is the reversal of the process of ego formation. It requires a great deal of thought when working with severely regressed patients. I've found two recalcitrant resistances, which do not respond to suggestion, support, interpretation or even reflection. These are the inadequate self, undifferentiated from object in the very earliest stages of development, and the over-evaluated object in a confused object/self state. When Dr. Spotnitz was writing his papers in the late 1940s and early 1950s on insulating the ego and on maturational interpretation, there weren't many people talking about the analytic relationship in which the feelings of the analyst are as important as the feelings of the patient. In a paper at that time he pointed out that meeting the needs of the severely regressed patient would not lead to cure, and that what is required is resolution of the blocks which prevent the person from having his own needs met. There are patients who

have lost all ability to differentiate past and present, and when they're in our office they're making demands that we love them or that we do something for them. When they're suffering from extreme feelings of deprivation, they are reliving early conflicts.

Dr. Robbins described this recreation of original situations that led to pathology. Patients may have lost the ability to discriminate primary and secondary level thinking. Each patient, not only the severely disturbed, will work through early stages of development where symbolic communication and emotional communication are the only ways to reach them. When the patient is in that stage we move to a new level in which we silently study what the patient is asking. Patients often say "I've told you what the problem is, why won't you tell me what to do? If you cared for me, you'd tell me." The human instinct is to tell the person what to do. Why shouldn't we share what we have learned with the patient? We decide that it's not in the interest of the patient for us to share our insights with him, but that it would be far better if we could find out how to help that patient to arrive at a point where he can figure out what to do. We do not make contact with a patient until he or she reaches out to us and makes a contact. When they say why won't you tell me what to do, we do make a number of different kinds of reflective and joining contacts with the patients. We begin to know the patient through empathy with what the patient is experiencing. But the question becomes what are we going to do with those feelings. We observe and study the way the patient makes contact with us and respond in a reflective way or in a joining way or we may give interpretations.

Interpretations are experienced by most patients as a feeding if they're not harsh or too far from the perception of the patient, and if they deal with things that the patient would be willing to hear. When we talk to a patient and give words to him, the patient may feel gratified. We do not interpret to gratify or to teach the patient something but to resolve the patient's inability to speak progressively or freely. When an interpretation designed to resolve a resistance is given, whether the interpretation is correct or not, it is successful if the patient can then communicate progressively. The concept of synchronicity between patient and analyst is one of great concern to modern analysts. I think some of our modern analysts have even gotten into studying the brain at this point to find out how we synchronize but we are interested in what the process is that blocks synchronicity between patient and analyst. We have words for blocks to communication such as transference

and countertransference resistance, but we're really talking about what keeps us out of tune.

We agree with Dr. Beebe's view of the interpretation. We all use interpretations, some use them for feeding purposes, some to convey information or to resolve resistance.

The interpretations that Dr. Beebe received from his analyst were of an authoritarian nature, and we don't consider those desirable. I find in my own practice that when I formulate a very clever interpretation of the unconscious meaning of a patient's communications I usually find out that I am feeling a very strong, probably negative feeling toward the patient. There are other ways to make interpretations. Modern analysis has arrived at the theory that in a relationship, if one person knows the answers and the other person doesn't, the fostering of dependency and a wish to please is going to fixate the patient in the status quo phase of analysis and will not help him to develop and grow. We work to bring the patient through the resolution of blocks to his own interpretation. I'm really not convinced that any interpretation of the unconscious is correct, although I am convinced that I know the correct interpretation of this person's history and sometimes patients get to a point where they believe they know the correct interpretation of their history. The goal in helping a person to arrive at his own interpretations is the integration of his ego. Most of the work in modern analysis is integrative—an attempt to work with either an undifferentiated self-object field of the mind or, on a structural level, a division between id and ego, or id, superego and ego. We're constantly working to have the person come to peace with himself; therefore we're looking at what part of himself he is isolating from the main stream.

We now think of both libidinal and aggressive impulses and the fusion thereof when we look at what might be bothering the patient about himself. We look at his self-evaluation and at his evaluation of the object. When there can be internal integrity we feel that we have achieved the goal of analysis.

Dr. Beebe gave us a dream which fit with the rest of his analysis. Can I tell you what I'm thinking about your dream, Dr. Beebe?

Dr. Beebe: O.K.

Dr. Meadow: Modern analysts tend to look at the manifest content of the dream as a picture of the current intrapsychic structure.* So we don't tend, when examining a manifest dream, to

*See Meadow dream article: *The Royal Road to Preverbial Conflicts* in this issue.

look for the disguised object relations, but instead look for the disguised problems within the psychic structure. Looking at a dream of that type we would be looking at the recalcitrant self, the baby in the self and the observing ego in the self. What the patient tells us about those interactions we would interpret to tell us the emotional conflicts with which that person is struggling on the road to integration of thoughts and impulses denied consciousness.

I regretted that when this patient, Dr. Beebe, reached the point of resisting the analyst angrily, he was not with a modern analyst because that's where we like to work. He had tried to please this analyst and this man didn't appreciate these efforts. This is one of the longest periods of analysis after all, working through the period when the patient doesn't want anything to do with us and doesn't want a relationship. We work in that status quo phase where the patient wants to please us and then we work to a point where the motivation for new understanding has been aroused in the patient, and then the analysis really begins. This is what we would call the interpretive phase of the analysis. But at that point this analyst just continued to act angrily and shove interpretations down Dr. Beebe's throat. I feel that rather than getting in touch with the great man inside himself, I'd rather get that great man to come down a peg or two and become a decent analyst so that Dr. Beebe could work through to all the things he's discovering about his psyche with the analyst, no matter how rotten he is.

Mrs. Zabriskie: It's nice to hear countertransference expressed so honestly and openly. Thank you very much. That was certainly more than one could have hoped for in an extemporaneous talk.

Question: How much of the analyst's personality, regardless of theoretical persuasion, becomes a pivotal point in the healing process of treatment? What is the place of the analyst's personality as part of the curative process, not only as a means of working through resistance but as solidifying internal self and object representations?

Dr. Beebe: This is a question that Jung himself was perhaps the first to address in his book, *Psychological Types,* in which he pondered why Freud, Adler, and he went their separate ways. He kept coming to the conclusion that there must be a personal equation, something in an analyst's personality that makes him develop a particular psychology or ideology or philosophy. Out of that came his idea that there are extroverts and introverts in thinking, feeling, sensation and intuition. Subsequently, a lot of Jungian analysts have continued to ponder this question and I tried to get

at it in my paper indirectly by sort of showing but not telling you a difference in the styles of the two analysts. I think you did pick up that the first analyst had something of an authoritarian approach. The second analyst, I think, was far more receptive and holding and it just happened that that second analyst, for me and for where I was in my analysis, was the right person. It isn't so much that an authoritarian, dogmatic analyst isn't helpful but they are sometimes hard to swallow in a certain way. The most interesting new material that might interest you is going to be in a book by Joseph Henderson called, *The Psychological Study of Culture*, in which he says that we orient to the world according to four cultural attitudes: the social attitude, the religious attitude, the aesthetic attitude and the philosophical attitude. I think it makes all the difference whether or not the patient and the analyst share the same cultural attitude because it affects completely their attitude toward how the unconscious shall be approached.

The first analyst had a religious attitude that was very strong while the aesthetic attitude is strongest in myself, and so we were destined to clash sooner or later. Joe Henderson does say that a fifth cultural attitude has come to be in our time which is a psychological attitude, and if we can all find that higher ground of psychological understanding sometimes we can transcend these differences.

Dr. Meadow: From doing supervision I can tell you I have never met two modern analysts who work the same way, so we have to determine what the factors in personality are that make for the differences. We have a common groundwork. We believe in aggression, we believe in emotional and symbolic communication. We have a common understanding of dreams and the meaning of other symbolic communications. That's the background from which we begin. Some people's characters change during the process of supervision. As they become motivated to be successful with patients they change significantly. When pathology is minimized there is a core personality and style, and as training analysts our job is to find out how that person can use that style most effectively, and what kind of patients they work with best.

Question: Could you say something about the effectiveness of interpretation in groups, not only from the group leader but from the members of the group to each other?

Dr. Meadow: The wonderful thing about group is that the analyst only has to concern himself with the group as it joins forces to have a common resistance. However, Les Rosenthal, who has

written a great deal on group therapy, has pointed out that the individuals engage in a curative process and they provide each other with correct and incorrect interpretations. People are supportive and protect each other and process interpretations. A great deal that could not be said by the analyst to the patient can be said by the group members.

Question: Do you notice a difference in the way an interpretation is received, if it comes from someone who is already perceived as a peer?

Dr. Meadow: Group membership is very complicated; not everybody is perceived as a peer; so interpretations are taken according to their intent—the intent of the presenter of the interpretation—and according to the relationship that's unfolded between two people within the group.

Question: I'd like to tell you about an experience of mine from the 1950s, at the Jewish Board of Guardians. One of the psychiatrists who supervised many of the therapists made the discovery that just the fact of a patient going from one therapist to another promoted growth. He recommended that in some part of everyone's treatment they work with another therapist of the opposite sex from the one they were working with. He believed that this would give the opportunity for aggression to come to the fore and would help in the reduction of dependence and the development of individuation.

Dr. Meadow: When we're working with an oedipal case it's true that one can make a decision about an analyst, try another and maybe find a better analyst. Despite object transferences the person's intuition can tell him things about that. I don't think the sex of the analyst matters, when we're dealing with object relations in the preverbal phase, a stage on which frozen internal interactions are being reenacted. It's my impression that the sex of the analyst is not so important as the personality of the analyst, his ability to tolerate extreme feelings, to contain those and use them appropriately and interact with the patient as a mother and child might do in an ideal situation.

Dr. Robbins: I have a similar reaction. As analysts we are often seen and experienced as female when we are male, and vice versa. It is the personality that seems to be much more important. What patients need is different parts of ourselves at different stages in treatment, and to be able to give up old relationships within the treatment context when you hear a call for something new. Treatment becomes for the analyst as well as for the patient a series of

separations, of using one part at one time, another part at another time. As each part is utilized in this interaction, and this is where I think there probably is some difference here, I believe that it is not just a matter of empathy but some degree of internalization of the analyst that goes on. Treatment is not a series of externalizations and projections but a series of both externalizations and internalizations.

Question: When an interpretation is rejected by a client or it doesn't lead to progress, to what extent do you feel this may be client resistance and to what extent is it an incorrect interpretation?

Dr. Meadow: Failure of the analyst. Dr. Spotnitz reported in one of his earlier works a brilliant communication he made to a patient about the nature of a perversity that he was suffering with and the cause of it. The patient shook his hand, told him it was brilliant and never came back. Dr. Spotnitz felt that had he said, "Don't give up your perversity, dire results could occur if you do," that might have been a more successful intervention. The analyst has to find a successful intervention.

Dr. Robbins: It is the incorrect interpretations that often make most progress in treatment. I think that the more we not only screw up but recognize how we screw up with our patients, the more we recognize when we are inappropriate and are offbase. It is these subtle interactions that often become the very nature of therapeutic growth. If you have the courage to understand where you got off and then struggle with the patient to indeed understand the problem, both parties then have a chance to become somewhat more equal as two participants struggling along the same continuum.

Question: I'm interested in a position that Hans Strupp takes in trying to explain why people from all different schools get good results to some extent. He hypothesizes that perhaps the central factor in interpretation is one of ego modeling. Can one argue that any interpretation, as Robbins has mentioned, is an act, and the crucial importance of the act is that the analyst is demonstrating for the patient how to handle the dynamic conflicts underlying that particular resistance? I wonder if the panel would comment on Dr. Strupp's approach to understanding interpretation.

Dr. Meadow: I take it you're talking about identification with the analyst. I'm hesitant to leave the model in which the analyst must be extremely well-educated, must be able to sit with a patient and get to the roots of the emotional conflict, and must time his interventions, whatever kind they are, according to the needs

of the patient in relation to the blocks that he's presenting. The analyst is giving the patient a corrective experience out of knowledge and working through his own feelings of what would be corrective, but he is not necessarily giving the patient his own personality or his own style of personality. We can pull almost anything out of our personalities after a lengthy analysis, I think, so he's pulling out those parts which are needed by the patient. So I'm not too keen on the patient's identifying with me.

Question: When Dr. Beebe spoke about the interpretation eliciting curiosity as to what it means, I recalled a dream I reported to my first analyst about thirty-five years ago. I dreamed of a fresh tank of water in which there was a huge sluggish fish, swimming in the bottom. He interpreted my dream and said, "That's your father." That's as far as we got and I've been working on that dream ever since.

Dr. Beebe: It seems to me that everything stands the test of time, that really is the only test. I've experienced violent resistances to interpretations that ten or fifteen years later made a lot more sense to me, and I had patients come back whom I thought I would never see again. I've said things that I regretted terribly and felt guilty about, only to find out that they were absolutely right and why did I feel guilty about that. As I tried to express in my paper, we don't know exactly what personages we are enacting when we make an interpretation.

Of course, in Jung's psychology all of the various archetypal figures of the unconscious can be seen as modes of relationship to the unconscious. The shadow is a way of getting into the unconscious, the anima is a way of getting into the unconscious, the animus, even the persona which we often think of as the way of meeting society, is also a style of meeting the unconscious. At times the analyst incarnates the anima, the animus, the persona, the self, the shadow of the patient and acts that out right in front of the patient's eyes, all the while thinking that he or she is making a conscious, honest interpretive effort. I think only later is it possible to sort it all out and to figure out who the analyst has been at those moments. Very often the wrong or rightness of those moments is all part of the process of integrating those contents by the patient.

Dr. Meadow: With that dream, as with any dream, I would be interested in the communication to the analyst about the relationship with the analyst; and I would make the assumption, although I might not tell the patient what my assumption was, that this

was a complaint in the treatment; the patient didn't feel energetic enough for the task at hand and needed a lot of help from the analyst.

Comment: I don't think that Dr. Beebe was saying that he disapproved somehow of the first analyst's interactions with him. I think part of his point was that dealing with resistance and aggression happens outside analysis as well as in it.

Dr. Beebe: As I said before I think that this experience that I had, had to happen because of something in that analyst's superego. That Christ remark was a very destructive interpretation because I had not been baptized and I had grown up in a home in which there was no religion. I had gone to a prep school where there was a little bit of Christian religion, and it was the first place I had ever heard anyone discuss ethics; so I had really latched on to Christianity as a kind of nucleus of the self. I felt that my entire rather shaky and embryonic religious attitude was being trammeled by that interpretation. It was indeed a violation. But, on the other hand, it was probably the only thing that could have set me free. I can't really vilify the analyst who did that because I think it was so incredibly healing. I think it's what Jungians often quote in Kipling, called a "just so" story. So much of what happens to us in analysis is a "just so" story right down to whom you got referred to, let alone who comes into your office. If you don't believe in Jung's concept of synchronicity just watch the referral process, how coincidental the people who come into your office are with the leading edge of your psychological work at that time. I don't regret a minute of it, although I was very angry about that interpretation for a long time and even writing about it I was scared to reopen something that I'd had to struggle with so deeply.

Dr. Robbins: I want to clarify the issue of identification and the use of the analyst's personality in more detail. I think there is such a thing as introjection of the analyst's personality, where basically there is a compliance and a submission to the aggressor. The introjection of the analyst becomes like a foreign body within the ego, and it is not really worked through in any kind of identification process. Now when indeed a faulty interpretation is made, when the analyst takes on the superego or shadow or whatever kind of externalized material, he is able to struggle with that piece rather than acting it out, that struggle becomes part of a new form of identification with the patient. The patient is not identifying with us completely but they're identifying with a process, our process, that they're taking into them.

Comment: I just wanted to share a thought that came to me as I was listening, about interpretation, which compares the analytic process to the process that the Zen student passes through on the road to masterhood. For the analysand, like the Zen student when beginning the treatment, a river is a river, and a mountain is a mountain. In the course of treatment, the student learns that a river is no longer a river and a mountain is no longer a mountain, but when he or she is finished a mountain becomes a mountain and a river becomes a river.

Dr. Beebe: I can't resist an anecdote that I heard in our own institute. One of the candidates went to her analyst for a morning session, her personal analyst, and said, "Can you tell me what God is?" After some reflection the analyst said, "Well, to me, God is a fern—and went on at some length as to why this was so to her. In the afternoon that same candidate went to her control analyst and said, "I had the most wonderful session this morning. I was told that God is a fern." The control analyst looked at her and said, "God is not a fern," and they talked about that for a while. Then the candidate went home and she said, "You know, I spent $130 today and we talked about that God is a fern and God is not a fern."

Question: I'd like to address a question to John Beebe. I have the sense that although there are many things we hold in common, we're not adequately picking up on some of the differences, at least from the Jungian approach, in this issue of interpretation. It seemed to me that John's emphasis was on the response not only of his instinctive reactions but also of his unconscious, through a dream that was important to his experience with his analyst. It is my experience, in working in this particular school, that very often when we risk an educated guess, a hypothesis or an authoritarian statement, whichever may be our style, we wait for a response, not only from the patient in the session but also—as you made very plain in what was read—by going to bed and dreaming on it. There's another level of response, and that response is not necessarily a reflection of what's going on between the analyst and the patient directly in an interpersonal transference/countertransference way of looking at it. It may well be, but I think when Jung is speaking of the two-million-year-old man it is not to be confused with the somewhat authoritative personal analyst. I wish you would talk a bit more about that.

Dr. Beebe: I tried in my example to give the sequence. Two people are together for a while in apparent harmony, and then

someone says something which produces an emotional response and the first step is to pay close attention to that affect. Sometimes one takes it back and it can be metabolized and harmony comes back but sometimes it can't be metabolized, as this apparently could not be at that time. So the first step is at least doing everything one can with the conscious mind to identify where one is, which means really spending some time with one's affects. I think only then is one truly entitled to go to bed and turn the question to the unconscious, because what the dream can then show us is where the affect is and what may come of it. In a sense our feelings are always right, but there's also a certain blindness and arbitrariness, and we're very much in the dark with our affects until we have some kind of image that can give us a sense of where they are. When I had that dream, it took a lot of long, patient suffering in the dark with the emotion that felt like it should be stayed with but I didn't know why. Then the question is, is this needless suffering that I'm imposing on myself for willfulness, or is it the necessary suffering? Jung says that neurosis is the refusal to accept legitimate suffering, but of course we often don't know whether our suffering is legitimate or not; and we often don't know whether we're neurotic or not. Finally the dream comes and shows the affect, and it is just as ugly as I thought it was; but out of it comes the baby. That dream gives the meaning and gives a completely objective center. Now we haven't mentioned enough about the role of the second analyst in this process. The second analyst was holding the dreams. I was expressing the affect and leaving the dreams behind, and his interpretation was to say there was a baby born in one of those dreams you left behind. That was a somewhat chiding interpretation: You're wallowing in your affect, but you're not really looking at your unconscious; and I didn't fail to get his message. He asked me in a completely different style to take seriously what I had actually communicated with him and left with him, and also to take my unconscious seriously. He did it in a way that was very resonant to something in me that was ready to happen anyway. I really looked at the dream and it makes its own interpretation.

Question: Dr. Robbins, I would like to know whether the interpretation you made to your patient was when the patient was in the chair or on the couch, and what difference if any that would make to you?

Dr. Robbins: The patient was on the couch. I don't think it would make any difference whether the patient was sitting up or

lying down. There are some patients whom I do have sitting up when I find that I personally cannot bear the aloneness and need to work out some type of relatedness that I don't think, from my particular personality, can be best done when the person is on the couch. In this particular intervention I struggled with the question of whether I wanted to share this image because I could not bear the aloneness and could not make any other kind of contact.

Interpretation—Is That All There Is?

HAROLD H. MOSAK

MRS. ZABRISKIE: We'll be hearing next from Dr. Harold H. Mosak, who has come from Chicago where he's Chairman of the Board and a professor at the Alfred Adler Institute of Chicago. He was a trustee of the Illinois Board of Examiners of Professional Psychology. Dr. Mosak is on the editorial board of *Individual Psychology*. He was formerly the Director of Training of the Alfred Adler Institute in Chicago and the President of the North American Society of Adlerian Psychology. Among his many publications are "Alfred Adler, His Influence on Psychology Today." He is also the author of *Early Recollections of Adler, Freud, and Jung*.

I am not a born Adlerian. Some practitioners attend a school or take a residency where one form of psychotherapy is taught, and they identify with that particular school, sometimes without ever having been exposed to other systems of psychotherapy. In my own training, beginning thirty-five or forty years ago, I led a "schizophrenic" existence. I first learned psychotherapy from Carl Rogers. He taught me that interpretation was not essential, even *verboten*, and that if I provided a warm, permissive, accepting atmosphere, the client would provide his own insights and find his own "cure." (I put that in quotation marks because that is something at which Rogers and the Rogerian group did not aim.) Simultaneously, in almost four years of internship at a Veterans Administration hospital, I was being supervised by therapists all of whom were Freudians, with the exception of one Jungian. They taught me, and I oversimplify, that the only genuine psychotherapy was deep and intensive, that change depended upon the acquisition of insight, and that the acquisition of insight al-

ways *preceded* change. The best vehicle for promoting insight was interpretation, and of the interpretive methods, the dream was, of course, "the royal road to the unconscious." Later, upon graduating, I was assigned to the VA Mental Hygiene Clinic in Denver where all of my supervisors but one were Adolf Meyer psychobiologists who practiced distributive analysis and synthesis. They taught me that interpretation was OK but if I used it, it didn't have to be deep in the Freudian sense; it didn't have to tap unconscious processes. They prided themselves upon having developed a "common sense psychiatry." In the rather parochial way in which psychotherapy was viewed at the time, each school knew and taught that the other schools did not represent the true road to psychological salvation. Only after exposure to these schools did I finally, through an accident of fate (I wouldn't have called it that at that time because my Freudian teachers were indoctrinating me with the notion that there were no accidents) come into contact with the Adlerian school.

My teachers and supervisors were real "pros," and I was impressed as I watched them work so effectively. Yet how could they all be right when their viewpoints were so disparate? Yet they couldn't all be wrong because if they were, why were they achieving such beautiful results? It was at this point that I recalled the story of the blind men and the elephant, and I saw it as a metaphor for what the therapists of the time (and some today) were doing. In their groping about, each discovered a bit of data and on the basis of this "touch" defined the elephant from his particular point of view. From my own groping about I concluded that in spite of the partisan rivalries existing at the time, no psychotherapy or personality theory was truth, that every therapy and underlying theory was like a pair of eyeglasses. If one looked through one pair of glasses, the world looked closer; through another it looked more distant. Some glasses made the world look fuzzy and others made it look sharp. Some glasses made the world look rosy and others made it look dark. Therefore, theory, like a pair of glasses, must fulfill two criteria: It must give you—not others necessarily—a sharp view of the "world," and you shouldn't have to squint, to force theory, in order to see it that way. Adlerian psychology became the prescription that best suited me. It was not a matter of truth but merely that I had tried on other pairs of glasses and they didn't seem to fulfill these two criteria as well as the Adlerians did.

As an Adlerian I discovered several things over the years which conflicted with my early teachings. Although I still considered

myself an insight therapist, I no longer could accept the notion that insight must accompany change. From even naive observation I could often see that people were engaged in the growth process without any insight. They would never see the inside of a therapist's office. I also observed that in many instances people with so-called insight—and many of them had more insight into themselves than I did because they had seen several therapists before me and could recite their story very well—they still didn't change. In my early training, the explanation was that such insight was intellectual insight in distinction to true insight which was called emotional insight. This sometimes led to the necessity of converting intellectual insight into emotional insight. Here I had a problem because while I saw my teachers doing this, at least as I understood their theory, I could never figure out how they did it, nor were they very adept at telling me how they did it. It was reminiscent of the story of the 75 year-old man who consulted his physician with the complaint, "I'm 75 years-old, and I want my sex drive lowered." The physician chuckled and answered, "At your age you want your sex drive lowered?" "Yeah," replied the man pointing to his head, "Right now it's all up here!"

This process of converting intellectual insight into emotional insight doesn't occur in Adlerian therapy because insight always involves a movement, a behavioral change. If the patient doesn't move he merely talks a good game, but he doesn't have insight. There is the story of the two friends talking about the psychoanalysis of one of them. The analysand is asked by his friend, "You mean if Van Gogh had been analyzed, he wouldn't have cut off his ear and sent it to the prostitute?" "Oh no, he still would have done it, but at least he would have known the reason why!" Knowing the reason why is not sufficient for the Adlerian therapist. Putting theory aside I further observed that insight often followed rather than preceded some behavioral event. This morning you heard Dr. Beebe pointing out that after something his analyst did, and after struggling with it, he developed some insight.

The goal of any therapy is to move the patient from here to there—wherever these two points might be in any particular psychotherapy—to move the patient from a minus to a plus position both in therapy and in life. To do so Adler, in addition to interpretation, utilized several methods. He used encouragement techniques because he felt that the patient was not sick but was discouraged. These techniques have best been described by Dreikurs and also by Perman. Adler also introduced paradoxical tech-

niques into psychotherapy, and his student and colleague, Viktor Frankl, made one method central to his logotherapy, renaming Adler's anti-suggestion as paradoxical intention (a decided improvement). Shulman, who is a member of NAAP, has written on confrontation techniques based on what Adler indelicately called "spitting in the patient's soup." I have described various methods in a chapter in Corsini's *Current Psychotherapies:* acting "as if," image creation, the push-button technique, humor, fable and parable. Having been taught by both the Rogerians and the Freudians that one must not give advice, I refrained from doing so since I was taught as a youngster that "Reverence for one's teachers is equivalent to reverence for God." However, I read an article by Hans Strupp in which he states, "It has been said that Freud, following his own recommendations, never gave advice to an analysand on the couch but did not stint with the commodity from the couch to the door." I now occasionally give advice.

What I'm saying is that while Adlerians still use interpretation as a major technique, they have never regarded it as the sole intervention method. When they do interpret, Adlerians center their interpretations around disclosing the patient's goals to him. Like the Jungians we are purposivists. We also disclose to the patient the line of movement that he takes toward these goals. These goals may be immediate goals, either in life or vis-à-vis therapy or the therapist, the latter incorporating interactions which are often called by others resistance and transference. In that sense Individual Psychology is a transactional psychology, and indeed the Transactional Analysis people have acknowledged Adler as the first of the transactionalists. The other goals to which the therapeutic process addresses itself are the long-range goals which are embedded within the person's lifestyle. In each lifestyle there are what Raimy calls "misconceptions of the self," and Adler would add to it, misconceptions about the world. Through interpretation and other techniques which Adlerians employ, our aim, as Adler said, is to replace large errors with smaller ones: errors of perception, errors of conclusions of the self and the world, errors in goal choice, and errors in behavior. We try to help the patient distinguish between past and present, that the old modes of thinking, feeling, and acting are no longer applicable today—otherwise most of us would still believe in Santa Claus.

We gear our interpretive style to the patient. Adler said that to understand a patient you have to see with his eyes, hear with his ears and feel with his heart. We have to gear our interpretation not

to theory but to the person we are working with. Consequently, in observing behavior, we would come up with different interpretations of the same data; and from our point of view, unless we were just being dumb, we would be coming up with a valid interpretation. The necessity for making a correct interpretation never occurred to Adler. When Adler made an interpretation he would often follow it by this often-quoted statement, *"Es kan auch anders sein:"* It could be entirely different than I say. Only good and poor interpretations exist. A good interpretation is one from which the patient can learn and can grow, perhaps sometimes way down the road. He doesn't learn it today when you're telling him about it but he learns from it somewhere. Now I don't have to be correct, since I don't acknowledge the correctness of interpretation, I and other Adlerians will often preface interpretations with, "I wonder if, is it possible, could it be," rather than "This is what your dream means." In fact, just parenthetically, I once treated a psychiatrist who gave me the following dream, and I am sure that all of you could come up with an adequate interpretation; some of you would even call it the correct interpretation, I fear. The psychiatrist in the dream is standing at the bottom of a majestic-looking mountain, and on top there is a beautiful eagle, and she stands there looking up with awe and reverence. Well, there are all kinds of symbolism inherent in mountains and eagles and things like that. But actually the Adlerian says you cannot understand the dream unless you know the dreamer, and this dreamer grew up as German-speaking. When you understand that in German the word for eagle is *Adler,* the dream becomes a bit more transparent.

I have learned that I am the instrument upon which I play. It's not those interpretations that my theory says one ought to give in this or that circumstance because other people give these interpretations—the very same ones dictated by theory—much better than I in some instances; and in some instances in a more inferior way than I. In being the person, the instrument upon which I play, I discover, like any musician, that some people like my music, some hate it, some like it at times, some have to learn to like it as they see it, and for some it changes from session to session. ("I like your interpretation today much better than the one you gave me last week.") So the personality of the therapist is at least as equally important as the content of the interpretation. I as therapist, using interpretation or other things or even sitting silently, can only facilitate, collaborate, and share. Incidentally, with respect to sharing, even before I knew very much about psychotherapy, I wrote

in my doctoral dissertation that therapy is a two-way street; not only the patient gets healed. I can also, as therapist, invite the patient to risk, and I also have to risk. Somebody raised that question today—what happens when a therapist leads you—and here the Adlerian has an antidote both for himself and for his patients. He may even provide a role model for it if the patient sees his interpretation or his behavior is incorrect, and that antidote is the courage to be imperfect. And if I can do all these things then I can help the patient to grow; in Adlerian terms, help the patient to evoke his *Gemeinschaftsgefühl*.

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Existential Psychoanalysis and Modern Psychoanalysis

HERBERT HOLT

MRS. ZABRISKIE: And now we're privileged to hear from Dr. Herbert Holt. Dr. Holt is director of the New York Institute of Existential Analysis, founding president of the Association for Applied Psychoanalysis, formerly chief training psychiatrist of the American Foundation of Religion and Psychiatry, the medical director and training psychiatrist for the Hudson River Counseling Service. He has also been editor of *The Journal for Modern Psychotherapy*. In the past Dr. Holt has been Dean of the Westchester Institute for Training and Counseling in Psychotherapy, assistant attending neurologist at Bellevue Hospital, and an assistant attending psychiatrist at Columbia Presbyterian Medical Center at the Vanderbilt Clinic. He also has many publications to his credit. He is a contributor to the *Comprehensive Textbook of Psychiatry* and also he is the author of a book entitled *Free to Be Good or Bad: A Choice*.

Existential psychoanalysis was born in the 1920's and 30's in Middle Europe. At that time, the main representative of existential psychoanalysis was Ludwig Binswanger, a late pupil of Sigmund Freud. Being a Swiss and two generations after Freud, he had no desire or need to break his personal relationship with him. In 1936, Binswanger, in his address in commemoration of Freud's eightieth birthday, felt that Freud's conception of man is an oversimplification and constricts a full human, realistic understanding of man in his world. He felt that Freud's scientific psychology must be based on and include the ontological problem of man's total being. Freud and he carried on a famous correspondence in which Freud pointed out that the ideas which occupied Binswanger about the human being in the world could only be discussed *now* because he

had laid the groundwork for the unfolding of the human personality in his biologically grounded ideas of psychoanalysis by his concept of the power of unconscious processes. Freud said, "I've always lived only in the 'parterre' and basement of the building. Your claim that with a *change of viewpoint* one is able to see an upper story which houses such distinguished guests as religion, art, etc. . . . I am a revolutionary and you are a conservative. If I had another lifetime of work before me, I have no doubt that I could find room for these noble guests in my little subterranean house. . . ."

Ludwig Binswanger felt that his *Daseinanalyse* (existential analysis) complements and corrects the view of modern man. It is not a clinical alternative to classical Freudian analysis, but the ground of both schools of thought and helps them both together to explain man as a living object in the world. Each different perspective focuses on different problems in living and a false assumption would be that one school of thought has the total answer and understanding of how a human being lives in his world. Many of the students of Freud, and even he himself, de-emphasized or wrongly emphasized the philosophical and cultural mainstream in which a therapy is invented. For example, the genetically grounded psychotherapies such as classical Freudian psychoanalysis, and later on the interpersonal schools, and the many object relations theories, have created different conceptual frameworks which added to the understanding of human beings. Existential psychoanalysis' sphere of interest—the meaning and purpose of life in this world—supplements and synchronizes our understanding of the human condition and the difficulty of man living in a modern world of fear, conflict, and the danger of being oppressed by mass ideologies controlling his freedom and destiny. Freud wanted to create and study the archaic and primitive structures of the unconscious processes and be able to establish a scientifically accepted theory of man, while de-emphasizing, for political and personal reasons, his interest in the philosophy of Franz Brentano under whom he studied philosophical psychology at the University of Vienna.

Franz Brentano held at the time the unpopular view that man lives intentionally and that what is common to mental phenomena and distinguishes them from the physical phenomena is "intentional inexistence." By that, he meant that a phenomenon points toward an object whether it exists in reality or imagination. By intentionality, he meant that we intend or actively create a subjec-

tive image of ourselves and the world we live in without often being aware of it, and that this image does not necessarily correspond to the way other people see themselves in their world. Brentano used to say that God did not create men, but men created gods. Through concepts and percepts which man develops, he creates a world view for himself. His creative structures give him a way of experiencing the world, *ein Sitz im Leben,* which makes it possible for him to comprehend part of the world as he needs to see it. This is a necessity for man because without structuring the world in this sense, he could not comprehend himself in his physical surroundings.

Freud made a major contribution to scientific thought by transposing the concept of intentionality, which a person might not be aware of, into the libido theory and therefore opened to the world a new way of investigation and observation. Since he felt that man's behavior is determined by organic needs (aggression, sexuality), he continued the ideas of Brentano and transposed them from the idealistic world view to the materialistic psychological world view. By this rejection of idealism as unscientific and by assuming the language of 19th century physics and biology, he succeeded in making psychoanalysis respectable in the eyes of his medical colleagues and helped them to see him as an objective scientist.

Freud, as well as many of his contemporaries, thought his theories had perennial scope, but since we in the field of existential psychoanalysis feel that "being" reveals itself to us only in time and that "truth" is a product of its temporal manifestations, we feel that he wrote only from his age and for his time. It is often as impossible to capture the truth in a different time as it is to capture an optical image; therefore, it becomes our task to attempt to demythologize Freud's theories so that what is essential can emerge, and by making the essentials more and more visible to modern man, we can avoid the wholesale rejection of his teaching by the current generation of young social scientists who feel that classical Freudian psychoanalysis is irrelevant to an understanding of their daily lives and themselves.

Freud was born in a province of the Austro-Hungarian Empire and was of Jewish background. When his family and he moved to Vienna, they brought with them all the virtues, points of view and prejudices that come from such a provincial town to imperial Vienna with all its psuedo-morality, Bohemian freedoms and political upheavals. He had a difficult time adjusting and experienced

a life-long love/hate relationship towards Vienna and the Viennese which was reciprocated. He lived beyond his income and was under financial stress almost all his life. He flirted with Catholicism but consciously rejected its theology, its philosophy and its political position. As a bourgeois conservative, he could not join the then prevailing political Social Democratic Party. This created great problems for him and his family, since he also had difficulty until late in life, affiliating himself with the Jewish Zionist movement which gave him a place in the political life of Vienna.

He had a tyrannical, authoritarian bent and believed and experienced society as a potentially hostile mass and protected his privacy against the curiosity of the crowds. He believed that man, if he wants to maintain his identity, must never become part of a group since there is a danger that he would regress to more primitive mental states. This social anxiety and concomitant fear of public opinion prevailed all his life. He was mostly personally unaware of his and his family's social anxieties. Nevertheless, he wrote a book about group psychology in which he explained his view of and the reason for the power of group man. He felt that in a group, the voice of individual conscience is silenced and that the group, through conscious repression, violates the standards of individual conscience and the uninhibited hostile behavior of group man can be acted out without guilt.

Since he was not aware of his own authoritarian bent, he had great difficulty with some of his better known pupils like Adler, Ferenczi, Jung, Rank, etc., and experienced them as "ungrateful and hostile." These festering conflicts with his younger colleagues could only lead to a separating out and disillusionment in life. He felt threatened as a leader and avoided intimacy by behaving formally with his colleagues.

Freud died in the late 1930's and felt more or less disillusioned with psychoanalysis as a therapeutic technique and therapy. He hoped that pharmacological solutions would be found to relieve suffering humanity from self-aggressive and anxiety producing problems. Being a trained research neurologist, he intuitively grasped the three-part concept of the brain which 30 years later was supported by the work of Dr. Paul MacLean and his concept of the triune brain. Working with animals, MacLean established a theory that the human brain consists of three cooperating individual brains. These three brains have different chemical compositions and are millions of years apart in their development. Survival mechanisms are genetically built into the two lower brains. The

pre-frontal areas of the cortex are the most unusual event in the evolution of man and leads him to be consciously aware of himself. It is this new development that made possible the insight required to plan for the needs of others as well as those of the self. In creating for the first time a creature with a concern for other living objects, nature through evolution accomplished a 180 degree turnabout from what had previously been a reptile-eats-reptile and dog-eats-dog world. Psychoanalysis now had, therefore, a biological theory which underpinned the metapsychology of classical Freudian psychoanalysis and explains to us the genetic impulsive basis of psychological problems and shows us how the environment, human and natural, can over millions of years, influence the genetic code and vice versa. The Heideggerian concept of *Dasein-in-the-world* can be understood as living simultaneously in the subjective, triple experienced world structure of the *Eigenwelt, Umwelt* and *Mitwelt,* and now had a scientifically explainable basis.

I tried in this paper to give you a glimpse of the development and place of existential psychoanalysis in the field of modern psychoanalysis. The deep humanity and personal difficulties of Freud while living in Vienna which he overcame to a great degree by self-analysis, have been touched upon. I proposed that Freud's theory and clinical practice were not only grounded in biology and psychology of his time, but also in the social, moral and political world he lived in. The ideas underlying his theories were based to a great extent on the work of Franz Brentano and the later developing schools of phenomenological psychologies. His thoughts were revolutionary and were often rejected as radical innovations by his contemporaries even though he personally lived a private and conservative life. He anticipated many developments in pharmacology for the treatment of mental illness and as a humanitarian scientist, he was a precursor of the biological-genetic theory which has as its present representative, Dr. Paul MacLean. I feel that modern psychoanalysis takes into account not only genetic and early developmental factors, but also cultural and social influences which constitute the present as well as the future of psychoanalytic development. Existential psychoanalysis, with its focus on *Dasein,* gives meaning to modern psychoanalysis by highlighting the shift from genetic and interpersonal views to a more comprehensive and holistic view of man in the modern world.

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DISCUSSION Following Dr. Holt's Address

Question: My question has two parts. One is how do you defend yourself against the accusation of committing the genetic fallacy in your discussion of Freud? Were you criticized for committing that fallacy? And the second is if we forget about all this genetic stuff and talk about his ideas instead, what do you think was his connection with philosophy, not with Brentano, but with Schopenhauer and Nietzsche? Perhaps what Nietzsche and Freud have in common is the notion of health not as simply a matter of relationships with other persons but as an intrapsychic matter.

Dr. Holt: I'll address myself to the second question first. Freud was naturally aware of Nietzsche and Schopenhauer and friends of the same feather flock together. When you think of Freud, he was a bitter man; so was Schopenhauer and Nietzsche. Of course they focus on the sickness of their time and of themselves if you want to call it sickness. They lived in a time which was unbelievable and they were persecuted. As you know syphilis of the brain was very prevalent in Europe. It wasn't only the disease of the working class, it was the disease of the kings, the Hapsburgs and everyone else and Nietzsche, of course, had syphilis of the brain. One of the symptoms of syphilis of the brain is delusions and I do not want to go into it, to draw too close an analogy, but I assume that Freud knew about these people quite well. To me the interesting thing was that the novelty in Vienna was not Nietzsche and Freud, but Brentano, who was a revolutionary. You have no idea what it means to stand up against the king, the emperor and his troops. Don't ever think of Vienna as just the beautiful Danube and Sachertorte. It exists but that's not Vienna. There are little side issues. Now to the first question—what was it again?

Question: I think you've done it again. You're not discussing Freud's ideas or Nietzsche's, you're discussing his life.

Dr. Holt: Well, that isn't true at all. Of course, you have to know the life before you can know the ideas. Existence comes before essence. You do not have to agree with me, but everyone who observes people knows there are no ideas which come from heaven; ideas are *au courant* in the environment in which you are.

You have learned certain things, you react to certain things and Freud's ideas are traceable to the environment in which he lived. I'm not saying that all his ideas are based on Brentano. I say that one essential idea on which his whole theory is based, the libido theory, is based on the transformation of Brentano's intentionality on a biological level and using the physics and chemistry, the mechanics of his time, to describe the movement; which is understandable. He was a genius, and the purpose of this was not to minimize him. I show the humanity of Freud like the humanity of all of us. Anybody who has ideas of grandeur, and who thinks that in becoming an analyst you'll become a super person, well, super persons are all in the mental hospital. I have never met an analyst who is successful who is not a human being, and aware of his limitation as a human being. But he created these ideas which have had such an influence on the world. In fact our founder Binswanger said that without Freud, existential analysis could not even exist, or even be thought of, because by us you have to have a thought in your brain first before you can label it and the basis of our field, the ground floor, is Freudian psychoanalysis.

Question: Dr. Holt, you emphasize, if I understand you correctly, that it is not technique but the relationship within the therapeutic environment that is crucial, and the use the therapist makes of his own experience, his own wounds, his own coping as he's learned in the process of living his life—bringing that into the therapeutic situation. How then would you summarize the process of what goes on in existential therapy between these two people who are trying to make their lives better?

Dr. Holt: I was afraid that I would be asked such a question. But I must tell you I am prepared. The issue is simply this. We have to agree with Jung that the individual is the most important aspect of any therapy; but we conceive of individuality only in reference to another human being. We call it being, or being-in-the-world. Without another human being you are the human *organism,* but only in reference to another human being can you become aware of your *humanness* as you become aware of the other who is human in his way, not in your way. Therefore the first requirement—and we share that with all the interpersonalistic schools from Adler, Sullivan, Horney—is that we human beings need other human beings and this is called in German *der Sitz in Leben,* the seat in life. So if you want to feel alive, you need a reference, another human being who is different from you and will maintain his different identity so that you can become aware

of your own identity. This is the basis of existential analysis. The second thing we focus on is the *dasein*. This is a Heideggerian term and—it means being *here*, standing out over and against, maintaining your identity with other human beings; and that is (*à la* Sartre) authentic being. Now inauthentic being is when you live with your own images, your own thought, and your own feeling—and remember intentionality. You need, to be aware of anything, concepts or percepts in your head of other people; but if you live *only* by concepts and percepts then you daydream or you dream. The basic idea, as I mentioned in my paper, is that you live in the world in a threefold manner: first in the *Mitwelt; Mitwelt* in German means in relation to another human being. Then the *Umwelt* which means the surrounding environment in which human beings live in space and time. And the *Eigenwelt* which means the inner world of dream states and fantasies and hallucinations, illusions. Therefore in this three-part universe which goes on simultaneously, the human being exists. If he lives only in one and/or the other he is not fully human, therefore inauthentic and doesn't live a full life.

The goal, therefore, is, if the person wants to—but he has to want to—to help him to live in all three worlds simultaneously.

Mrs. Zabriskie: We'll now be hearing from Dr. Meadow who will give a modern psychoanalytic statement to Dr. Mozak and Dr. Holt's presentations.

Dr. Meadow: Holt said that someone told him when he got here that I was a tough cookie. I have the idea though that he was talking about himself. It looks like in Holt's training he only missed one school of thought, and that is modern analysis. I think though that he may have, somewhere along the line, picked up a little modern analytic training because he did illustrate one of the modern analytic principles. You can tell a patient anything and if it's emotionally communicated he'll laugh and feel good. Now he also mentioned, and I think here again he's demonstrating that he knows something about modern analysis, that analysis doesn't necessarily lead to good feelings. It may incidentally lead to good feelings but it leads to a lot of other feelings, too.

Now for Dr. Mozak. Dr. Mozak left out one technique in his list of interventions and that's the command. And that midbrain that we work with in modern analysis usually is very responsive to commands; so to Dr. Mozak's list I would like to add authoritarian commands. And if you have any questions about that I'll be happy to answer them. But with that exception, I agreed with

everything Dr. Mozak said. Now, that's a terrible state of affairs for a modern analyst. I don't think we emphasize the correctness of our interpretations but I do think we are interested in valid interpretations and for a valid interpretation we need a system. Therefore we go to great lengths in modern analysis to expose the student to the lengthiest training experience known to man. And following that experience, in which he adapts himself to a system and makes valid interpretations within that system, we send him over to NAAP for membership and at NAAP he learns the ecumenical approach. He broadens his base and pretty soon *he* has a system. But, we can't call it a system anymore. He's incorporated more and more of other systems and now he has to make valid interpretations based on this expanded base; and I hope we're doing that here today. I certainly got the feeling I was. Thank you.

General Discussion

Mrs. Zabriskie: And now if the speakers would like to say anything to each other or if anyone in the audience would like to address any questions, it's the moment.

Dr. Mozak: I'd like to say a number of things. First of all, Adler was heavily influenced by Husserl, from whom Adler got his phenomenological approach; and apparently he was also influenced by Brentano. In fact, one of the foremost Brentano scholars in the United States, teaching at a Jesuit University, the University of Dayton, was the late Antos Rankorelo, who was an Adlerian as well as a Brentano scholar. It's rather interesting that Dr. Holt says that Freud was not a *menschenkenner*, a knower of people; in contrast Adler wrote a book in German called *Menschenkentnes*, which here in this country was rather liberally translated as *Understanding Human Nature*. For those of you who are interested in the patients of Adler and Freud there is a paper by Heinz Ansbacher, called "The Socio-Economic Status of the Patients of Freud and Adler," indicating how the differences that were described in the talk led to their choice of certain kinds of patients and the choice then *by* certain kinds of patients.

Adler, in terms of his own socialist approach, started very early in community outreach programs, and in 1898 he indicated that we don't have to bring people into the consulting room, that one of the places that a therapist ought to work is out there in the

community. His first book in psychology, written in 1898, was the description of such an effort, an initial effort on his part to attend to the health needs, physical and psychological, of tailors. He later started day care centers, family education centers in the schools of Vienna, and things like that. When I heard him speak of intentionality at this meeting I heard one of the things that his school and mine hold in common. We use the very same kind of phraseology.

One of Adler's students was Rollo May, who also speaks about intentionality, and of meaning. In fact one of Adler's books was called *What Life Should Mean to You*. Adler, at least in one article, and certainly among people in many circles, is considered one of the earliest existentialists, or a forerunner of existential psychology. I was happy to hear him say that he is willing to be authentically himself and share his hostility and all kinds of other feelings with patients. I, of course, was taught otherwise and felt very uncomfortable doing that in the early years. But as far as I am concerned I can only be me and since I can only be me, the patient gets me; and sometimes I am angry and sometimes I am moved and sometimes I am sad and sometimes I feel, "Gee, what crap" and sometimes even say it, and that kind of thing; so that both of us, or at least our schools, speak of the authentic therapist. We're not magnanimous, we don't play games. We're us. Adler's social interest is a psychological restatement of Hillel's statement which was later put in positive form by Jesus, etc. Adler acknowledged that; in fact in one place Adler says individual psychology makes excellent religion if you're unfortunate enough not to have any other. And the only other thing is I'm wondering who Dr. Meadow has been reading or listening to when she speaks of the one method I didn't mention and that was authoritarian command. I certainly have seen Adlerians who are authoritarian. I also have seen Adlerians who use authoritarian command but—outside of the Rogerian school—I have also seen that in a good number of other contexts that I work or have worked in. But in addition to that, there are Adlerians, and I happen to be one of them and perhaps this is part of the residual of the Rogerian training I had, who would never command; and I was just wondering if you would expand on what you meant by that.

Dr. Meadow: I'll have to start with the idea that when we talk about the authentic relationship with the patient in modern analysis we are talking about a willingness to share those feelings we experience in response to the patient that will promote growth.

Now within that framework, the fear of loss of ego and the fear of an inability to control one's impulses is sometimes responsive to commands that reflect a side of the patient's conflict.

Question: May I give you an example? A patient wanted to leave a session because she had uncomfortable feelings. I ordered her to remain in the session. And she stayed.

Dr. Meadow: On the other hand, I might have ordered her to leave. For a patient with a compelling wish to get away the order to leave may have a calming effect.

Question: I recently had an experience with an 11-year-old girl which made me think that interpretation is not only a one way street from the analyst to the patient but a two way street from the patient to the analyst, and maybe a continuation of the street from the patient to the analyst to the previous analyst. In my own technique I've tried more and more to use questions as a method of interpretation. When I want to interpret something I'll constrain myself and try to put it in the form of an inquiry. Well, the little girl turned the tables on me and she said, "I want to ask you a question." I said, "That's fine." She said, "Tell me, are you more interested in the money or do you really care about me?" Well, that was a wonderful question and I told her that is a great question. Before I answered her question, I wanted to know from her what she perceived. She was thoughtful and then she said to me, "I don't want to tell you because it would hurt you too much." I said, "Why can't you hurt me too much?" And she said, "Look, let's change the subject." If you understand the girl's life, she couldn't tell her mother and father what she felt about their sometimes neglect of her. The inability to express her feelings was related to her whole family life story, where the mother and father, similarly as a couple, could not express feelings to one another out of the anxiety of being hurtful and harmful to one another. Therefore, I think interpretation is very much related not only to the question of procedure but also to the family life history of the particular individual.

Now I would like to ask Dr. Holt how he thinks Freud would have responded if Holt was Freud's patient and he was free to say everything in Freud's presence.

Dr. Holt: Well, that would require a fantasy answer from me which I unfortunately cannot give you, but I can tell you my impression of Freud when I was a medical student. He lectured in a part of the institute which was nearly inaccessible to any of his students. Freud was not well liked by the faculty, nor amongst the

usual students. He lectured somewhere off in the corner and he wasn't thought of as an important person in Vienna. It sounds ridiculous to us. I went out of my way to hear Freud's lecture on an introduction to psychoanalysis and I must tell you how I felt, and that is, "My god, if this is an analyst I wouldn't want to be one." Now the reason I share that with you is that these prejudices which the medical faculty had were shared by the majority of good students at the university. Freud was more important outside the university than to us students. I cannot tell you how Freud would have felt but he was a very reserved kind of fellow who couldn't establish personal relationships easily. He was similar to Sullivan and Frieda Fromm-Reichman and many of the first and second generation analysts who have not been "fully analyzed." That means they haven't learned to charm, to relate to other people in a positive and meaningful manner, and were very reserved. Freud was the Herr Professor. You didn't approach Freud like you might have approached any doctor here.

When I came here I learned to my amazement that everyone called me Doc. I thought they meant dog. I got used to it and it took 17 to 20 years to become familiar with the American way of calling you by the first name. It's a reeducation process and Freud lived in a world of his own. The Freud family were distant people. You could not come really close to them. They were very formal. Freud probably would not have liked this but he had a rule which did him in. And the rule was, a typically classic Freudian rule, that you must say everything which comes to your mind when you are on the couch. So I assure you he heard everything. He was very sensitive. Look what he did to Adler and Jung and so many of his students. If somebody disagreed or was a little bit hostile or had ideas of his own he couldn't stand it, and excommunication was the price you paid for differences of opinion. Psychoanalysis lost many of its valuable men like Sandor Ferenczi and so many others who couldn't stand the personality of Freud.

Now what I could tell you about hostility is how it is handled in existential analysis. The hostility is different from destructive aggression or acting out. We make a clear distinction that it is natural for the human being, being a human animal, to be hostile. I will give you an example from my own life. When my youngest daughter was four years of age I gave her a birthday party and she was very elegantly dressed as becoming to her life style and mine at the time. We walked to the Plaza Hotel and to my misfortune there was an ice cream man standing on the corner and she said,

"Daddy, you promised I can have everything today." I knew what was coming. She wanted some ice cream. Now she had to take ten steps up the stairs and there was a beautiful ice cream cake waiting for her and all the little girls and boys all dressed up and I was stupid enough to say to her, "No, you can't have it." That crushed her faith in me completely. But she said, "Daddy, you said I can have everything I wanted. Didn't you say so?" I said, "Yes." And then I was twice as stupid. She said, "I want ice cream now." And I said, "You can have everything you want. I didn't say *when.*" And I expected a four-year old to know the concept of present, past and future. What an analyst, you would say. Well, at this time I was a father and if I have learned one thing, it is, never confuse the role of a father or husband with being an analyst. But it took 20 years to learn that. It isn't easy. And you know what she did? She turned around with real disgust with me being inconsistent and violating a promise—a promise *is* a promise—age 4, remember—and kicked me as hard as she could on my shin. Do you want to see the blue mark even now?

The lady has graduated Princeton and is a grown up woman; I still have the mark. Now if you want to call that malignant hostility you are entitled to do it. I don't call it that; I call it a natural response to a very confusing situation which I created by not buying her this lousy ice cream.

Now how to deal with it in existential analysis? As a father I didn't deal with it well. I hit her. Now what we existentialists do is use the epoque. According to the phenomenology which we use, the epoque is a method of dealing with emotions in which you help the patient to separate himself out from his emotions, so he *isn't* his emotions like a little kid is, but he *has* an emotion; and that is done by saying in an angry tone, "Why are you hostile? What is the purpose of your hostility? Why do you do that? What meaning do you give to this?" And by this little trick you help the person to separate out enough that he can distance himself to the first level, of separation from *your* emotion, and therefore we can now deal with the hostility. I might acknowledge that I am angry, that I might even have caused it—as with my daughter—I made this stupid remark. Many times analysts make stupid remarks and then you discuss it and negotiate that his anger might be appropriate, and an adequate response, and so therefore you deal with your anger, the patient deals with your anger, you deal with your patient's anger—and you're still talking to each other. That's one way.

Question: I'm wondering what the difference is between your approach, Dr. Mozak, and your approach, Dr. Holt. I'm getting what seems to me a clear picture of the congruencies between the existential and the Adlerian systems. They're sounding more and more alike to me.

Dr. Mozak: Actually there are considerable areas of convergence between Dr. Holt and myself. We talk about intentionality. We talk about meaning. If somebody had asked me the question about what do you do about hostility I could not have answered it differently than he answered it. This would be exactly our approach. When a patient does almost anything in therapy we ask, "What is the purpose of that? What is the meaning of that?" and that kind of thing. I have already pointed out that the meaning of life, the meaning of existence, etc., is part and parcel of what we do. I believe that almost every form of therapy is a form of ideological conversion. You change the person's ideas about something or other. You help them to see it in different ways than he has previously seen it. So that if you see large degrees of congruence between what he says and what Adlerians say I have to agree, basically.

Of all the things that were said today—outside of some of the historical things that I don't know about and that Dr. Holt does about Vienna—in terms of the way we practice, I suspect I would come closer to practicing the way Dr. Holt does than to any of the other speakers.

Question: Would Dr. Meadow comment on that way of handling hostility in the session.

Dr. Meadow: The "why" question is reserved for a little later in the treatment than the phase that they may be talking about. First of all we operate on the assumption that we want to reinforce the ego as it is now with its current perceptions and therefore we don't want to get too much insight and we don't want too much thinking about what's wrong with the way the patients are thinking. There is a tendency not to ask too many of the "why" questions. I would like to say one thing in defense of Freud. I think Holt described Freud pretty accurately but he was a growing human being too; the way he treated Dora was just abominable and by the time he got to Emma he was starting to stay up nights thinking about what he might have done wrong. I have the idea if it wasn't for Hitler and all the other things he had to contend with, and had he not been such a great theoretician and researcher, and was really

interested in working with patients—he might even have gotten to the point where he would entertain hostility from patients.

Mrs. Zabriskie: I think all the speakers today have been extraordinarily generous. It's not just been an event. It's been a phenomenon. I enjoyed it enormously. I hope you did as well.

The Royal Road to Preverbal Conflicts*

PHYLLIS W. MEADOW

Using Dreams to Mature

There is a tribe of Senoi Indians living in a remote Malayan mountain range who are reputed to have no wars, no crime, no violence, no destructive interpersonal conflicts and no mental or physical illness. Anthropologists report that they have a complex system of social interaction quite like Western civilization, but have different methods of discharging tension. Furthermore, dream interpretation plays an important part in the education of Senoi children.

Children tell their dreams to their parents who explain that images of the outside world are created in the mind, and that the dreamer sees his fears disguised in images. Some are hostile and can turn the dreamer against his fellows, and some can make him sick, but with the help of family and friends the power of these images can be fought and overcome.

If a Senoi child says his dreams terrify him, he is encouraged to pursue them to their conclusion. If attacked in a dream, the child is advised to finish the dream by attacking and killing the hostile character. But when he awakens, he must tell the dream to the person who appeared in it so that damage done by the negative image can be repaired. If the dreamer harms someone in the dream, then he must, on awakening, be especially friendly to that

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person. It is said by some that this integration of dream conflict into daily life and dialogue may explain the absence of crime and war amongst the Senoi.

The Dream Experience

We take for granted that dreams occur in sleep and that they preserve sleep by providing a form of discharge that stabilizes the organism. From the reports of patients, we have learned that dreamers experience the visual narrative of their dreams as real events. Some dreams are reported in color, others in black and white. It would seem that a dreamer's strong feelings find expression in color while dreaming in black and white may be a dreamer's attempt to defend against strong feelings. We know that dreams are dominated by visual imagery and that a small fraction of dreams utilize other senses. We say that in dreams, thought is replaced by hallucination though in view of the developmental history of the mind we should say that in waking life hallucination is replaced by thought.

The manifest content of dreams takes us back to picture language, to symbolic forms of communication used prior to the development of language (Spotnitz & Meadow, 1976). Freud (1900) noted that on waking, the dreamer attempts to convert the visual experience back into thought and, in the process, some of the unconscious meaning is lost. Freud (1895) reported a dream demonstrating the wish fulfillment function of dreams: that of a lazy medical student who saves himself the trouble of getting up by dreaming he is already at work at the hospital. According to Freud, dream content may be provided by residues of the dreamer's recent waking life but old longings and fears provide the energy to create a dream. In the analysis of his own dreams, Freud learned that preverbal conflicts find expression in dreams by aligning themselves with an impulse from the conscious waking life, and by transferring the intensity of buried longings onto the current wish. He said (1900) that "a conscious wish can only become a dream instigator if it succeeds in waking an unconscious wish with the same tenor and in obtaining reinforcement from it." As we listen to dreams clinically, we find confirmation that an infantile wish invariably lies behind the day's wish, and that the motor

power to create a dream lies in the strength of the infantile wish to attach itself to a present-day wish.

During the course of his self-analysis, Freud (1900) discovered the layering of wishes in dreams, a process in which conflicts from various maturational stages in early life are transferred onto a current wish. He warned: "Dreams are most vivid when there are multiple determinants. He who forgets about the superimposed layering of dreams will be overlooking one of the most interesting problems in dream interpretation and can easily go astray from understanding the nature of dreams."

These are the basic principles gleaned from Freud and used as the foundation of modern psychoanalysis.

In a discussion of one of his own dreams, Freud (1900) included a description of how he worked with patients. The patient lies on the couch with his eyes closed. After a dream is reported the analyst asks for associations to details of the dream. By exploring the associations to details of the dream, the analyst gathers the background thoughts of the dreamer.

In Freud's two-year self-analysis, he associated to his own dreams, and studied and interpreted these dream associations as expressions of his feelings of neglect by colleagues. Although he hinted at deeper meanings, he failed to pay attention to the evidence that the feeling of neglect in the dreams might be derived from early maternal conflicts.

Through a study of the latent meaning of dreams, Freud clarified the relationship of dreams to the repressed content of the mind, particularly to those early life experiences around the oedipal conflict and the incest taboo.

When we examine Freud's dreams today using his concept of multiple determinants, we are delighted to find layer on layer, back to such preverbal struggles as life against death. Unfortunately, as later learned, the dream distortion begins with the dreamer's attempt to recall a dream, and continues in the analytic session as the patient associates to his dream. It was first noted by modern psychoanalysts (1976) that when a patient is asked to provide detailed associations, to elaborate on the manifest dream narrative, he leads the analyst from primary to secondary process and away from earlier history. In the process of association, the dreamer leads the analyst's attention to layers of the dream meaning that are acceptable to his ego, and in the process dream feeling may be ignored.

Using the symbolic content of the given dream has yielded

more insights into preverbal conflict than Freud's technique of free association.

If Freud's method of dream interpretation is used, our attention is drawn to conflicts emanating from the oedipal period. Grinstein (1968) used Freud's associations to reconstruct problems with paternal approval and sibling rivalry. Velikovsky (1941) interpreted the same dreams as they related to persecution of the Jews and to Freud's self-hatred, symbolized as hatred of his Jewishness. Spotnitz and Meadow, in 1976, interpreted Freud's dreams as maternal longing and despair, a desire for revenge on the seductive mother, and Freud's wish that he had never been born. The modern mode of interpretation, concentrating on dream feeling, emphasizes the longings, rage and existential anxieties experienced by the dream characters in the manifest dream. Still deeper conflicts may be uncovered through the use of feelings to trace destructive impulsivity back through biological and archaic genetic history.

The Use of the Dreamer's Feeling State: Irma's Injection

Modern dream interpretation began with an analysis of Irma's Injection, Freud's specimen dream (Spotnitz & Meadow, 1976). With an interest in determining how patients sort, file and discharge early conflicts that are still active, the authors turned to dreams. Dreams proved to be an important tool in a study of the preverbal psyche.

If analysts recognize that associations are a further defense against primitive conflicts, they will use connecting thoughts provided by the patient during the session to elaborate on prehistoric residues in the personality and to trace the conflicts through later developmental stages. Using associations the analyst examines the layers of the patient's defense structure constituting his current character.

To understand the modern view of dream interpretation, let us reconsider Freud's specimen dream. Freud's analysis of Irma's Injection (1900) revealed oedipal wishes, sibling rivalry and emotional conflicts emanating from the phallic phase. To understand archaic, somatic, and constitutional prefeelings that occur prior to the acquisition of language Spotnitz and Meadow studied

the visual, auditory, tactile and visceral experience of the dream characters.

When we examine the manifest dream we enter a world where words are used to create pictures. It is a world of visual hallucinations. A verbal web is woven around the dream itself as the dreamer moves towards wakefulness, and later, as he "thinks" the dream. We view the process of converting to words as the ego's defensive response to early wishes.

Freud wrote that on the evening before the Irma dream, a thoughtless criticism from his friend Otto had troubled him. His colleague had seen Freud's patient, Emma, and said that although she was better, she was not well. Freud retired to his study to go over his notes, and that night, Irma, the dream figure, experienced the feelings Freud had on retiring. To understand the message we assume that in the dream Irma, the patient, represents Freud's wounded ego.

Freud (1900) said that "every dream deals with the dreamer himself. Whenever my own ego does not appear in the content of the dream, but only some extraneous person, I may safely assume that my own ego lies concealed . . . I can insert (it) into the context." Freud added in a footnote, "The person who in the dream feels an emotion which I myself experience in my sleep is the one who conceals my ego." As Freud reviewed the notes the night of his dream, he asked himself, "Is Otto correct? Am I not facing my failing?" This current conflict over his work produced a dream reflecting deeper conflicts ranging from a wish to be "boxed up" in his mother's uterus, or by his half brother (and the nose man), his guilt over the death of a younger brother when he was two, and his nanny's sudden disappearance from the household and imprisonment, his wish to be dead and to blame his mother for his organic troubles. These connections are more fully discussed in *Treatment of the Narcissistic Neuroses,* p. 114.

In the dream, Freud, the professional, appears as himself chastising the recalcitrant patient for not accepting his solution. Freud, the criticized child, is hidden in the character of Irma who appeals to the professional (Otto) for sympathy, "See how I suffer." Dreams dealing with conflicts going back to the formation of ego and superego present different characters representing different parts of the dreamer's psyche as they struggle with each other. Analysis of dreams can tell us the history of ego formation unique to the dreamer, and in reviewing these develop-

ments the analyst learns what must be reversed in the analytic relationship.

This is Freud's specimen dream:

> A large hall—numerous guests, whom we were receiving. (Thoughts crowding in)—Among them was Irma. I at once took her on one side, as though to answer her letter and to reproach her for not having accepted my "solution" yet (Superego). I said to her "If you still get pains, it's really only your fault (The self rejecting responsibility)." She replied: "If you only know what pains I've got now in my throat and stomach and abdomen—it's choking me"—I was alarmed and looked at her (Concern for infantile pain or guilt for harshness of his criticism).

Freud, the dreamer, is alarmed by the severity of Irma's (his) illness. Freud, the dreamer, blames Irma as Otto had blamed him the night before (introjection or reintrojected projection). The injection that is choking her is the criticism that is choking him and alarms him. The dream continues:

> She looked pale and puffy. I thought to myself that after all I must be missing some organic trouble. I took her to the window and looked down her throat and she showed signs of recalcitrance, like women with artificial dentures.

Freud questions whether he should be looking to deeper levels. Is his suffering caused by some innate condition? Freud does not want to look any deeper. It is difficult to look at what is there. He chastises himself for his recalcitrance at not being able to look at himself.

> I thought to myself that there was really no need for her to do that. She then opened her mouth properly (examination of notes) and on the right I found a big white patch; at another place I saw extensive whitish grey scabs upon some remarkable curly structures which were evidently modeled on the turbinal bones of the nose.

Freud concluded that he was organically impaired. Did it occur at birth, or during the nursing process? In this segment, criticism is equated with poisonous milk. The illness represented by the grey patches, thrush, is a disease of infancy, usually transmitted

through mother's milk or through an infected vagina during the birth passage. The white spots in Irma's throat suggest something indigestible in mother's milk and the weakness in Freud which led to the personality that could not tolerate criticism, his and that of others. Again, in going to the thought that mother is to blame, or father (Oscar's injection which created the pregnancy) he escapes the nose connection.

DAY'S RESIDUES

The nose reference was to a current anxiety. Having sent his patient, Emma, to his friend Fliess, the nose man, an unfortunate surgical result had occurred. Had he been remiss in this referral? Another determinant of this segment was his sensitivity to Fliess' criticisms of him. However, Freud concludes that his diagnosis of his patient had been correct. He reassures himself that his illness is his sensitivity to criticism, an infection set off in this instance by Otto's thoughtless injection.

The infantile period is one in which any bodily weakness or early infection lays the groundwork for later somatic complaints. The connection between early conflicts, depressions, withdrawal, and somatic symptoms led Spotnitz and Meadow to thoughts about Freud's later cancer of the palate. The dream continues.

> I at once called in Dr. M. (interpreted in associations as Freud's half-brother), and he repeated the examination and confirmed it . . . (Thrush.) Dr. M. looked quite different from usual; he was very pale, he walked with a limp and his chin was clean-shaven . . . My friend Otto was now standing beside her as well, and my friend Leopold was percussing her through her bodice and saying: "She has a dull area low down on the left."

All agree Freud is ill.

> He also indicated that a portion of the skin on the left shoulder was infiltrated. I noticed this, just as he did, in spite of her dress. (Pathology seen despite defense structure.)
>
> . . . M. said: "There is no doubt about it, it is an infection, but no matter; dysentery will supervene and the toxin will be eliminated." . . .

He will be cleansed of self attack by spilling it all out.

> We were directly aware, too, of the origins of the infection. Not long before, when she was feeling unwell, my friend Otto had given her an injection of a preparation of propyl, propyls . . . propionic acid . . . trimethlamin (and I saw before me the formula for this printed in heavy type) . . . Injections of that sort ought not to be made so thoughtlessly . . . And probably the syringe had not been clean. (S.E., IV:107).

After all it was not his mother but his father who was to blame for the poison of self-hatred that had been injected in him. The dream ends with the formula for a pregnancy and the thought that the fetus was poisoned by a thoughtless injection.

Otto's criticism aroused a feeling of rage and a search for who was to blame (attempt at projecting painful self-accusations). Because of the intensity of the buried conflict, anger at this arousal of feeling attached itself to the repetitive self-blame from which Freud suffered. This is reminiscent of many other dreams of Freud. In his dream, "Up the Stairs," the child in process of beginning birth is confronted by the entrance of the father's (brother's) penis into the mother.

This dream provides a clue to the origin of Freud's feeling that he was damaged. Freud's early suspicion that his mother made babies with his older half-brother left him unable to work effectively with colleagues, as he struggled with dissatisfaction with himself and blaming colleagues. On the oedipal level, we find that Freud's perceived rejection (sexually) by his mother and her acceptance of his brother are represented by Otto as he prepares to inject Irma with the contaminated injection. To the extent that he longs for his mother, feelings about the betrayal of his father by his brother would sanctify his rage. In all this, the dreamer hides his early secret desire to make babies with his mother and his wish that she would stay away from bad injections.

Summary

To understand the dreamer's intention in the production of a dream, the analyst looks to the dream characters in the manifest content. Dream figures may be analyzed as the dreamer in his different aspects. Dreams can tell the story of the nuclear conflicts set up during the formation of the psychic structure; they represent

the self combined with various aspects of preverbal objects. The preverbal objects are those experienced early in life when merged self and object representations existed in the mind in fluid states.

At this stage of development causal thinking dominates; the only defenses available are introjection, projection and denial. Within these representations, the analyst seeks the transference meaning of the dream. The transference reveals the conflicts of object and preobject stages including existential anxieties predating self awareness. The genetic history of the patient and unresolved conflicts recur in the patient's life and transference and are symbolized in dreams. Dreams may be understood on each psychosexual level, in their libidinal and aggressive meanings, in fused and pure states, condensed in one story line according to the unique history of the individual. The analyst prefers to study them in their transference meanings. Dreams are an indirect communication which the patient shares with the analyst by reporting them. Insofar as the manifest content of the dream reveals a major transference feeling with which the dreamer is struggling, its communication function is greater than is its resistance to communication.

In Irma, Freud attacks the analyst, himself, his mother, father and colleagues for the strictness of his superego. This dream was important enough to be called by Freud his specimen dream, because it reflected a number of current conflicts: his possible impotence with his wife, reflecting his father's impotence and replacement by a half-brother in his mother's bed, his wife's pale and puffy condition resulting from her pregnancy with Anna (born December 3, 1895), his relationship with Fliess (their shared nasal conditions), Freud's guilt in referring Emma to Fliess, and in introducing Fleisch to cocaine addiction, and death.

A Casebook of Dreams

Modern principles of dream interpretation are now taken for granted at the modern training institutes, much as traditional analysts took for granted the method of free association developed by Freud. As we have hypothesized, dreams do seem to appear in analysis when the patient wants to tell us something. When a patient produces a dream revealing a conflict from the first two years of life, he is cooperating with the analyst (Spotnitz & Meadow, 1976). Patients frequently help us to understand something that

they either cannot verbalize in any other way or do not want to know themselves. To demonstrate these principles, the dream yield from the author's practice over a one-week period is reported. Some of these dreams were reported by patients, others by analysts in supervision. Limiting this discussion to dreams produced during a given week precluded the enjoyable exercise of bringing out favorite dreams collected over the years, but it is hoped that this limitation will permit a review of modern dream theory.

Certain differences were expected between patients, in that the more advanced in the analysis the patient is, the more freely one expects him to present preverbal memories in the manifest dream content. In this sample, cooperative patients in a positive state were able to produce painful and negative images from the beginnings of mental life regardless of the length of the analysis. From this we infer that communicative dreams may appear early in a working-through process, with its intermittent cooperative and resistant periods. It should be noted that in the case of psychotics, dreams regularly reveal more early material.

The Dreams

Usually an event in the patient's current life or transference aroused deep-seated longings or fears. Frequently the patient was coping with such issues as birth, marriage, illness, death or a fear in the analysis—such as one of separation or loss of caring.

A male patient produced a dream that unravelled the mystery of two long-standing symptoms which had been unresponsive to all interventions. The patient had a recurring fantasy that a prostitute was performing fellatio. He has been a chronic gambler, most recently taking bets and writing them down on slips of paper.

Freud (1900) said about this: "If a pathological idea of this sort can be traced back to the elements in the patient's mental life from which it originated, it simultaneously crumbles away and the patient is freed from it." (Vol. V, p. 100) Until this patient, whose symptoms bewildered me, reported the following dream, I was not entirely convinced of Freud's principle that unravelling pathological symptoms coincides with removing them. In the patient's recurrent fantasy, he is visiting a prostitute who performs fellatio

as she kneels before him. In his fantasy the patient distances himself from the fantasy by imagining he is watching the scene at a movie or on TV. The dream helped me to understand his obsession with prostitutes, and temporarily released the patient from his compulsion.

> It was early evening, around five; I was home with my mother. It was a tiny apartment, as the one I remember when I was very small. A kitchen in the center and a bedroom on either side. I was lying on the bed in the second bedroom. B., the musical director, came into the apartment.

Patient reports that he sang professionally as a child, and he would keep the slips listing dates and amounts each time he sang, and give them to his mother.

> B. was there to pay my mother. He tried to touch her . . . touch her sexually. I sensed this. I couldn't see or hear everything. I turned my head away, but I heard it. She was kind of laughing. She was saying things like, "Oh, B., not now. Stop it." But not all that seriously. He left soon after that. I was very embarrassed. I felt terrible. The humiliation.

Speaking of the feeling in the dream, the patient said, "I was so embarrassed, so ashamed. B. was an overweight pig. She was ugly but she looked good to him."

Bearing in mind the principle that all characters of the dream are representative of aspects of the self, we can infer that what was particularly humiliating for this patient was his own prostitution and humiliation. He remembered that B. withheld payments and let time go by until the amount he owed was meaningful enough to make a visit. These events, recalled from puberty, have always been part of his conscious memory, serving as a screen memory of an earlier period. What was forgotten was the connection between early feelings and the defense in his repetitive fantasy of the benevolent man who uses the prostitutes with compassion, not hatred. In this session he said, with dramatic emphasis, "What my mother did was different from what the prostitutes did. They are poor creatures unable to help themselves. But my mother didn't have to do anything. She could have said no. That money was *already earned*. She was being paid for *my* performance."

It is in the symbolic condensation of his fantasy of prostitutes

that the facts of the structuring of his character lie hidden. Unlike the scene in the dream where he turns his head away and only hears what is happening, in his fantasy of prostitutes he watches the action as a movie. The fantasy serves the purpose of turning back his head to see the visual imagery that accompanied what he sensed. By this fantasy he recreates himself in the mother he found disgusting, raising her to a noble creature who cannot help herself, identifying himself with her now also ennobled by *altruistic* motives. Through identification with the dream figure B., the dreamer remembers his own desire for visual knowledge and gratification denied to him when he refused to watch his mother and B. His current marital relationship reflects a fixation in the passive position. Early neglect led to guilt and both the object and self are forgiven over years of fantasy. After much analysis the dream reveals his rage.

The fantasy of the poor victimized prostitute who loves sex with him serves several other purposes. It recreates his humiliation as his mother belittles his earning capacity (he also is prostituted). In the thought, "She couldn't help her lot in life," he protects his mother from his rage. He attempts to escape from the passive role he reenacts with his wife by placing himself in the active role of voyeur, but it fails as he defends against seeing by distancing himself.

* * * *

Another dreamer fears pressure to move along in the analysis. A new patient predicted a relationship-destructive action would occur as an alternative to experiencing negative feelings for the analyst. Several dreams were used to tell the analyst something the patient did not want to know himself. One of the dreams helped the analyst understand something of which neither patient nor analyst had an awareness.

> There was no visual dream, just a lot of sensation. (This alerted the supervisee to a very early ego state.) I was in an enclosed place. I put my hand into an opening, like a cranny. I could feel the ridges. Then I was in a long narrow passageway, open at one end—I could feel myself being pressed.

The supervisee who recounted this dream reported that the patient felt anxious and concerned about what the dream meant.

When the patient asks for a dream interpretation, the analyst may provide an interpretation. In this dream, the patient was conflicted between the desire for rebirth and the feeling of being moved too fast in the analysis. When the patient asked for an interpretation, the analyst used a birth interpretation to explain the dream. When the analyst said simply, "It's a dream of being born," the patient seemed delighted and relieved. The supervisee reported that she has felt analogous relief and delight at being told something similar in her own analysis. She asked me why these interpretations are so extraordinarily liberating. The supervisee suggested that perhaps it has something to do with getting an explanation of the uncanny, even an uncanny explanation that reproduces one of the truly satisfying interactions small children have with their parents —reassuring explanations of the seemingly inexplicable.

The analyst withheld the transference interpretation that the patient felt pressure to move ahead, and that this feeling represented the analytic conflict about establishing a relationship in which the analyst (like earlier figures) might be too demanding.

* * * *

The birth dream is common among patients who have been in analysis for many years, and among patients earlier in treatment when they are dominated by a compulsive struggle between life and death drives not successfully fused. So is the death dream. Before reporting a dream, one patient said, "I feel much more in a life and death situation, aware of my mortality." I had treated this patient for many years.

> My wife and I are away on an island with another couple. We decide we want to go gliding, and each of us has his own airplane. There is no motor—you just glide along over the ocean with the beach behind you.

Current wishes about his wife get connected to an earlier conflict at birth, as the patient leaves the place where he has been "beached," the uterus, and glides over the ocean.

> It looks easy to land. But a terrible windstorm takes hold and I am moving down very fast towards the ocean. I see that under the water there are large pieces of rock (the birth canal). A boulder comes up out of the water—the water is very shallow. I unharness

> my seat belt; I'm getting ready to dive. The wind shifts and I don't crash. I'm carried back up and land gently. The other three people are also in their planes. The other man comes down very fast, crashes with his plane, and dies. My children come running, very delighted because B. and I are alive. They want to know what happened. The other woman fades out, disappears. There was much more to the dream. I can't remember now. I feel this is particularly revealing.

(Part of himself dies. Rebirth will leave aspects of himself behind, but also aspects of his relationship with his wife based on maternal transference. Thoughts of the sexual situation arouse the original conflict of birth.)

The terror of annihilation created in the crib and repeated in major relations through life may lead to dreams that tell us how the patient defends against these early fears.

* * * *

A patient whose father had died a few days earlier reported this dream:

> I saw my father running. I knew he had heart trouble. I knew it was dangerous. I called to him as he ran around a corner. I ran after him and into his apartment. He had disappeared off the face of the earth. The police were there but they couldn't explain it.

(Death is incomprehensible; so is separation.)

> Then I had a revelation; he had disappeared into me. I had his clothes on and I smelled like him.

In this dream, the object is both eliminated and incorporated. Separation is successfully dealt with through a primitive mechanism.

* * * *

In yet another death dream, the patient is beginning an analysis. A first dream usually reflects thoughts about analysis. The weekend after her first session, this woman dreamed what she called a Halloween death. Death is preferable to bringing into

awareness the horrors of her wishes. She revealed the wish to slip into death without living through life.

> It was morbid. I was the woman in the dream. A child was there. Very frightening. I was clutching death, wanting to get out, to go to sleep and not wake up. There were Halloween skeletons. I took their shawl and wrapped it around myself and the little girl, too. I knew it was the end, but I was happy. I didn't have to deal with all the darkness. I just died.

* * * *

Anxiety and fear of loss of control account for the creation of many dreams. Another patient, a writer by profession, has just begun a relationship with a woman. He reports a dream:

> I am a director on a stage and I'm introducing people, showing them how to be with one another.

(His profession is to create characters and action.)

> I stand back to observe the relationships (the observing ego.) I seem to be in control of everybody. It feels safe.

Safety lies in limiting the possibility of chance events, but the patient disapproves of his pathology. He says of the dream: "It's very negative. I do tend to be subtly manipulative."

* * * *

One psychic state dating back to early terror connected with dependency and helplessness is a feeling of being trapped or imprisoned in a relationship. A patient who had been withdrawn from feelings and blocked in her perceptions is beginning to express feelings of being trapped in relationships. In the analysis, as in marriage and family life, when conflicts are aroused this patient experiences loss of ego control. Through her dreams, the patient offers the analyst a danger signal that underlying this is the trap of her psychic state when feelings are aroused. When she feels like getting rid of the analyst, it is like an explosion. She keeps trying to "get out" but can never figure out how to get free.

> I was somewhere in a prison (that is, her family, the analysis, and her psychic state); not exactly, but some place which I wanted to get out of. I was like a revolutionary—not exactly, in that I didn't want to round up people and start a war. I just wanted to get out of this place. I was attaching little wires and things to other things in order to cause an explosion, and then in the explosion I would be free, but the thing was that it seemed that other people were going to die—like innocent children and people would be killed. (Conflict: unintentional damage if she escapes the prison.) Anyway, I was caught because whatever it was—I didn't make a connection. I was rounded up—the police came and got me. I put my arms around my son, felt a very loving feeling for him, and said that we would be together. When I woke I was very upset that I was being taken off and would never see him again. I wondered why it was my son and not my husband I was sad to be parting from.

It is wished that she could escape from an explosive psyche to find love.

* * * *

Analysis, like the past, is a prison with no escape from repetitive imagery. In the following dream, the dreamer is alone but there is an awareness that the premises (the psyche) are shared communally.

> I'm living in some kind of communal arrangement, in a house that seems to go on and on and on—like an endless railroad flat, come to think of it.

The dreamer wishes an integrated ego but does not experience this unity. The dream feeling of endlessness is reflected by a lengthy dream.

> Anyway, it's my turn to do the dishes. The room I'm in is very squalid—a bed, a sort of old washstand where people do the dishes. The room's very musty. The sink has wooden legs and seems to be connected to an old bed, and the drainboard is on another piece of furniture, and the drainboard seems to have some disgusting-looking stuff in the cutlery part, and it's my turn to do the dishes and I'm looking forward to it. I like to play with soapy

water. On the other hand, I'm disgusted by the stuff that is still in the drainboard.

She likes soap, hates dirt.

Also, other people are assuming that I feel resentful about having to do the dishes, so it spoils my fun.

Attacks on her defense cause resentment. The cleaning she resents is the effort to clean up her dreams. The communication in the transference: I have to produce these endless dreams dealing with disgusting stuff in order to satisfy my analyst.

Anyway, I start cleaning off the drain, making it ready, and there is one of those rubber mats under the drain. They get pretty disgusting, too. Anyway, I decide the best place to put all the stuff is on the bed. (The best way to deal with the analysis is for all the gook to be put into dreams, associations, because that's really closest to where the sink is, closest to the analytic material.)

But then I think it is really unconventional to drain your dishes on the bed, and it might make the bed wet and whoever slept on it that night might not really like that. I might be the one to sleep on it because I wasn't satisfied with the room I had, but then I realized that someone had been murdered in that bed just the night before and the mattress was probably soaked with blood and I didn't want to sleep in that bed anyway. (The analyst, a murderer.) You couldn't tell that because the bed was covered with clean linen but I know the mattress was soaked with blood. (Beneath the surface.) So then I go over to the sink and find two disgusting rusty old covers over sort of bottles or jars—the kind of things one sort of has around sinks, my mother has. It was calamine lotion in that thing, and it was all rusty. Oh, yes, and the grooves around the top where you screw on the cap were all encrusted with that gook, so I started to clean it off even though I don't need calamine lotion to do the job. And I don't want to have anything to do with these things—even touch them, but then I thought that this murder was done by an Eskimo (the analyst or the patient in disguise), and this calamine lotion had a label that it was a product of Eskimo lard—Eskiloo it was called. A shoe brand also called that, so I was actually destroying evidence.

(Evidence that would reveal who is the real murderer.)

* * * *

In this dream the patient uncovers important information, but since the police (analyst) ignore it, it cannot be important (Denial).

> And in fact, I think there is someone else in the room with me and I think the thing to do probably is to call the police, let them know about these two things I've gotten in my possession; then I think it's inconceivable. The police were here, they searched the whole room. Why did they leave these two bottles out, open like this, if they were important evidence? So, therefore, they are not important.

The patient is not responsible; it is the analyst who must find the evidence.

> But I still seem to be a little uncertain about it, and I still plan to follow . . . the right thing seems to be to follow procedure and call police, but it was a *pro forma* thing. I was sure it wasn't important.

A voice whispers to her to tell all.

> Meanwhile I take these two things into a back room, a sort of pantry, and that's even more squalid, more old, more disgusting and more messy than the room I've been in, so full of rusty junk that no one could ever find their way.

The deeper she probes, the more disgusting what is revealed.

> And there is another drying rack there with old lids and things on it, all rusty, and I still take this thing out—there's still some stuff in it, and I'm washing it out. I can't stop myself, and I say to myself, "Now you're really ruining it; it's no use whatever." If there's anything in there, *it's been washed already*.

By bringing out lengthy and numerous dreams this patient appears to follow her own instruction to tell all. The dream reveals that she is compulsively destroying the evidence.

> And I just added the calamine to the drying rack with all the other junk.

* * * *

Patients fear that the analysis will change them. A relatively new patient thinks of who she is and how she might change. She is alone in the dream:

> I'm in the old house that these new people are living in. I'm looking around and noticing all the new changes they have made, physical changes, since they moved in. It wasn't the major things that stuck in my mind. I wasn't happy that they had changed the whole structure of the house.

The patient stated, "I am afraid people are beginning to really see me at work. And my husband, if he knows, he'll leave me. The improvements weren't my choice. All these years I've always thought that this choice was my choice. I've always felt that 'Yes, he was right. These are the ways in whch I should change.' I know now I must change, but I'm not sure I will necessarily change in the ways he wants." (The new people in her are alien; not integrated into her concept of self. She is unhappy with structural changes acquired passively.) Responsibility for her new house is projected. This represents a transference complaint that is to be dealt with in the analysis.

* * * *

The fear of analysis and what it will reveal takes many forms. If the patient is overstimulated by the analysis, resistance to treatment may become an insurmountable obstacle. In the following dream, a patient who feels undeserving and unworthy of the analyst avoids these feelings with bravado hellos in the sessions and many other maneuvers to distance himself from feelings. He had talked for several months of leaving treatment. The state of his psyche is revealed in this dream, which also reveals the intensity of his feeling:

> I dreamed I was on my way to this harem, and the problem was it was located in a swamp and all kinds of natural disasters were befalling me—floods, earthquakes. My greatest concern was that my shoes wouldn't get muddy. (Imagine) I finally arrived and met a new girl I never saw before in any of my dreams. (This is the original object of all his dreams.) I said to her, "Look, you

> must realize I'm going to wake up very shortly, but don't worry; because when I fall back asleep again I know you'll still be here." What does it mean?

Because of the availability of other information regarding his wish to get away, the analyst responds to the patient's question, asking whether it was a termination dream. Did he want to leave and know that when he came back, the analyst would still be here? The patient continues his report of the dream.

> I am in a Victorian house, large porch around it, built up on piles because of the swamp around it; and when inside, instead of an interior, it turns into a whole little world of its own. In other words, I went through the door into a little room; then I went through another door and it was a street with buildings, all kinds of things going on. It didn't look real. Colorful, careful design. I wonder about the color schemes of this dream.

He says, "In dreams you can design the entire world because you represent some kind of authority. I feel I always want to please you, so you won't think, "What is this guy coming here and paying me for if he has nothing to say?"

* * * *

Some patients fear that without analysis they are doomed. One patient, whose father committed suicide, reported this dream:

> There is something wrong with you. You are sick or depressed. It's my job to cure you. I must be entertaining. I was doing it but it was a chore.

She said: "The second part was about my father."

> My father and I were walking up a hill together. To continue to be with him, I worried I would have to go to death with him. Then we were in a car and he was feeling my breasts with sex play. I was feeling sexual but blocking myself from feeling excited.

The patient presents her repetitions to the analyst: the past, her

current repetition and the repetition in the transference. Only in death will there be relief.

* * * *

The fear of growing up, with the new responsibilities of adulthood, motivates the following dream in which pressure from the patient's wife that they have a child has revived those feelings of psychic unfitness with which the patient entered treatment.

> My parents are in Europe on holiday. My wife and I are alone. Suddenly my parents are sitting behind me. My father is holding his jaw, like a toothache. I ask him how he is. He says, "Not too good. The doctor says it's probably cancer." I stand up and say, "Oh, no," feel a sense of pain, and I embrace him.

"Something in me realized I have no place inside me for a child until I don't have a father. I can't be a kid and have a kid. I'm feeling my own tentative entry into the world. Most of the time I feel swallowed—the fact that you're there no matter what you say. I can't feel like an adult or that I live with my wife. If I can get you to talk, I can magically recreate what I needed as a child. I can go backward into childhood or forward into fatherhood."

* * * *

The patient as a victim is reflected in the dreams of patients with early damage. One of my patients is a child of the Holocaust. In a dream segment, he produced two memories that reflect the transference feeling.

In the first reported memory he is four years old, in his hometown in Germany. Signs are posted everywhere, restraints, etc. "Jews are not allowed." He and a girl friend go to the park where there is a puppet show. They take two seats near the rear. The feeling he has during the show is mild terror. He does not belong there.

In a second segment he remembers his parents huddling around a radio, listening to broadcasts. They are not supposed to be listening. The feeling is the same—"We are doing wrong. We are the ones who are bad."

As with many of the other dreams, the patient relives the formation of self and other fields of the mind as they were being

structured. Through dreams and transference he tells us how he is stuck.

* * * *

The session in which this dream was reported opened with the patient admiring that the analyst knows how to indulge herself. This is a man who feels victimized if the analyst or others offer suggestions about his life. He would like to be like the analyst, but in a world of victim–victimizer his choice when he changes may be victimizer.

> We were taking a walk and I was telling you that I had been away from my wife for some time period. I was with this woman (the analyst) who was seducing me, and I refused to be seduced. I was telling you the story. In the dream you said, "Well, why didn't you go ahead and screw her!" That's all I remember of the dream.

I asked the patient why I encouraged him to indulge himself. He said that he hopes someday to be able to do things like I can and get away with them. I get away with murder (as the Germans did), but no one seems to suffer from it. He would like to be able to do these things, yet not destroy me, his wife or himself. The anger at his family for being victims runs deep, and the dream hints that others have what he desires—to be conscience-free to take what he wants.

Dream fragments are usually thought of as repetitive statements of a recurrent life problem in which no solution is offered, only the pain is repeated. In his dream, the patient never achieves. The problem is posed—how will he achieve pleasurable discharge —but there is no resolution. The phrase "That's all I remember" tells us the feeling of the dreamer that the dream is incomplete. The compulsion to repeat is a more primitive phenomena than wish fulfillment. Dreams in which the dreamer solves a conflict reflect the maturity of the dreamer. Repeating without solution represents a deeper regression.

In a similar dream fragment, a woman was sitting in a circle, sitting in the bottom of a pit. She didn't remember anything else. She said, "I remember waking up just feeling good." This woman is in group analysis with a group working on early problems. When analyzing preverbal problems, the group is either nonexis-

tent or experienced as a good or bad maternal figure from whom one wishes to receive nurturance and/or by whom one is deprived. When oedipal conflicts are reenacted, group members are viewed as siblings, and the leader as parent, usually the father.

* * * *

A supervisee reported a patient's recurring feeling that she is crazy. In the first few years of life when her father acted crazy, she felt crazy.

> I thought I had scratched my son's face in the middle of the night. I woke up thinking I had really done it, that I was crazy.

The dream and the fear of being crazy were her way of remembering, through reliving actual or imagined craziness from the past.

* * * *

Many patients produce dreams that provide gratification of their wishes followed by traces of conscience that have not been integrated into the self.

> "She" and I are together. I'm going to spank her for some reason. I take several hangers from the closet. The hook part seems to disappear, and I'm left with four gently curved and possibly padded things which form an old-fashioned-looking bunch (like a bunch of twigs). I bend her over the bathtub edge, but she slides down so I am striking her back instead of her buttocks. I change places with her and lift my buttocks properly (we are both undressed) and have her spank me instead. I have to urinate and I am leaking urine while I have an orgasm.
>
> Afterwards a man comes in and possibly remonstrates. I am feeling great remorse remembering that she is a lesbian and this experience won't help her. I am most disturbed to realize I cannot tell Dr. M. about this. She would be morally obligated to throw me out of treatment. I also think when I wake up that I can't tell her this dream.

* * * *

Dreams may express a wish for symbiosis and tell the analyst that negative feelings stand in the way. In the following dream, an increase of positive feeling developed following a discharge of negative feelings in previous discussions with the analyst.

> I'm dancing with a woman, not you (but I think it was) and she's the most remarkable dancer. The first impression I had when I went into her arms was that she was huge—my head only went up to her shoulders—and I said to myself, "How does her husband handle this?" (negative)
>
> And then as we began to dance to the music, she was so exquisitely in time with my rhythm that even the slightest hand pressure on her back got her to move in a certain way. (Elation, he's in control.) Then I did a little undulating thing and it was perfect; it was like harmony in motion.

In this dream happiness is having an analyst who moves to the patient's rhythms. The patient's associations describe a completely positive attitude to the analyst. She said, "The thought came to me today that it was really you; and the feeling that we're really in harmony was based on the recognition that you are really the only person who knows me—that as crazy as I can be, or as crazy as I am, you move with me. It's incredible; it's a wonderful result to have achieved with me. In the violent dream I had last week, I was killing someone, I was pressing something and severing the neck, and feeling no remorse, just pure pleasure and discharge of rage. It was not a defined figure. I guess your listening to it made me feel . . . okay." This is the patient's explanation of our perfect harmony.

* * * *

Although patients use their dreams to present preverbal conflicts, dreams are also a resistance. This theme was elaborated upon by Spotnitz (CMPS Lecture Series, 1975). When a patient uses dreams to resist, he may flood the analyst with dreams or produce complex dreams which disguise the message. One patient who fears self-discovery learns that I will read a dream paper. She floods the session with dreams and brings in a folder with more dreams. One possible meaning: she will crowd all my other pa-

tients out. The significance of her dreams to the current transference lies in their quantity, not the content, although the content reveals other areas of concern to her. As she puts it when describing her dreams, "The endless analysis demands endless disguises."

* * * *

In another patient's dream, the fear of death and the potential to murder are condensed in the wish to produce a baby. The dream fragment was associated with his wish that his sperm have mobility.

> I went to prison to take two prisoners away who have been released, I am feeling their happiness at being released and I'm glad I'm there to take them away.

He connects this segment to a repetitive dream in which he cannot go the distance:

> I'm taking a drive along a particular road in Georgia (Georgiana is his wife's name.) It is a road I've driven on thousands of times. Two boys are to sit in the back seat. They put their bags in the trunk, and I pull up to a gas station to fill up because it's going to be a long trip. Then when I fill the car up and turn it back on to drive away, I notice there is something wrong with the engine and I'm afraid to take too long a trip. Then the mechanic checks it out, or someone, and it's necessary to repair the car; so I can't take the trip.

The mechanic who is not helping him is the analyst. The analyst offers a transference interpretation of his current difficulties. Attempts to conceive and his many consultations with doctors on the potential of surgery are related to the failure of these specialists to get to the cause and cure. The long trip in Georgia is equated with the journey of the sperm along the road to fertilization. His fear of infertility and of the necessity for surgery, combines with earlier inadequacy feelings and is expressed in "Something is wrong with the engine." Is the analyst failing to get to the root of his difficulties?

The patient prefers meanings connected to archaic history rather than to the plight of this sperm. It's almost like an argument for reincarnation, he says, "like it happened and I don't remember

it, consciously, not like from my early life. It has adult symbols." He adds a wish to the next segment.

> I'm driving a car, and I can see a place, a terrain, I've never been to before, a place that has vast lawns, roads, driveways; and I always drive in a particular direction when I'm going somewhere. I stop on the way, and I feel anxiety. It's really like a reincarnation I'm feeling. (Creation of life.) Is it a dream so vividly defended against my past? I don't know, am I going crazy? It feels like something I'm not supposed to remember (or something I never experienced). There's a conflict over remembering this. Remembering it increases the tension, and I get a headache. Very strange that it seems not to have happened in actuality. It sounds psychotic, yet I feel rational in my thought processes. This pain that I have in my head while thinking of this—who knows, maybe this relates to a psychotic period in my life. Maybe the period when I was in the service. I was very anxious in the war. I went to sleep afraid every night, thinking I might be killed. I felt like an expendable feather, but I was supposed to be a tough guy—able to shoot to kill.

Procreation, prelife experience, merge thoughts of murder and death. The biological fear of death and death of his sperm represent different levels of experience. His associations of fertilization to shooting to kill represent an as yet unresolved connection between procreation and killing. This hostility relates to the connection with mother and her role in his incapacity.

* * * *

Destructive fantasies trouble patients, and sometimes they are frightened by a dream; the patient replaces a defense structure with destructive fantasy encapsulated in cartoon balloons.

> I'm wandering down a terrain like Scottish moors, to a beach. I'm lying somewhat drowsy, when I begin to get cartoon-like images of explosions. It was all my brain could think of. I got the idea to wake up, walk back up, and find the moors. I did, and got a series of psychotic images. I call them psychotic, then I realize I'm dreaming. I was dreaming a psychotic dream. I woke up trying to separate the dream within the dream. In the outer dream, I was thinking "I have to tell Dr. M." I woke up and felt it was a

nightmare, particularly the power and fantasies of destruction in the cartoon images.

* * * *

Conclusions

The above week of dreams helped the analyst to understand how early self-other interactions formed the structured mental apparatus, providing lifelong patterns of defense appropriate to the infantile phase of development. Patients dealing with difficult current life situations created dreams in which they relived their own birth or the terror of annihilation. When the analysis threatened closeness, there were dreams of: (a) maternal longing, (b) unity with the mother, and (c) fear of loss of self, terror and feelings of succumbing to the will of the other. When material threatening to the ego was aroused by the analysis, the patient alerted the analyst to his disturbed psychic state. In each case, a current event in the life or transference of the patient could be connected with an early unresolved conflict.

From this study we learned that a dream may free a patient from a symptom, clarify a resistance, or show how a primitive defense is used to cope with a rearoused infantile conflict. It may point up a transference conflict, or tell what the analyst is doing wrong. It may warn of an impending action in the analysis, of a potential abandonment of the treatment, or that the patient will be doomed if he loses the analyst.

Some dreams reveal unresolved struggles between life and death, or the lack of fusion of these innate tendencies. In one dream a patient revealed fear of digging up the dirt, another revealed fear of being tied down by analysis, of growing up, of going crazy; and others expressed fears of destructive impulsiveness. A patient may dream of fear of change, or avoid self-discovery by flooding the analyst with dreams. Patients depict themselves as victims, or as in control with power over events. To understand what motivates a patient's dreams, we may consider Freud's view of emotional conflict as it developed from the individual's unique experience of the family romance, or Jung's understanding of how archaic history is incorporated into the collective unconscious, or the biologist's insights into innate tenden-

cies, or the existentialist's insights into longings of the human race—any or all the wishes and impulses created before language developed.

Each of the dreams reported contained a transference feeling. A new patient predicted a relationship-destructive action as an alternative to experiencing negative feelings for the analyst. Several dreams were used to tell the analyst something the patient did not want to know himself, and one of the dreams helped the analyst understand something of which neither the patient nor the analyst had conscious awareness.

I try to consider a dream in the light of what I am working on with the patient; that is, the transference phenomena that lie behind current resistances. In any discussion of the dream with the patient, current resistances are joined. In analyzing Freud's dream, or a patient's dream, it is important to understand in what ways the transference relates to a narcissistic state. One attends first to residues of oral or anal aggression, insofar as they may lead to relationship-destructive resistances. The approach to different patients is basically the same.

When there is very little narcissism in the personality of the patient, the analyst may move quickly to interpersonal conflicts. When preverbal problems are being reenacted, the patient develops a narcissistic transference and experiences the analyst as a part of himself, part of a condensed self-early object, or as a rejected part of the mental structure. In more extreme cases, the patient experiences himself as alone in the universe.

A patient in a narcissistic state may not express any interest in the meaning of his dreams. If he does not, the analyst need not offer explanations. With narcissistic patients, it may be useful to say something nonstimulating about the dream as a means of controlling the patient's regression. The analyst's voice and words are powerful means of preventing further regression, when that is desirable. On the other hand, the dream material relevant to transference resistance can be discussed with the patient when that is desirable. Although frequently dreams do give up their secrets to the analyst, when the patient is in a pre-object phase they are not used to get at hidden meanings.

As the narcissistic patient moves to an oscillation between narcissistic and object transference states, detached reporting is replaced by more interaction with the analyst. When the patient feels an increase in the urge to ask questions, the meaning of dream material may be explored as it would be with a patient in a full

object transference. When the patient does not feel he is a separate person, his contacts with the analyst tend to be questions. "Is that the kind of dream you wanted to hear? Did I tell you something that helps you to understand me? Was that a good dream?" These attempts to be pleasing may reflect a fluctuating attitude towards self more than an awareness of a parental object. The feedback of the "yes" he seeks is a mirror of the "yes" he looks for within himself. However, the "yes" is meaningless if the negative image has not been worked through.

A patient may impress us with his skill in dream interpretation, or he may engage us in dialogue about the relation between the dream content and his emotional life. When a patient is interested in communication, he may reach out to the analyst through dreams while still presenting his conflicts in a disguised form.

Ella Sharpe (1937) reports the following dream of a patient:

> I was screaming in my dream and terrified, and then I went through with the scream by gradual stages, so modifying it, getting it into cadences and harmonizing them that when I woke I was singing a tune.

We know the theoretical bias of an analyst leads to selective attention. Such selectivity also is a function of the current resistance, both transference and countertransference. When the analyst is fully aware of feeling states chronically induced in him by a particular patient and understands how the induced state reflects that patient's history, he is in a position to understand symbolic communications and to use new insights provided by dreams to unravel the mystery.

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Book Reviews

INPATIENT GROUP PSYCHOTHERAPY. Irvin D. Yalom. New York: Basic Books, 1983. 350 pp.

Irvin Yalom, an outstanding theoretician of the group process has addressed this book to the group therapists on inpatient psychiatric wards. On the premise that the clinical setting of the contemporary psychiatric ward differs radically from conventional group psychotherapy, Yalom suggests the need for significant modification of traditional group therapy techniques and proposes a body of strategies and techniques appropriate to the exigencies of acute inpatient care.

The author visited 25 inpatient units in preparation for this work, interviewing staff and personally observing group sessions. This careful reconnaissance is reflected in his understanding of the multiple variables inherently operative in the inpatient setting. The "stark clinical facts of life" that the inpatient group therapist faces are:

1) Considerable patient turnover, with an average length of stay of from 1-3 weeks, with a new patient generally present at almost every group session.

2) Insufficient time for working through or termination.

3) Great heterogeneity of psychopathology.

4) All patients are in crisis and in acute discomfort or despair, and they strive for relief from these feelings rather than toward personal growth or self-understanding. Many patients are unmotivated and see no need for therapy.

5) Therapists frequently do not have time to prepare or screen patients.

6) Therapists frequently have no control over group composition.

7) Patients see the group therapist in other roles throughout the day on the ward.

8) There is little therapist stability since many have rotating schedules and may not be able to attend all group sessions.

9) There is little time for development of group cohesion or for members to learn to care for or trust one another. There is also insufficient time for the recognition.

10) A multiplicity of therapies is offered: psychotropic medication, individual and group therapy, ward meetings, activity, art, music and occupational therapies, family therapy and shock treatment. Administrative decisions made about one therapy may influence any or all of the others—to the detriment or enhancement of group therapy.

Yalom emphasizes the centrality of interpersonal learning and the group setting as a social microcosm in which each member inevitably reenacts his or her maladaptive patterns. The data which illuminate these patterns are present in the therapy group sessions, in *the here-and-now* group interaction. The *here-and-now* focus deemphasizes consideration of the patient's history and his or her current life structure. The author strongly advises against attempts in the group to solve the patient's outside problems—"an attempt that is always unsuccessful because the data are presented to the group by a demoralized, biased observer." The *here-and-now* approach is viewed as a two-level phenomenon—the first *experiencing* step and the second *understanding* one. Thus, the group must examine itself and study its own transactions. In activating and maintaining this approach, Yalom likens that role of the group therapist to that of a shepherd who is continually heading off strays—strays into outside material, into discussions of past events. Thus, if a member began with an abstract complaint such as "I am too easily intimidated," the group therapist would guide this into an interpersonal, *here-and-now* context by asking, "By whom in this group do you feel intimidated?"

The book contains an excellent section on bizarre and disruptive incidents which contribute to disequilibrium in the group. Recognizing that these may have a deeply unsettling effect on therapist and group, Yalom suggests that even the most convulsive group events can yield therapeutic dividends. This principle that all events of the group are to be used as grist for the therapeutic mill is illustrated by useful vignettes.

This reviewer found himself seriously questioning the author's stance on the expression of anger in the group. "Inpatient group

therapists must not make the error of concluding that, since many patients have problems in the sphere of anger, the therapist should find methods to help such patients 'get their anger out' and deal with it in therapy. The inpatient group therapist's aim must be rapid conflict resolution, not conflict evocation." Yalom's concern is that expressions of anger will be too disruptive to the group atmosphere. He indicates he wants only "young" anger, i.e., where it is in the incipient stage of irritation or annoyance.

This attitude runs counter to modern psychoanalytic theory and practice, and to the reviewer's years of experience in observing and supervising inpatient groups. He has repeatedly observed the salutary effects on depressed group members of the opportunity to verbalize their suppressed anger to therapists who convey that their egos can take it. "Dead" groups become vibrantly alive when therapists are able to channel aggression from members' egos onto themselves. Individual therapists then frequently report immediate therapeutic carryover in greater openness, progressive communication and measurably lessened depressive symptomatology. It is true that the inpatient group leader enhances the ego capacities of group members to tolerate direct aggression from each other. However, massive subgroup and group resistances of silence and avoidance are quickly resolved when a therapist investigates the basis for strong negative feelings amongst group members.

Yalom has made a valuable contribution to the development of a systematic approach to short-term inpatient group psychotherapy. His sensitivity to the complexities and nuances of the setting, his well-chosen clinical vignettes, and lucid style combine to make this a highly readable and instructive book for all clinicians.

Leslie Rosenthal

Reminiscences of a Viennese Psychoanalyst. Richard F. Sterba. Detroit: Wayne State University Press, 1982. 184 pp.

Although the author modestly asks the reader to consider this brief book not as an historical study but merely as an eyewitness report, the contribution it makes to psychoanalysis is significant. The book's main focus is on the years 1924–1938 in Vienna, during which Sterba became a psychoanalyst and involved himself deeply in the activities of the Viennese psychoanalytic community. Those years also coincide with the final and profoundly significant phase

in Freud's life and scientific productivity, as well as the last stage of the psychoanalytic movement in Vienna, birthplace and center of psychoanalysis until its dissolution by the Nazis in 1938.

Sterba writes: "My main goal is to make it possible for the reader to participate in the atmosphere, the spirit, and the ardent excitement that the direct or indirect contact with Freud stirred in our group." The author's goal is realized. Written in an easy narrative style, Sterba's account of his experiences, observations and personal opinions is marked by candor and spontaneity, and informed by an acute observing ego.

Richard Sterba was born in Vienna on May 6th, 1898, on the same day that Freud turned 42 years old. Like Freud, Sterba attended the Gymnasium, the elite institution for boys, where he acquired a strong grounding in the humanities. In 1916, while in military service in the First World War, he met Victor, the son of Alfred Adler, who introduced him to the writings of Freud, thus sparking his abiding interest in psychoanalysis.

In 1924, the year in which the Vienna Psychoanalytic Institute started functioning officially under the direction of Helene Deutsch, Sterba started his training analysis with Edward Hitschmann. His analysis, however, was not as decisive an influence on his training as was his work with Wilhelm Reich and Helene Deutsch. Sterba had attended Reich's biweekly seminars on technique, which after the establishment of the Institute became continuous case presentation seminars. Reich possessed an outstanding ability to detect all manifestations of resistance, and "unusual acuity in sensing hidden and disguised hostility." His contribution to the development of psychoanalytic technique was invaluable to the early analysts. His seminars were so useful that they were often attended by older analysts eager to learn. Helene Deutsch, who took over after Reich's departure in 1932, was not able to provide the technical guidance that her predecessor had. Nonetheless, she brought to her work an uncanny understanding of the patient's dynamics and unconscious communications which enabled her to prophesy future developments in a case. Of the seminar experience, Sterba writes: "I consider the continuous case seminar the most essential part of the training if it is conducted by an analyst with vast experience and supervisory talent."

It should be noted, however, that Hitschmann had not undergone a training analysis, in contrast to both Reich and Deutsch, who had been analyzed by Federn and Freud respectively.

The Vienna Psychoanalytic Society held three types of meet-

ings: 1) presentation of original papers, 2) brief communications, and 3) discussion of Freud's recent publications. It was at one of these meetings that Sterba presented a paper in 1929 that contained the seeds of his formulation of the concepts of "therapeutic ego split" and "therapeutic alliance," which were later incorporated into psychoanalytic theory.

But it was the meetings in which Freud's works were discussed that provided the greatest inspiration and made the deepest impact on Sterba. He writes: "The period of which I am speaking is one of the most revolutionary in Freud's own scientific development. Most remarkable was the radical change brought about by the recognition of aggression as a drive in its own right. It always amazes me how, late in his theoretical development, Freud acknowledged aggression as a drive equal to, if not of greater importance than, libido."

Sterba engages in an interesting analysis of the way in which Freud's own aggression was expressed. For example, Sterba notes that Freud enjoyed quoting from Heine "some of whose satirical, often nastily cynical remarks against authorities and contemporary writers Freud loved to quote, with noticeable delight." The same was true of the work of the writer and cartoonist Wilhelm Busch, whose sadistic characters appeared to amuse Freud greatly. Sterba concludes that "A strong inner defense against his own aggressive inclinations must have prevented him, I think, from recognising the importance of aggression in human psychology earlier than 1921 . . . This unwillingness to recognize the dynamic importance of the aggressive drive is particularly remarkable because many years earlier Alfred Adler had proclaimed aggression as an innate force in the human mind."

But some of Freud's followers had difficulty in accepting aggression as a separate drive, and preferred to continue thinking of aggression as a reaction to frustration. The same was true for Freud's concept of the death instinct, which Sterba tells us Freud treated more and more in his later years as part of his established theory, even though he had originally presented it in the nature of a far-reaching speculation.

The staunchest opponent of the new theory was Wilhelm Reich, whom Sterba describes as "vociferous" in defending the earlier theory. Although in his clinical work Reich was able to detect and deal successfully with resistances fueled by aggression, he refused to recognize it as a separate drive.

Sterba reviews in brief the profound changes wrought by

Freud's postulations in *Beyond the Pleasure Principle, The Ego and the Id* and *Inhibitions, Symptoms and Anxiety,* in the last of which Freud developed a new theory of anxiety. Sterba writes: "This theoretical reversal, the new structural model of mental anatomy, and the acknowledgment of aggression as a drive in its own right were three heavy impacts. They demanded fundamental changes in an analyst's theoretical thinking. These concepts profoundly increased our dynamic understanding while they brought about decisive changes in the therapeutic approach."

As we know, the changes referred to by Sterba are to this day the subject of research and controversy among psychoanalysts. Sterba also points out that Freud, prolific to the very end, continued to make contributions in his minor papers. For instance, in *Female Sexuality* Freud "acknowledged the fundamental importance for both sexes of the pre-Oedipal relation to the mother." In addition, it laid the groundwork for future research and formulations in the area of object relations.

Among the most interesting chapters in the book are those devoted to the meetings of the Vienna Psychoanalytic Society and to Freud. Early in 1928, Federn, then vice-president of the Society, announced that Freud was well enough to resume participating in the meetings from which he had been absent for some years, owing to his illness. Freud stipulated that attendance was to be limited to no more than 12 members. Held at Berggasse 19, these meetings, unlike the earlier ones at which Rank had taken minutes, were informal, and at Freud's directive no note-taking was allowed. Sterba, however, defied Freud, and whenever possible took notes during the proceedings, taking care not to be seen by Freud—a difficult undertaking in such a small group! Sterba quotes Freud as to how his surreptitious records should be viewed: "Remarks made in unpublished discussions establish no claims at all."

Freud's comments after a presentation by W. Reich on the therapeutic and prophylactic effects of a perfect orgasm, as well as on a child-rearing model that would prevent the development of the Oedipal conflict, stand out in particular. "We have to say that the Oedipus complex is not the specific cause of neurosis. Reich neglects the fact that there are many pregenital drive components that cannot possibly be discharged, even through the most perfect orgasm." Thus Freud left for posterity a reaffirmation of his drive theory as well as an unequivocal statement of his full acknowledgment of the preeminent importance of pre-Oedipal life.

By the author's own design, his descriptions of events and personalities of the period, especially of Freud, have primacy over autobiographical material. Yet, from the account of his life and development, we are able to appreciate Sterba's special gifts as analyst as well as his integrity as human being. A non-Jew among Jews, he unswervingly stood by Freud and his Jewish colleagues. Unwilling to compromise, he repudiated the Nazi regime and, at great personal loss and risk, left Vienna with his family in 1938, ultimately to settle in this country where he founded a psychoanalytic institute in Detroit.

Of Sterba's complete and loving commitment to psychoanalysis and its founder, it is best to let his own voice speak: "The reader will have become aware of the deep affection that ties me to the man to whose cause I have devoted my life's work." Sterba quotes Goethe to explain his profound emotional tie to Freud: "When confronted with the great superiority of another person, there is no other means of salvation but love."

Sara Sheftel

JUNGIAN ANALYSIS, Murray Stein, ed. New York: Brunner/Mazel, 1982. 445 pp.

In his preface to this enormously important book, its editor, Murray Stein, president and one of the guiding spirits of the recently founded C. G. Jung Institute of Chicago, writes:

> In the popular view . . . Jungian analysis still retains an esoteric aura, bearing the overtones of a cultic experience and a "mystical" approach to psychological life. . . . Persons who enter Jungian analysis are often surprised to find that it is analytically tough-minded and mostly devoid of cultic or mystical qualities, that it is not always supportive of lofty spiritual strivings, and that it is usually geared more toward mundane psychological conflicts than toward purely symbolic inward journeys.
>
> A major goal of this book is to spell out how Jungian analysts actually work, and how they understand what they are doing. As the reader will see, these accounts have the effect of distancing Jungian analysis from the mystical and occult traditions with which it has been too closely identified by misguided or misinformed lay persons and professionals, and of relating it to the

broad spectrum of modern psychotherapies and to other schools of psychodynamic thought and research.

It is perhaps a reflection of just how identified with the mystical and occult traditions Jungian analysis has actually been (and not only mistakenly perceived as being), that, while to the Jungian reader this text will seem a long step away from those traditions and towards the broad mainstream of psychological thought, to the professional at home in that mainstream I suspect it will persist in seeming quite mystical and occult. The distance that remains to be covered may be appreciated by considering the large number of Jungian analysts practicing today who think of the Jungian approach not primarily as a better kind of psychotherapy but as a spiritual path for our time.

In the hopes of closing that distance, *Jungian Analysis* sets for itself three related objectives, each of vital importance, it seems to me, to the future of Jung's approach as a pragmatic psychotherapy (as distinguished from its tendency to become a salvational scheme and community): first, to elucidate the essentials of Jungian practice; second, to demonstrate its practicality; third, to place it within a larger context of dynamic psychology.

Certain typical features of Jungian practice conform (in structure if not in content) to what is generally accepted in the clinical world as "psychotherapy," as distinct from "psychoanalysis": the use of chairs in a face-to-face position; rarely three or more sessions per week, and usually two or one; the avoidance of technical neutrality as a therapeutic stance (indeed, a rejection of it as largely anti-therapeutic, if not impossible as well); and a more active role of the therapist, including greater attention to the real relationship. But the specifics of a distinctly Jungian practice are very hard to pin down. Not infrequently, I have been asked by psychiatric and psychoanalytic colleagues, "Just what do Jungian analysts *do?*"

It is a stated aim of *Jungian Analysis* to provide an answer to this question. The book succeeds to a very impressive degree despite limitations imposed on it by history. It is a fact that many Jungians find awkward that the fundamental basis of analytic practice was established by Freud, and that certain of its psychological parameters as defined by Freud remain pertinent, even when that basis is modified (as in psychoanalytic psychotherapy). Because of Jung's ambivalent relationship to Freud, and unresolved parting from him, following generations of Jungian analysts have, by and large, failed effectively to integrate and utilize (or even consider

important) classical psychoanalytic methods. We have rejected, rather than allowed for organic alterations in, those methods. This is all the more striking in light of the fact that the stated psychological parameters of Jungian practice go by the Freudian names and label the same psychological phenomena. It is as if we had repressed and therefore skipped over a major traumatic milestone in our field's developmental history and, consistent with a consequently defensive application of our own (likewise consequently restricted) theory, are forced to take an exclusively non-developmental view—non-genetic, non-causal, non-reductive, "synthetic," in Jung's term, as opposed to the reductive term "analytic"—both of that history and of the psyche in general. This kind of approach to the psyche, a powerful current in Jung's own thought, may be seen in its purest and most influential form in the writings of James Hillman and his followers. Given their extraordinary influence on current Jungian thought, these are most notable in *Jungian Analysis* for their absence. This absence is appropriate, I feel, given the book's clinical and ecumenical aims, but the necessity to exclude them shows how far our field as a whole has to go to bridge the gap between practical psychotherapy and occultism, or a puerile fascination with "imagination."

Following Jung, however, I believe that we must assert both original and final cause, and that even though an integrated theory of the psyche is thereby rendered at least as yet unattainable, the resulting uncertainty does greater justice to the observable conditions of psychopathology than does a consistent but one-sided approach.

A therapeutic conundrum appears as soon as someone versed in the synthetic method begins to take reduction seriously. Given the ego's propensity for defense and the deeply discomfiting nature of most original causes (infantile conflicts) revealed by the reductive method, the use of synthesis can be, and I believe frequently is, used to ward off these painful truths about ourselves. Indeed, how is it possible at all, once one has acknowledged the nearly endless capacity for self-deception, to adopt a synthetic understanding free from the suspicion that it is not yet another more sophisticated deception? It seems to me that the only way of obtaining any assurance at all is by a prior thoroughgoing reductive analysis of the same material. This notion is implicit in Jung's assigning individuation to the second half of life, and is explicitly (if only partially) formulated in his *Two Essays in Analytical Psychology* (1953).

Joseph Henderson, in his introductory essay to *Jungian Analysis*, "Reflections on the History and Practice of Jungian Analysis," addresses the issue immediately.

> I soon realized that the Freud-Jung controversy was inhibiting the process of separation from, or repair of, my own parent images and, if allowed to go on, could become itself a kind of false parent.

Henderson's comments are pertinent to the Jungian movement as a whole. He continues:

> To save myself from introjecting their personal conflict, I began to study the history of the psychoanalytic movement, and Jung's deviation from it, from a cultural point of view. . . . I saw their relationship as the inevitable result of cultural forces at work behind the scenes, bringing these two great men together and then inevitably and, I think, meaningfully sending them on their separate ways.

Henderson has thereby dealt with the internal conflict between synthesis and reduction (and its personal consequences) not by allowing the introject to be worked through and its infantile elements integrated (reduced and "metabolized") but, in Jungian fashion, through synthesis and amplification. As my remarks above suggest, I believe that it is now time to deny ourselves the more comfortable feeling that Jung was an avatar of an advancing *Zeitgeist*, and rather come to terms with the implications of the "reductive" self-understanding from which he turned away.

Two essays on the transference ("Transference/Countertransference: A Jungian Perspective" by Ann Ulanov and "Countertransference/Transference" by Harriet Machtiger) take steps in this direction, the latter farther than the former. Both cite psychoanalysts whose theories are strikingly synthetic to reference the "Freudian" position: Klein, Kohut, Winnicott and Kernberg. Ulanov's and Machtiger's expositions of the Jungian approach, especially on the role of the archetype in transference, are lucid and cogent. But the intercalation with Freudian theory is somewhat looser, since the central psychoanalytic concepts relating to transference, as elaborated by Freud under the aegis of the structural hypothesis, and by later theorists such as Hartmann, Arlow,

Brenner, Eissler, A. Freud, and even Federn or Jacobson, to name a few, are not addressed.

Joe Wheelwright's little essay on termination is as witty and pithy as everything he says and writes. Non-Jungian readers will recognize in this essay much of what is truly therapeutic in the generally less formal Jungian approach. The question inevitably will be raised as to whether one simply has to be the author to use his approach. But then the greatest strength of Jung's ideas is in their emphasis on the genuine individuality of the therapist as the wellspring of therapeutic effect.

James Hall's longer piece on dream interpretation demonstrates what I think will generally be perceived as the strength of *Jungian Analysis*. It provides a clear and precise discussion of the method in a way which should make it easy for general readers to comprehend the rationale behind the Jungian approach.

The essay does share the character of the book as a whole: while strong on content, it nowhere discusses the process of dream interpretation, or how and where it might occur in therapy. It leaves the impression (to this reviewer, already familiar with the technique) that one simply asks for dreams whenever one wishes and then basically tells the dreamer what the dream is about.

Alex and Naomi Quenk's article on typology similarly reflects both the strengths and weaknesses of *Jungian Analysis*. They provide us with a readable, condensed description of Jung's typology with evocative examples. Further, their short section on "Typology and Couples" explicates what I feel to be one of the major strengths of Jung's schema: providing a rationale to be non-judgmental and non-reductive of another person's character, in settings where diagnosis and dissection would be inappropriate, e.g., in marriage. The weakness of the essay, and also, I believe, of the theory, lies in its avoidance of a hard look at how typology arises. Fairbairn (1940), for instance, recognized Jung's astuteness in characterizing an introverted personality type, but went on to demonstrate how such a type arises instead of assuming it to be *a priori*. Such reductive understandings are, of course, crucial to the psychotherapy of many individuals.

Two of the strongest essays come from analysts of the San Francisco Institute—not surprisingly since, more than anywhere else, in San Francisco Jungians compete on a comparable professional footing with the strongest non-Jungian psychotherapists. (The Mount Zion residency program, in its heyday one of the strongest in the country, was led by two analysts, one Freudian,

the other Jungian.) Katherine Bradway's essay on "Gender Identity and Gender Roles" demonstrates what the Jungian approach can add to this widespread controversy, without attempting to make a dogma of Jung's pioneering theories about this topic.

Donald F. Sandner's and John Beebe's paper on "Psychopathology and Analysis" is another excellent piece which demonstrates the relevance of Jung's theories to the kind of psychopathology which most well-trained practitioners will inevitably spend much of their time treating. They provide what will appear to the first-time reader of Jungian material as a new, striking, and in many instances compelling re-explanation of many psychopathological conditions. These explanations—like comparable psychoanalytic ones—are a return to the Bleulerian and *Einheitspsychologische* models: i.e., to a view of the normal psychic process as essentially unitary, with multiple possible divergences leading to the various pathologies. This kind of model stands in contrast to the earlier Kraeplinian and current DSM III models which are exclusively descriptive, presuming no common underlying psychic process subject to distortion, and which therefore lend themselves to the assumption that different symptom-syndromes represent distinct diseases. What the psychiatric reader of this essay will miss, however, is some acknowledgment of other analytic models (for instance Frosch, 1983) as well as recent advances in diagnosis. Many of the patients whom Beebe, following Perry, describes as "schizophrenic" would now almost certainly be considered bipolar. In England, they have long since been so diagnosed. On the other hand, if one adopts an *Einheitspsychologie* and chooses not to treat such conditions with medication, the label is of not much importance, being little more than an opinion about poor versus relatively good prognosis.

There is not the space to do justice to the many excellent essays contained in this volume. The book as a whole is a watershed for Jungian analysis, marking the end of its previous isolation and the beginning of what I hope will be a new period of creative ferment. Now that this step has been taken, I believe that the present, and coming, generations of contributors will find themselves, of necessity, integrating more and more of the psychotherapeutic world around them as they offer that world much of equal and heretofore unappreciated value.

For leading us in this first step, Murray Stein is to be congratulated.

Jeffery Satinover

FREUD ON SCHREBER: PSYCHOANALYTIC THEORY AND THE CRITICAL ACT. C. Barry Chabot. Amherst: University of Massachusetts Press, 1982. 173 pp.

This volume represents a sophisticated effort to demonstrate the relevance of literary criticism to the type of intervention that psychoanalysts use with patients. Chabot eschews the direct relevance of historical reconstruction to interpretation, insisting that historical chains are forever endless, one event always traceable to one before. He states that lives have an undeniable *coherence* and unity that can best be understood through the concept of personal identity, which should be applied to an understanding of current life relationships, including the transference. Freud's ideas about the homosexual origin of Schreber's paranoia is considered by Chabot to be secondary to an injured sense of identity, his "struggle to undo a wounded sense of worth, to soothe anguish at expectations left unfulfilled" (p. 143).

This sketchy summary does not do justice to Chabot's intricate philosophical and literary disquisitions. He recognizes that he is presenting merely one avenue of approach among many to Schreber. His concept of the unity of the coherent life identity is central to his own literary approach to the interpretation of the patient's conscious awareness. Chabot recognizes that dissonance and inconsistency of the human mind are equally relevant, although he does not explore this avenue to interpretation that leads more directly to the unconscious. Nevertheless, Chabot uses the concept of dissociation to describe Schreber's chaotically ambivalent relationship to his psychiatrist Flechsig (p. 112).

The major thrust of the volume, aside from these propositions, is Chabot's belief that literary people are better equipped than are psychoanalysts to apply interpretation to an analysand's free associations. They are so qualified, he says, through their training to deal with literary metaphor. Analysts, on the other hand, are equipped through their training in psychoanalytic theory. However, psychoanalysis should now turn to literary theory to help extend its realm.

This is a worthwhile contribution in certain respects. Certainly its emphasis upon a literary and textual analysis of the language a patient uses to communicate is valuable. However, Chabot does not attend to the influence of emotional factors upon the interpretive process. The analyst's own countertransference feelings are not even mentioned by Chabot, and interpretation is here con-

ceived as a purely intellectual process. In point of fact literary criticism, when it is first rate, relies heavily upon the subjective feelings induced in the critic, which are often specifically cited by him.

Further, from a clinical viewpoint the practicing analyst will find little that is directly helpful. Freud's theory of repressed homosexuality still seems more relevant to Schreber's bizarre delusions about being transformed into a woman and sexually abused by God than Chabot's ideas about Schreber's identity crisis and feelings of anguish. Freud was dealing with unconscious forces, whereas Chabot's emphasis upon the coherence of identity seems derivative and secondary. Although the psychoanalyst must deal directly with the analysand's conscious ego, his own guiding constructs should be rooted in the unconscious.

Literary criticism does have a vital contribution to make to both the theory and practice of psychoanalysis, but this book misses the mark despite its sophisticated awareness and sustained effort. Nevertheless, a continuing dialogue between analysts and literary critics is most stimulating and promising, and needs to be continued.

Murray H. Sherman

THE ASSAULT ON TRUTH: FREUD'S SUPPRESSION OF THE SEDUCTION THEORY. Jeffrey Moussaieff Masson. New York: Farrar, Strauss, Giroux, 1984. 308 pp.

While it is obvious why Freud's theoretical work should continue to dominate psychoanlytic discourse, the enduring influence of his private life is a more curious phenomenon. Both of his homes have been turned into museums. His dreams, his sexuality, his cigars—even his prosthesis—seem to hold endless fascination. He has become a permanent transference object. As the great single parent of the psychoanalytic movement, he is the authority with whom many analysts must come to terms, often in a very personal way. In studies of Freud's life and work the influence of the writer's personal feelings about Freud is sometimes striking, regardless of the quality of the intellectual work. Some writers seem intent on painting ever more idealized portraits of Freud. Others are determined to shatter the icons. It is difficult to escape the feeling that Jeffrey Moussaieff Masson's new book is an at-

tempt to shatter one particular icon—the image of Freud as the paragon of personal and scientific integrity.

Masson makes use of investigative research and ill-formed psychohistory in an attempt to prove that Freud abandoned the seduction theory because of a failure of personal courage. He claims that Freud's crucially important insight, the fantasy theory, was developed on a foundation of intellectual dishonesty. Although the book is presented as a historical study, it reads like a sustained attack on Freud's character. Masson never misses an opportunity to point out Freud's unkindness, insensitivity, or dishonesty.

In the course of preparing this indictment, Masson does uncover a good deal of interesting historical material. A large portion of the book is devoted to the case of Emma Eckstein, whom Freud was treating at the time of his intensely idealized relationship with Wilhelm Fliess. Fliess had developed a new nasal operation which he claimed would alleviate some of Eckstein's symptoms. Freud referred her to Fliess to undergo this experimental surgery. Not only was this operation unnecessary, based as it was on Fliess's bizarre theories of nasal sexuality, but Fliess performed it incompetently. He left a large piece of gauze in Eckstein's nose after finishing the procedure. Eckstein nearly died of the hemorrhaging and the infection that resulted from Fliess's treatment.

Masson's interpretation of the shift in Freud's thinking on the seduction theory is based almost entirely on Freud's behavior towards Fliess and Eckstein in the aftermath of this bungled operation. Masson quotes extensively from Freud's letters to Fliess on the subject. Most of the material that Masson presents was left out of the standard edition of Freud's letters to Fliess. Almost all of it, however, was published, in German and in English, in Max Schur's article "Some Additional 'Day Residues' of the Specimen Dream of Psychoanalysis" (pp. 45-85, *Psychoanalysis, A General Psychology*). Although Freud was clearly horrified when he first understood what had happened, his immediate reaction seems to have been to protect his friend. He wrote to Fliess informing him that "nobody is blaming you for anything, nor would I know why anybody should." Freud continued to reassure Fliess of his innocence in the months following the operation.

More important from Masson's perspective, Freud interpreted Eckstein's bleeding as being a purely hysterical symptom, unrelated to the trauma that had been inflicted upon her by Freud and Fliess. Nearly a year and a half after the operation he wrote, "Her

story is becoming even clearer; there is no doubt that her hemorrhages were due to wishes." It is uncertain from the context in which this passage is quoted whether Freud is referring to her incidents of childhood nose bleeding, or indeed to the hemorrhages which followed the operation. Nevertheless, Masson appears to be correct in asserting that Freud's use of interpretation in this instance was motivated, at least in part, by his wish to deny his own responsibility and to protect his relationship with Fliess. Max Schur has also suggested that these same wishes were expressed in "Irma's Injection."

The incident certainly reveals Freud in a most unflattering light. His interpretation of Eckstein's bleeding is a travesty of psychoanalytic thinking (though one must remember that the incident occurred before the theory and technique of psychoanalysis were fully developed and understood). His conduct flies in the face of the flawless image of Freud that has been so carefully cultivated in some psychoanalytic circles. As reprehensible as his conduct may have been, however, it is hardly unheard of for even an exceptional man to behave badly. Referring Eckstein to Fliess was arguably the most serious mistake Freud ever made. The letters suggest that he was not able to tolerate his rage and his guilt. He responded by blaming the victim and protecting himself. Such an error would not be an easy responsibility for anyone to accept. It is an example of a regrettable but all too common human weakness.

For Masson, however, this incident was to determine the future course of psychoanalysis. He claims that in denying the consequences of Fliess's surgery, Freud turned decisively away from reality. This somehow caused him to turn away from other unpleasant realities, including the reality of childhood seductions. Just as his rationalizations about Eckstein's "hysterical bleeding" served to protect himself and Fliess, so (for some reason not offered) he felt the need to protect the seducers and abusers of children. Schur also suggested that Eckstein was the patient who led Freud to develop his theory of the importance of childhood fantasies. Masson agrees, but goes further in claiming that the theory was invented as an aspect of Freud's attempt to avoid his own responsibility in the matter of her surgery—that a failure of personal courage, rather than any clinical insight, led Freud to develop the fantasy theory and to abandon the seduction theory.

After reading both Masson and Schur, one is left with the impression that Freud's work with Emma Eckstein was indeed a turning point in his development. Masson's interpretation of the

matter, however, is unconvincing. In spite of all of the "evidence" that Masson produces in defense of his idea, his conclusions are reached by flights of sophistry. There is simply no reason to suppose that Freud's wish to protect himself in this affair should lead him to identify himself with the child abusers of the world, or to abandon the seduction theory. Masson's argument is a web of facile analogies. Masson seems to think that the fantasy theory can be invalidated simply by exposing the conditions under which it was developed—as if the beauty of a sapphire is diminished by learning that it was found in the mud. Its power has since been proved over decades of clinical practice. Even if Freud had developed the fantasy theory exclusively for the reasons that Masson suggests, this would not serve as grounds for rejecting it. It now stands on its own merit.

Masson seems also to think that the two theories are mutually exclusive. Here, it is as if for the fantasy theory to be valid, no child can ever have been sexually abused. Freud, who never hesitated to exaggerate an argument in order to make a point, surely contributed thereby to this misunderstanding (which Masson shares with others). However, there is nothing inconsistent in asserting that both real life events (the seduction theory) and internal mental processes (the fantasy theory) can be formative elements in the development of personality.

This is in fact the procedure that Freud used throughout his clinical work. Although Freud constantly referred to his rejection of the seduction theory as the most important turning point in the development of this thought, his case histories reveal that he never underestimated the importance of real life events. Nor did he ever deny that childhood seductions actually took place. Forty years after the Eckstein incident, in *An Outline of Psychoanalysis,* Freud referred to real childhood seductions as one of a number of traumas to which children are sometimes exposed. Freud realized (what has since come to seem obvious) that understanding even a seemingly isolated symptom is a complicated matter, often requiring reference to both fantasy and reality. He developed the concept of overdetermination in order to convey the richness of this complexity. Regardless of his own tendency to rhetorical hyperbole, Freud's clinical investigations were never hampered by the sort of theoretical oversimplifications that Masson ascribes to him.

In the history of psychoanalytic thought there have been disagreements as to the relative importance of real experiences and fantasies in the development of psychopathology. Individual ana-

lysts, as well as certain schools, have sometimes adopted extreme positions. But no reading of any breadth at all in case materials could leave any doubt that a study of real life experiences is always considered to be an important part of psychoanalytic treatment. Compare, for example, clinical writings of so diverse a selection as Fenichel, Winnicott, Greenacre, Spotnitz. The idea that personality is a product of the inevitable interaction of psychic reality and the external environment is fundamental to the psychoanalytic perspective. Masson's claim that Freud, and psychoanalysis, turned away from the real world is simply untrue.

Masson's larger purpose is to attack certain psychoanalytic practices that he sees as the legacy of Freud's rejection of the seduction theory. Most peculiar is his claim that the fantasy theory has led psychoanalysts to see the cause of their patient's misery as a sort of "character defect," and that analysts deny the validity of their patient's experience. He claims that, in doing so, they repeat the abuse that their patients experienced as children. He admonishes analysts to return to reality. Should they prove unresponsive to his appeal, then "it is time for patients to stop subjecting themselves to needless repetition of their deepest and earliest sorrow."

One wonders where Masson, who has trained as a psychoanalyst, acquired the notion that such behavior constitutes standard psychoanalytic treatment. Masson is certainly justified in his indignation at such practices. It hardly needs to be pointed out, however, that such behavior represents serious theoretical and technical errors.

Masson asserts that psychoanalysis "has always been more interested in fantasy than in reality." Comments such as this, as well as the nature of his complaints about psychoanalytic practice, seem to be based on a disagreement over the importance of historical truth in psychotherapy. Freud, displaying his penchant for rhetorical oversimplification, commented that it makes no difference whether a specific event that a patient "remembers" (such as a seduction) actually took place. Masson seems to interpret this as an "assault on truth"—a denial of reality. The accurate account of factual events seems to be the only aspect of reality which Masson recognizes.

Historical truth is certainly important from the point of view of social reform and justice. The reality of the sexual abuse of children and the importance of working to eliminate it are not at issue. From the point of view of psychotherapeutic cure, however, it is difficult to see what such an emphasis on strict historical

truth offers to the patient. Black lung disease will not be prevented without recognizing the facts of life in a coal mine. But a miner who now suffers from black lung is not cured because the unhealthy conditions in the mine have been exposed, or even rectified. Similarly, the analytic patient is not helped by simply setting up a historical inquiry. What is necessary in both cases is to treat the disease.

Psychoanalysis conceptualizes mental illness as a problem of pathological defenses. Spotnitz has described defenses as the best possible adaptation that a patient was able to make to a traumatic situation. No value judgments are placed upon defenses. They are seen as a problem only insofar as they diminish the patient's capacity for a rich and fulfilling life.

It is correct that psychoanalysis frequently appears to be indifferent to strict historical truth. As therapy, it works by resolving resistances. The information that the analyst requires for resolving resistances is usually not the strict historical truth, but the psychological meaning that real experiences had for the patient. Masson seems to object to the idea that there is a difference between psychological reality and historical reality. However, it is a historical truth that individuals respond to very similar external situations in a wide variety of ways. Even in extremely brutal conditions we find that people exhibit a variety of more or less successful adaptations. The range of psychological responses to "objective real life" experiences is vast. The analyst must use his empathy to comprehend the wide array of responses to reality. Freud's point in rejecting the seduction theory was not to deny the importance of real occurrences, but to emphasize that life is lived, and must be understood, subjectively.

In a properly conducted psychoanalysis, historical truth is not rejected, but it is often overshadowed by the patient's subjective account of his or her life experience. Far from denying the validity of the patient's experiences, psychoanalysis works by taking all of the patient's experiences very seriously, regardless of whether they are memories, dreams, or fantasies. The truth that is relevant to psychoanalytic therapy grows out of the complex intersubjectivity of the patient's transference and the analyst's objective countertransference and intellectual understanding. In short: it is not that psychoanalysts are more interested in fantasies than in facts, but that they consider fantasies to be a rather important type of fact.

This is not an academic, epistemological dispute. The facts of

psychological reality, including fantasy or "distortions," are the information that enables the analyst to cure the patient. According to modern psychoanalytic theory, any condition which was psychologically provoked can be psychologically reversed by means of psychoanalytic therapy. An accurate understanding of historical reality has a role in psychoanalysis to the extent that it is needed to cure the patient. Clinical experience demonstrates that it is not enough. At certain points in the therapy, such an insistence on historical truth can actually be damaging. One shudders to think what effect a therapy based on Masson's views would have on, for example, a patient whose symptoms seems completely out of proportion to what he or she had "actually" experienced according to a therapist's assessment of historical evidence.

Indeed, there is an oddly pitiless quality to Masson's complaints about Freud and psychoanalysis. Though he may not have been the most perfect therapist ever, it was Freud who got the world to take the sufferings of neurotics seriously. His emphasis on the importance of fantasy explained why even people who did not experience "objective" traumas could be miserable. Such complaints were no longer rejected as "imaginary." His whole point was to broaden, not to limit, the scope of understanding of human unhappiness. It is remarkable that Masson has failed to recognize this historical truth.

Masson has failed to stir much real controversy; there is just too little of substance in his main argument for even an iconoclast to find a grip on. But he has attracted considerable attention. Janet Malcolm's new book *In the Freud Archives* (Alfred A. Knopf, 1984; originally two articles in *The New Yorker*) gives a fascinating account of the brouhaha his work created in the inner circles of the classical psychoanalytic community. Masson had been a rising star among researchers who tended to idolize Freud, and his attack on Freud unleashed waves of indignant rage from many orthodox analysts.

It is perhaps more attention than he deserves. Yet his work does raise questions that are central to psychoanalytic theory. He is not alone in reexamining the rejection of the seduction theory, or in discussing the role of objective truth in psychoanalysis. And furthermore he is surely right as a historian to protest the secrecy that has shrouded Freud's unpublished material. His work reminds us that there is still a lot to be clarified in the history of psychoanalysis.

Paul Geltner

VICTOR TAUSK'S SUICIDE. K. R. Eissler, M.D. New York: International Universities Press, Inc., 1983. 322 pp.

Readers familiar with the case of Victor Tausk will be particularly interested in this book, Dr. Eissler's second on the subject, which uncovers new material and thoroughly analyzes the psychopathology which motivated the brilliant young doctor to take his life.

On July 2, 1919 Victor Tausk, Freud's junior colleague, made at least one phone call to say that he was planning to be remarried in a day or so. The person he called knew that Tausk's fiancée was pregnant. He wrote two fairly routine letters and saw at least one patient. He spent the afternoon with his 17-year-old son Marius. They had a pleasant early supper together. In the evening he escorted Hilde Loewi, his fiancée, to a concert at which she performed as an accompanist. In the early hours of July 3rd, Dr. Tausk wrote a farewell letter to Freud and a detailed will. He then shot and hanged himself.

Very little appeared about Tausk in the literature until 1969 when Dr. Paul Roazen, a professor of political science at Harvard, wrote *Brother Animal: The Case of Freud and Tausk,* in which he depicts Freud as a cold, selfish tyrant who was jealous of Tausk's youth, brilliance, creativity and attractiveness. Roazen holds Freud responsible for Tausk's death.

Dr. Eissler, who received his psychoanalytic training in Vienna, and who enjoyed Anna Freud's confidence until her death, is committed to guarding and strengthening the intellectual legacy of Freud, as well as to protecting his good name. In an angry rebuttal to Roazen he wrote *Talent and Genius: The Fictitious Case of Tausk Contra Freud,* in which he accuses Roazen of literary sleight of hand, poor scholarship and wild speculation. Now, in his introduction to *Victor Tausk's Suicide,* he says that he wishes further to counter Roazen's insinuation that Freud was Tausk's murderer.

Victor Tausk was a dramatic and tragic figure. He came to Vienna in 1908 to join the psychoanalytic movement, encouraged to do so by Freud himself who had been impressed by a letter Tausk had sent him. He was 29 years old and anxious for a new career, but he carried with him heavy psychological baggage.

Eissler sees in Tausk's early relationship with his father (restless, tyrannical, adulterous, financially unreliable) the etiology of his later neurotic involvement with Freud. Victor was the oldest

of nine children and developed strong antipathy toward both his parents. His dislike for his father was open and manifested itself in a repetitious rebellion against authority, as well as a repetition-identification. He was restless, did not support his wife and two children and pursued other women before he was divorced. Victor's mother was a more sensitive person than the father, but Victor's feelings toward her were unusually full of rage. Eissler suggests that Tausk was tortured by her constant pregnancies. As an adult he attracted women easily but was never able to sustain a long-term love relationship. His wife was pregnant at the time of their wedding. The marriage produced two sons, but the couple divorced the year Tausk came to Vienna. Professionally, too, he was at sea. His first career had been in law, but he soon dropped it in favor of writing, which also failed to hold his interest. In 1907 he spent three weeks in a sanitarium for a nervous disorder. Eissler believes Tausk's letters at this time showed schizopherenic ideation.

Despite his travails, Tausk was a brilliant and charismatic man, and, in Freud's view, showed great promise as a psychoanalyst, both as theoretician and therapist. So great was his confidence in Tausk's potential that Freud, along with four other members of the Vienna Psychoanalytic Society, offered to finance a medical education for him. He accepted, entered medical school and was graduated in 1914. In 1909 he was elected to membership in the Vienna Psychoanalytic Society. Hence, his medical and psychoanalytic training were concurrent. Tausk's many penetrating comments are duly noted in the scrupulously kept notes of the Society's meetings. He wrote 28 psychoanalytic papers and became the only person in Vienna, besides Freud, to lecture on psychoanalysis. He continued to have love affairs but was impelled in all instances to break them off, in Eissler's view, very cruelly.

One facet of the neurotic nature of Tausk's cathexis to Freud showed itself in a strange way. He accused Freud of plagiarizing his ideas. Eissler maintains that Tausk was identifying with Freud and actually repeating what Freud said, as if the ideas were his own, and then claiming originality. Thus the charge of plagiarism was a manifestation of the negative transference. In this way Eissler counters Roazen's charge that Freud actually did plagiarize Tausk's ideas, and that Freud regarded Tausk as a formidable rival. Roazen sees Freud as a tyrant who would not allow his followers to grow. The price of his friendship was utter subservience. According to Roazen, Freud kept Tausk near him in order

to control him, even going so far as to insinuate himself into a love affair Tausk had with Lou Andreas-Salomé. According to Eissler this is nonsense. Freud was a caring person, he says, who tried to soothe rather than crush young Tausk, and keep him in his circle.

The advent of World War I interrupted all. Tausk served in the army from 1915 to 1918, mainly as chief physician in psychiatric wards. When he returned, he was faced with having to start a practice. All Vienna was in economic shambles and Tausk still hadn't paid back his medical school indebtedness. He turned to Freud for help, asking him to refer patients; Freud complied. His relationship with Freud had cooled somewhat but he still remained a member of the Vienna Psychoanalytic Society. Then Tausk asked to become Freud's analysand and was turned down. It is on this refusal that much of Roazen's argument hinges. It was, he says, a near-death sentence; the ultimate rejection by the all-powerful master. In Roazen's view, Freud sent Tausk to Helene Deutsch instead because she was at that time in training analysis with him. This would provide Freud a conduit to Tausk's feelings. In that way Freud could keep control of Tausk, again through a woman with whom he was deeply involved. In his rebuttal, Dr. Eissler points out that Freud could not possibly have taken Tausk into analysis because the negative transference was too great. Then again, through interviews with Helene Deutsch, he has ascertained that Freud tried to persuade Tausk to enter analysis with other senior analysts but that Tausk would accept no referral except the one to Helene Deutsch because, since he too knew she was in training with Freud, he planned to use her as a way of expressing his negative feelings to Freud. After several months, Tausk's analysis with Deutsch was terminated. She concluded that Tausk wanted to *be* Freud and thus distorted Freud's teachings into plagiarisms of his own ideas.

It was now the spring of 1919; Tausk turned 40 (a depressing event for him, says Eissler) and, true to his pattern, he began a new love affair, this time with a 24-year old patient, Hilde Loewi. Here Eissler introduces a dramatic piece of new information, a letter from Dr. Olga Knopf to Anna Freud, written in 1970. Dr. Knopf reveals that in May or June of 1919, Dr. Tausk and Hilde Loewi came to her seeking an abortion, but she was unable to induce miscarriage. It was Dr. Knopf that Tausk telephoned the day before his suicide to announce his imminent marriage.

Dr. Eissler combs through the events of July 2nd with the greatest of care: the phone call, the two letters (one to Freud, one

to Tausk's sister), the time spent with Marius, and the evening concert with Hilde. Apparently he gave no one a sign for alarm. Eissler then brings his analysis of Tausk's psychopathology to its ultimate point. Tausk had written that penile anesthesia during intercourse is a universal phenomenon. Eissler believes this was Tausk's personal experience and supposes that when Tausk took Hilde Loewi home after the concert that evening, he tried to have intercourse with her but was impotent. This was the *coup de grâce* for Tausk. He was 40 years old; he was haunted by the "father ghost"; he was being trapped into marriage for a second time by pregnancy. He saw his life as a failure and decided to end it. Both Eissler and Roazen mention that it was rumored Tausk castrated himself before committing suicide.

It is to Dr. Eissler's credit that he has included in his book a 22-page section of comments by Victor Tausk's son, Prof. Dr. Marius Tausk, who disagrees with much of Eissler's thesis. Indeed, these comments are as emphatic in tone as are Dr. Eissler's replies to Roazen.

The final chapter of *Victor Tausk's Suicide*, entitled "Comparisons and Historical Deliberations," is a discussion that includes studies of the lives of Otto Gross (another of Freud's disciples), Frank Wedekind (the writer), and Freud, as well as Tausk. Although interesting, this chapter is an anticlimactic ending.

Dr. Eissler's analysis of the life and death of Victor Tausk makes fascinating reading. One cannot escape being impressed with the exceedingly meticulous delineation of the evidence he is able to adduce from available documents of Tausk and Freud. We have here not only an intriguing psychological puzzle but also a model of psychoanalytic investigation.

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