THE WIDENING SCOPE OF INDICATIONS FOR PSYCHOANALYSIS

DISCUSSION

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To open the discussion on the two prepared papers of this Symposium is an honor which I accept not without hesitation. Dr. Hawkins has remarked very kindly that I am myself responsible for one well-known extension of psychoanalytic therapy; she has not mentioned the fact that I have had no hand in many others. This omission is due to certain principles which govern the selection of cases in the practice of a lay analyst, even in a country like Great Britain where authorities and public are extremely generous in their attitude to lay analysis. It is true that my clinical experience extends beyond the run of the common neuroses to character problems of all kinds, including those with severe ego deformities; to perversions, alcoholism, manifest homosexuality, etc.; but it stops short of the severe depressions, as described by Dr. Jacobson, or the prepsychotics and schizophrenics, mentioned by Dr. Stone, except where cases of this kind arrive with their disturbances well hidden under a neurotic aspect. You may find that this lack of first-hand experience in important directions detracts from the value of any remarks which I may have to offer.

On the other hand, the subject of analytic technique and its legitimate variations has been a fascinating one to me since the times when I, as a beginner, attempted to treat children; when I had occasion to watch Aichhorn adapt the orthodox technique to the treatment of delinquents; when I listened to Federn's descriptions of his variations of technique for psychotic cases, and to Rank's and Ferenczi's explanations of "active therapy"; and when I witnessed Wilhelm Reich's exciting and promising beginnings of so-called strict defense analysis, etc. Later, when I was teach-

ing, my interest was quickened by the attitude of some of our candidates who seemed to regard our classical technique as little more than the "habits" or "conventions" governing analysis, oblivious in many instances of their firm theoretical foundations. Since then I have nourished the secret ambition to write a really exhaustive, theoretically well-founded paper on the practical, technical aspects of psychoanalysis. Naturally, I feel envious that, in my place, Dr. Stone has made the attempt and has succeeded brilliantly in its execution.

In a recent lecture on psychoanalytic technique, so far unpublished, I set myself the task to classify the variations of analytic procedure according to their causes, dividing these into four groups. Dr. Stone says, that "any number and degree of parameters [i.e., variations of procedure] can be introduced where they are genuinely necessary to meet special conditions, so long as they are all directed to bringing about the ultimate purposes and processes of the analytic end requirements." I agree fully with Dr. Stone. On the other hand, by no means all the variations of technique, which we find in the analytic field today, owe their origin to special conditions in the cases under treatment. An equal, if not larger, number of them are occasioned, not by a change in the type of disorder treated, but by a change in the analyst's outlook and theoretical evaluation of familiar phenomena. The intimate interrelation between theory and practice in psychoanalysis is responsible for the fact that every development in theory results inevitably in a change of technique. To the measure in which classical psychoanalysis splits up into different schools of thought, the orthodox technique undergoes variations the value of which cannot be assessed except on the basis of the value of the theoretical innovations which have caused them. It seems important to me to separate off these innovations from the parameters (to use Dr. Eissler's term), which owe their origin to "the widening scope of the application of psychoanalysis."

There are, further, individual variations in dealing with material, which Dr. Stone acknowledges in passing. Years ago, in Vienna, we instituted an experimental technical seminar among colleagues of equal seniority, and equal theoretical background, treating cases with similar diagnoses and, therefore, supposedly

similar structure. We compared techniques and found in discussion—not only as Dr. Stone put it today—"that no two analysts would ever give precisely the same interpretations throughout an analysis," but more surprisingly still, that such uniformity of procedure was never kept up for more than a few days in the beginning of an analysis. After that, the handling of the material would cease to run parallel, each analyst giving precedence for interpretation to another piece or even layer. These differences in timing would influence the emergence of the next material and this, in turn, influence the trends of interpretation. Even though the final results might be the same, the roads leading there were widely divergent. So far as I know, no one has succeeded yet in investigating and finding the causes of these particular variations. They are determined, of course, not by the material, but by the trends of interest, intentions, shades of evaluation which are peculiar to every individual analyst. I do not suggest that they should be looked for among the phenomena of countertransference.

It is different with the fourth and last variation of technique which is determined by the patients' personalities and transferences and the analyst's individual counterreactions to them. Just as "no two analysts would ever give precisely the same interpretations," we find on closer examination that no two of a given analyst's patients are handled by him ever in precisely the same manner. With some patients we remain deadly serious, with others humor, or even jokes, may play a part; with some the terms in which interpretations are couched have to be literal ones, others find it easier to accept the same content when given in the form of similes and analogies; there are differences in the ways in which we receive and send off patients, and in the degree to which we permit a real relationship to the patient to coexist with the transferred, fantasied one; there is, even within the strictness of the analytic setting, a varying amount of ease felt by analyst and patient. These wholly unintended and unplanned variations in our responses are imposed on us, I believe, not so much by the patients' neuroses but by the individual nuances of their personalities which may escape unobserved otherwise. If we become aware of these often minute variations in our own behavior and reactions, and cease to treat them as unimportant chance occur-

rences, their observation and scrutiny leads us directly to important findings. In the personal pressure which the patient exerts on us in this manner, he betrays the subtleties of his healthy personality, the degree of maturity reached by his ego, his capacity to sublimate, his intellectual gifts, and his ability to view his conflicts at least momentarily in an objective manner. In the variations of the analyst's "acting out" in technical behavior, we may, therefore, find new clues for the systematic study of character structures and personalities. Efforts of this type serve to deepen and intensify our work rather than to extend its scope.

This brings me to the one and only point where I find myself in disagreement with Dr. Stone. In concluding his paper, Dr. Stone calls psychoanalysis "the most powerful of all psychotherapeutic instruments" and expresses the opinion that "it is basically a greater error to use it for mild or incipient or reactive illnesses than for serious illnesses." Although I appreciate the weight of his arguments, I do not share the conclusions drawn from them. For years now, our most experienced and finest analysts have concentrated their efforts on opening up new fields for the application of analysis by making the psychotic disorders, the severe depressions, the borderline cases, addictions, perversions, delinquency, etc., amenable to treatment. I have no wish to underestimate the resulting benefits to patients, nor the resulting considerable gains to analysis as a therapy and science. But I regret sometimes that so much interest and effort has been withdrawn from the hysteric, phobic and compulsive disorders, leaving their treatment to the beginners or the less knowledgeable and adventurous analytic practitioners. If all the skill, knowledge and pioneering effort which was spent on widening the scope of application of psychoanalysis had been employed instead on intensifying and improving our technique in the original field, I cannot help but feel that, by now, we would find the treatment of the common neuroses child's play, instead of struggling with their technical problems as we have continued to do. How do analysts decide if they are given the choice between returning to health half a dozen young people with good prospects in life but disturbed in their enjoyment and efficiency by comparatively mild neuroses, or to devote the same time, trouble and effort to one single borderline

case, who may or may not be saved from spending the rest of his life in an institution? Personally, I can feel the pull in both directions, perhaps with a bias toward the former task; as a body, the Psychoanalytic Association has inclined in recent years toward the latter. Let us hope that the future analysts, who occupy our Training Institutes now as candidates, will be numerous enough to spread their energies over both fields.

I turn next to the problems of transference, discussed by both former speakers. Dr. Stone has enumerated many types of transference which raise special problems for the analyst, such as the primitive overwhelming transferences of the narcissistic disturbances; the insatiable demands of the oral types; the need to control and tyrannize the analyst, etc. He mentioned also the dreaded confusion in the patient's mind between the images of analyst and patient, as I have described it elsewhere in individuals who ward off *Hörigkeit,* i.e., complete emotional surrender, to the analyst. Dr. Jacobson's lucid descriptions of variations of transference in severe depressions I found especially helpful and instructive.

That Dr. Stone expresses doubts regarding the so-called "narcissistic incapacity for transference" leads me to mention another type of case where the difficulty of establishing full transference relations does not originate from narcissistic withdrawal caused by regression, but from certain basic defects in emotional development which date back to the patients' earliest years. I refer here to individuals whose relationship to their mothers was interrupted traumatically during their first year of life, or soon after, either by the death or removal of the mother, or by the disruption of the whole family, the child being cared for afterwards by repeatedly changing mother substitutes or in institutions. In London, we had the opportunity of analyzing emotional deviations of this kind in children and adolescents who were rescued from concentration camps. The degree of their abnormality depends, naturally, on the specific age when they lost their object ties. Where this happened before they had reached the stage of object constancy, adult people play for them a need-satisfying role only. They are important as protectors, as the suppliers of food and clothing, at best as sources of pleasure; but they are not love objects in the proper (object-libidinal) sense of the word. Relations with the

environment are usually shallow, subject to quick changes and promiscuousness. In analyses of such patients, we find that there is no hidden fund of archaic object love or hate on which the transference can draw. Relations to the analyst remain superficial and insecure, built on the only available pattern of relationships; since libido has never been concentrated fully on any one object, the concentration of material in a transference neurosis does not seem to come about.

The technical problems which face the analyst here are obvious ones. We all agree with Dr. Stone's statement that "the mobilization of the transference neurosis holds a central place" in analysis and, equally important, that "an adequate positive transference is necessary even to the *acceptance* of . . . . interpretations." Transference to the analyst as a need-satisfying object does not lend itself to either of these purposes; cathexis is withdrawn from the therapist and placed elsewhere whenever interpretations are painful and resistances increase, thus continually interrupting the formation of a transference neurosis. On the other hand, the intimacy of the analytic setting is well suited to reproduce—or where necessary to produce for the first time—the intimacy of the mother-child relationship. The technical question which arises here approximates the one concerning the psychotic patient who has been helped toward object cathexis by his analyst. Has the analyst disqualified himself automatically from continuing the treatment by using deviations in technique while ministering to the patient's object needs? This is a question raised by Dr. Eissler. Or, obversely, to quote Dr. Stone, "Is more lost by a change of therapist than is gained by an uncontaminated transference?" If the patient succeeds in establishing a more mature relationship to the analyst, will the change of therapist not repeat the traumatic separation from the mother, with renewed disastrous results for the newly won capacity for object love?

When we were reading and discussing Dr. Eissler's paper on technique in London, one of the cases in our Hampstead Clinic supplied us with a striking illustration of his views on the close connection between variations of technique and variations in the patient's ego structure. In this instance it was the young patient herself who suggested the parameter to her analyst in the context

of her free associations. The patient in question was an adolescent girl, victim of the Nazi regime, who had been smuggled out of a Polish ghetto as an infant and, from then onward, had been handed on from person to person in an endless series of "rescues," from one station in life to another, always cutting all her ties, including those to her possessions. There was no single figure, or even toy or other material object in her life which dated back to her past. There were, before the treatment, also no memories or cover memories. (Incidentally, this raises the interesting question how far our childhood memories are usually structured and kept alive by their intimate connection with the image of cathected and stable love objects.)

After several months of struggles in the treatment during which relations to the analyst went up and down, wavered, threatened to dissolve, to peter out, to extend to other figures in the environment in turn, the girl said to the therapist: "You analyze me all wrong. I know what you should do: you should be with me the whole day because I am a completely different person when I am here with you, when I am in school, and when I am home with my foster family. How can you know me if you do not see me in all these places? There is not one me, there are three."

It struck me that here, disguised as a piece of "technical advice," we were offered some insight into the basic deficiencies of her ego structure. There had been, in her past, no opportunity to introject any one object sufficiently to build up inner harmony and synthesis under the guidance of a higher agency, acting as a unifying superego. Her personality shifted, following the promiscuity of her relationships. She was well able to adapt herself to the varying environments in which her life was spent, but in none of these relationships could she build up a real feeling of self, or correlate the self experienced in one setting with those of another setting. What she asked the therapist to do was, as it were, to offer herself in the flesh as the image of a steady, ever-present object, suitable for internalization, so that the patient's personality could be regrouped and unified around this image. Then, and only then, the girl felt, would there be a stable and truly individual center to her personality which she could transfer and offer for analysis. To carry out a plan of this kind resembles the initial periods of psycho-

therapy which Dr. Knight proposes as necessary for psychotic cases. Again, we are faced with the technical question whether such preparatory assistance, if undertaken in all earnest, would be compatible with later analytic work.

It seems possible to me that our concept of incapacity for transference on narcissistic grounds has detracted our attention from further instances where, for other reasons, no or not sufficient object love is available for the purposes of analysis. I have in mind here patients of an altogether different type and background from the one described last. In these cases, the relationship to an existing mother failed early in life, with a severe ego distortion taking its place soon after. I had occasion to observe and analyze these phenomena in two young girls in their twenties who came to me with a diagnosis of severe ego deformities which had led to complete failure in their love life and their studies.

Patient Nr. 1 came from a highly irregular, intellectual family, her father being known as an eccentric and pervert, her mother as hopelessly promiscuous and addicted to alcohol. The parents were divorced, and both had remarried several times. The child was made a ward of the court, but remained in contact with both parents who made no secret to her of their sexual and other abnormalities. The young girl herself was attractive and intellectually brilliant, but completely unstable. She was promiscuous to the degree of not remembering either the names or the numbers of her lovers, and she lived in a whirlwind of changing plans, attempts at either intellectual or artistic careers, in constant uncertainty of the future, with debts, emotional upheavals with her friends, etc. Her human relationships were governed by passionate desire for any partner who refused her, with this attitude changing to contempt and utter rejection of him as soon as she could feel accepted. This was the one and only pattern of object relationship available for transference onto the analyst, and it had brought several attempts at treatment to an abrupt end. Here too, she desired the analysis passionately while no vacancy was available with the analyst of her choice, to reject it completely after she had been taken into treatment. She spent a short year with me during which I gained the impression that her acting out inside and outside of the analysis represented less an identification with the

abnormal behavior of her parents than with that of their respective partners whom she considered worthless for objective as well as for subjective reasons. Her erratic behavior seemed addressed to the mother especially and to express, as it were, the plea: "I am as bad and worthless as the drunkards, the homosexuals, the good-for-nothings with whom you associate. If you want to love such people, you might as well love me." True to her usual pattern she seemed to reject during treatment not only my person but also all the interpretations given by me. It was all the more surprising that, soon after leaving me and England, she married, became pregnant, had a baby, and told me the news on the very day of the birth over a long-distance telephone. Evidently, more had happened in the transference than I had been able to discern.

I began to see a little more light after treating a second, not dissimilar case. Patient Nr. 2 came from divorced parents too, her abnormalities centered around a deeply dissatisfying mother relationship. Her mother, whom she feared, was gifted, masculine, dissatisfied in her marriage, successful in an artistic profession, and had spent much time away from her children, fostering the careers of young artists. After a series of unsuccessful attempts to keep the family together, the child developed hostile reactions and unsatisfactory character traits with severe inhibition of work. There was one condition only under which she continued to react positively. She needed only to enter a studio to be transformed in her feelings from a lonely, unloved person to one who glowed with the secret satisfaction of being a member in the warm and sympathetic atmosphere of a close-knit community. Since she had no artistic gifts herself, this led nowhere so far as accomplishments and sublimations were concerned; on the contrary, her craving for this particular atmosphere rendered her unfit for other forms of life. What emerged in the analysis was that her passionate desire to join the "artists" had taken the place of her object relationship to the mother as well as to other people. In fact, she did not love artists. She loved being with the objects of her mother's concern; the atmosphere of the studio replaced that of a nursery, where she could feel loved, cherished, appreciated. The development of her ego had been placed wholly in the service of wooing the mother in the disguise of one of her imagined objects.

What troubled me in both cases was their inability to produce a transference neurosis, at least during the first year of treatment. Patient Nr. 1 seemed to transfer merely her instability, promiscuity and rejection of objects. Patient Nr. 2 went one step further: though apparently unattached to me, she developed a heightened attention for every detail of the analytic setting. Unreliable and forgetful, as she was in other matters, she had an excessive memory for every one of my words and sentences, for every arrangement concerning the sessions, the analytic rules, the other patients, etc. She seemed ready to replace at least some of her passion for the artistic atmosphere by a similar passion for the analytic one. But this devotion did not extend to my person; it avoided it; what should have been an object tie had been turned into an ego interest. Obviously, there are important differences between such a transferred ego distortion and a transference neurosis.

On the other hand, such identifications not with the mother herself but with her supposed or real love objects are familiar enough as occurrences. We find often that the children of doctors, dentists, analysts, will act ill, or in pain, or sad, to draw their parents' interest and care away from the legitimate patients; the children of policemen and of workers with dissocial individuals will often develop dissocial behavior for the same reasons. The most striking, pathological, instance of this kind has been reported recently by Dr. Alice Weiss-Stadthagen from Israel in the case history of a severe borderline patient of latency age, a study which we hope to publish soon.

This patient, a little girl, had grown up in the Children's House of one of the *Kvutzahs* (modern agricultural communities) in Israel where her parents were members. The mother worked in the stable, tending the cows and the child developed very early an excessive identification with the animals under her mother's care. This went so far that she actually gave up her human interests, abilities and behavior, and acted, walked and lived as a cow. Her relationship to the mother deteriorated and she showed little or no interest in other people; the tie to the mother remained fixed in the wholly pathological form of her imitation of and identification with the animals.

Here, as in the cases mentioned before, the analytic task consists

obviously in the undoing of the ego distortion and its retransformation into the object relationship from which it is derived.

I turn next to what Dr. Jacobson describes as the "highly illusory, magic quality" of the patients' transference feelings or what Dr. Stone calls the patients' "magical expectations and demands," their need for the therapist's being "omnipotent, omniscient, God-like." Such transference attitudes are known to be dangerous to the analysis where they remain unrecognized and uninterpreted. What interests me specially is the fact that they do remain so quite often and for considerable periods, at any rate more often than most other, more turbulent and less well-hidden transference reactions. For example, for the highly obsessional patient the analyst's omnipotence is a fact which is so obvious that it need not be commented on; it is simply accepted and taken for granted without further question. Since for the patient this omnipotence "goes without saying," it may escape the analyst's attention, sometimes until something happens in the environment to overthrow the established safety of the analytic setting and causes the analyst to "lose face."

Those colleagues who come from Nazi countries, as I do, will remember how this "magical" transference relationship of certain patients dropped to zero when Hitler seized power. Being ourselves victims of the regime had rendered us unfit for the role of powerful, God-like beings which they had cast for us. Outbreaks of severe and intolerable anxiety on the patients' part under such conditions testified to their urgent need for the upkeep of this particular transference defense.

I experienced two further, amusing as well as instructive instances of this kind during the war years. In the first year of the war I began the analysis of a highly intelligent, severe neurotic who, although himself not British-born, was in public service. Since this was the period when suspicion of spy activities was at its height, and since I myself was classed among the "enemy aliens," I wondered why his free associations never alluded to the possible adverse consequences which might arise for him under the Secrecy Act if it was discovered that he was in analysis with me. Finally, I referred myself to the omission. He replied airily: "Oh, yes, I have thought of that quite often. But if it is found out, you can always

set it right with the Governmentl" Another obsessional patient of mine reacted similarly in the London Blitz. He continued his attendance, undisturbed by the bombing and resisted all temptations to leave London until one night, when a bomb was dropped at the entrance to my street. This shattered not only the house on which it fell but also his belief in my omnipotence. After an outbreak of uncontrollable anxiety with hostile reactions against me for having disappointed him, he interrupted his analysis for the duration of the war.

Examples of this type are revealing, although hurtful to the analyst's professional pride. I cannot help feeling that, without this technical interference from outside, I might have analyzed both patients for a long time without realizing that, in their eyes, I controlled the British Government as well as Hitler's war machine. It makes me wonder just how often, without such help, patients' magical beliefs in us remain unrevealed.

Further, I refer briefly to Dr. Stone's remarks concerning the "real personal relationship" between analyst and patient versus the "true transference reactions." To make such a distinction coincides with ideas which I have always held on this subject. Many analysts express the opinion that the patient's transference, i.e., his fantasied relationship to the analyst, is strongest when he enters the treatment, and has to be worked through gradually through interpretation until, at the very end of treatment, a real relationship can come to the surface. This may be true for psychotic and borderline cases; for the common neurotic case the reverse order seems to me to be the rule. We see the patient enter into analysis with a reality attitude to the analyst; then the transference gains momentum until it reaches its peak in the full-blown transference neurosis which has to be worked off analytically until the figure of the analyst emerges again, reduced to its true status. But—and this seems important to me—so far as the patient has a healthy part of his personality, his real relationship to the analyst is never wholly submerged. With due respect for the necessary strictest handling and interpretation of the transference, I feel still that we should leave room somewhere for the realization that analyst and patient are also two real people, of equal adult status, in a real personal relationship to each other. I wonder whether our—

at times complete—neglect of this side of the matter is not responsible for some of the hostile reactions which we get from our patients and which we are apt to ascribe to "true transference" only. But these are technically subversive thoughts and ought to be "handled with care."

I turn next to Dr. Stone's point that "the decisive factor is the (analyst's) ability to stand the emotional strains of the powerful tormented and tormenting transference," a remark which I illustrate from my experience with a particular patient whose transference I, as well as his former analysts, found almost intolerable. This patient had a "good" and a "bad" side to his life, representing his anal and phallic strivings which claimed his attention alternatively. The phallic tendencies had been projected onto other men who became his official, treasured, homosexual partners, while the anal tendencies were projected onto secret, despised objects, contact with whom he avoided phobically and with the help of a complicated obsessional system.

His greatest wish was to merge with the phallic object; his greatest fear was to be forced into unwilling union with the anal object. In the first instance he felt raised to the status of a glamorous male, in the second instance he felt dragged down to the depth of anal passivity, dirt, depression, loss of personality. This complicated state of affairs was revealed in the transference where the analyst had to play both, the phallic as well as the anal role. So far as the analyst stood for the anal partners, the patient had to defend himself against contact with him by refusing to co-operate; so far as the analyst symbolized the phallic partners, i.e., in the last resort the penis, the patient had to cling to the analysis to avoid self-castration. Under these circumstances to carry out the analysis became as frightening for the patient as the idea to give it up.

In this particular instance it could be demonstrated clearly that the specific torment which the patient experienced in the transference was identical with the most tormenting element of his neurosis, namely his inability to decide between two equally desired and equally dreaded instinctual urges. I believe that the specifically tormenting element for the analysts of this patient lay in the quick succession in which they had to fulfill the role of the

desired glamorous and the dreaded dirty partner with whom contact was sought and avoided almost simultaneously.

And now, briefly, a last addition to these discussion remarks. There is, I believe, a similarity between the "good" and the "bad" side of the last-named obsessional patient's transference and the "good" and "bad" side of the book produced by Dr. Jacobson's depressive patient. Dr. Jacobson describes how this book which had become a "devouring, obsessional interest" of her patient, was "on the one hand the one great goal of his life; on the other hand, a monster which tortures him day and night with depression and anxieties." Within the framework of Dr. Jacobson's interpretation this means to me also that the book, during the act of writing, symbolizes a phallic erection; once produced it is no more than a piece of anal dirt.

By describing what she calls her "deliberate supporting counter-attitude," Dr. Jacobson offers a further instructive example of a parameter for the treatment of severe depressives. To "share" in the transference the patient's belief in the "goodness" of his book, serves here to reinforce his hopeful phallic strivings against the impact of his depressive archaic attitudes. But the same measure, if applied for example to my severe obsessional, would prove useless, or even dangerous. No doubt, he would revolt with hostility against the analyst's singling out for "sharing" (i.e., for approval) one side of his strivings only. His ambivalence would force him to react to the implied condemnation of the other side by throwing his own weight wholeheartedly in that direction.

I have reached the end of my points, having taken up more time already than should be allowed to any single contributor to a Symposium. To return to my beginnings when the organizers of this Symposium suggested "THE WIDENING SCOPE OF THE APPLICATION OF PSYCHOANALYSIS" as the topic of discussion, I doubted the wisdom of their choice. While listening to the opening speakers, and while collecting my own thoughts, I realized that no other subject would have offered better opportunities for fulfilling the long-standing need of approaching the practical problems of psychoanalysis from the side of psychoanalytic theory.