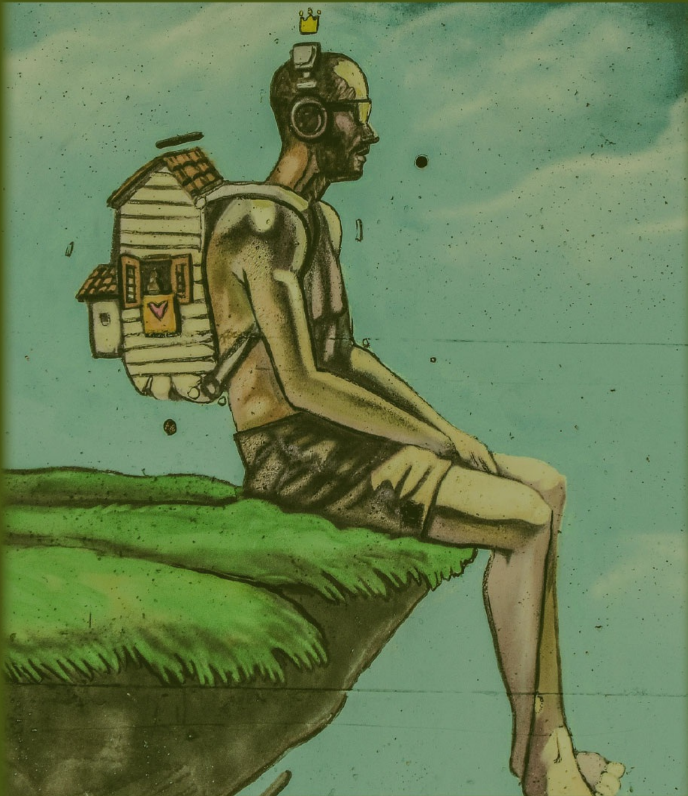
Symbols in Psychotherapy

Psychoanalytic Symbols and Transference



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PSYCHOANALYTIC SYMBOLS AND TRANSFERENCE

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e-Book 2016 International Psychotherapy Institute

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PSYCHOANALYTIC SYMBOLS AND TRANSFERENCE

INTRODUCTION

Transference And Symbols

Transference production is a form of psychoanalytic symbol formation. To the extent that he serves as a cryptic manifest representation of parental referents, the therapist as transference object serves as a psychoanalytic symbol. Psychoanalytic symbols change in concert with the developmental phases of the symbolizing function. The nature of the role projected onto the therapist as the result of transference during child therapy changes with maturation of the symbolizing function. The nature of regressive transferences in adult patients will be better understood if their origins and paradigms are studied in the symbolic forms that appear during the unfolding transferences seen during psychotherapy with toddler through latency age children.

The intensity and form of the transference experienced by the young changes with the phase of symbol ontogenesis and the quality of the parent child relationship. All forms of transference in children from intact families are less intense than those forms found in emancipated adults. Youngsters remain involved in intense relationships with parental primary objects. Drive energies are absorbed into these relationships. As a result, there is a drain on the force of the child’s drives and the resulting symbols needed to express them. Strong parent-child ties tend thus to undermine sustained transference in therapeutic relationships.

In spite of persistent family ties, sustained transferences can occur in child therapy. This occurs when finding a new object (i.e. the therapist), toward whom to direct the drives, helps in the process of individuation, or when overcoming passivity in relation to the parents, and when the protection of the parent child relationship from the effect of incestuous and aggressive wishes, requires displacement of drives from parent to therapist. At any developmental level, regression to a protosymbolic form can take place, resulting in the transference representation being seen as real and not as a metaphor. Reexperiencing in the transference takes on the cathartic potential implied in reliving and correcting the

original experience.

TYPES OF TRANSFERENCE

Introduction

Characteristic patterns of behavior, which appear in the daily life of patients, often invade the psychotherapy session. Freud (1912 - S.E.) saw such “anticipatory ideas” (Page100) as inherent templates that contribute consistent and characteristic form to behavior noting that (1914G - SE) “ . . . the transference is itself only a piece of repetition, and that the repetition is a transference of the forgotten past not only onto the doctor, but also onto all the other aspects of the current situation” (page 151). (and) “ . . . every other activity and relationship which may occupy his life at the time. . . ” (page 151) When the forgotten past comes to be represented by the doctor, we have an example of a representation (manifest symbol) and a forgotten (repressed) referent (latent content). These are the elements that make up a psychoanalytic symbol. When the doctor is the manifest conscious symbol, the clinical phenomenon is called transference.

This description of transference by Freud can be resolved into two related phenomena. The first consists of a group of generalized repeated patterns that occur in daily life and extend into treatment, properly called characterological behavior, but often called transference specifically because it involves the therapist. The second are patterns of behavior that occur only in the therapy situation and are expressions of repressed infantile wishes, here called primary transference, primal transference, and transference proper (V.I.) [1].

Characterological Transference

Character develops in the following way. Infantile wishes become masked by the appearance of defenses, especially repressions reinforced with symbols. Such symbols become linked and are organized into core fantasies, which in turn inform one’s interpretation of the behavior of others. These fantasies give rise to responses and behavior that may owe more of their content to the past and its patterns than it does to the inputs of current reality. These core fantasies and their component symbols become conduits

for the transmission of preformed intrusions from past experience that underlie adult repetitive behavior, fate neuroses and clichés of character. (Character "Cliches" are repeated patterns of surface behavior, which are shaped by defenses usually to counter unconscious fantasy.) When these invade a therapy session the phenomenon is called characterological transference.

Early childhood and latency psychotherapies contain such characterological influences to a greater extent than they contain transference proper (V.I.). Since these budding character patterns are quite fluid and changeable until middle adolescence, psychotherapy, including characterological transference interpretation, can be used to shape and guide the outcomes of character during this period of metamorphosis.

The development of patterns of behavior reaches a point (usually by the age of sixteen) where behavior becomes so predictable and reliable that one can give a diagnostic name to the pattern of behavior, and expect the behavior and diagnosis to persist into adulthood. Prior to this, character patterns are not sufficiently consistent to support a characterological diagnosis.

Characterological "transference" becomes most important in the therapies of adolescents, when much energy is expended in the recruitment of peers to play out the roles of characters in the fantasies, at the expense of symbols and symptoms. In this recruitment process, the psychotherapist is not exempt.

PRIMARY TRANSFERENCE

Primary Transference is a manifestation during psychotherapy of a need for nurture and care from a well-regarded object (i.e. the therapist). The situation in which a loving parent puts a bandaid on the small child's knee provides the paradigm for the child's expectations years later in the therapeutic situation. In child and adolescent therapy, primary transference is strong and if encouraged would dominate the child's relationship to the therapist. It can aid in the early establishment of the therapist as helper. In this form, it is called positive transference. It turns into negative transference when needs exceed the available responses of the therapist either as a result of therapeutic requirements or personal limitations. Primary transference is a derivative of immature oral dependent needs. The older the child, the less acceptable is it as an universal attitude. Its pervasive presence in the characterological behavior

of a patient requires that it be attended to psycho—therapeutically. In such cases, the resolution of primary transference is a developmental task, which dominates the living through and abreaction experiences of the child in treatment.

PRIMAL TRANSFERENCE

Primal transference is defined as the emergence for the first time anywhere of infantile sexual and aggressive wishes during an ongoing therapy with a young child in the process of negotiating age appropriate stages of infantile psychosexual development.[2] The presence of an accepting analyst in the course of a therapy encourages the first manifestations of both instinctual and cognitive maturational achievements in behavior symptoms and attitudes that involve the therapist. This phenomenon results in the bringing of unalloyed and scarcely altered elements of drive energy into the sessions. The ready appearance of primal transference is enhanced by the fact that in the prelatency years repression is weak. Weak repression encourages primary and primal transference. The energy and attention that could have gone into transference proper is dissipated. The need for and development of organizations of defenses is reduced. Should this persist into late adolescence, potentially adaptive characterological behavior, superego, and inhibitions fail to develop. Primal transference occurs predominantly in the prelatency years.

TRANSFERENCE PROPER

Transference proper is usually what is meant when the word transference is used without a modifier. It is defined as an unique situation that occurs during dynamic psychotherapy. It is created by the fantasy forming function of the patient. The analyst is involved in a fantasy distortion of the therapy situation into a relationship whose content is derived from a repressed infantile wish. When the defenses of the symbolizing function have been mobilized against these wishes, the result is repression. The therapist is used as a countercathectic manifest symbol, which hides the true identity of the parental referent. Transference proper is rarely manifested in true form and strength in children. It is the form of transference that underlies transference neuroses.

TRANSFERENCE AND THE SYMBOLIZING FUNCTION

The ego functions that are the underpinnings of transference are products of development. They are not present at birth. Transference is produced by the symbolizing and fantasy forming function of the ego and is therefore intrinsically part of the group of psychological phenomena that includes fantasy, delusion, dreams, and creativity involving narrative elements.

Specific to transference is the characteristic that the object of the drive that underlies the fantasy is the therapist and the venue of the experience is a session within a psychotherapeutic situation. Transference proper and the beginnings of characterological behavior can be present at the earliest only after the maturation of primary creativity and symbol formation.

Primary Creativity

The capacity for transference at its most primitive level begins with the development of primary creativity. Primary creativity is the ability to create a preconscious word encoded memory that is intermediate between the referent and the presenting manifest symbol. This memory is used for interpretation of inputs and for shaping the manifest expression of drive impelled wishes. These memories inform primary creativity. Typically these memories are shorn of detail and feature inexact recall. Held below awareness, they avoid secondary process confrontation. As preconscious blurred representations of a specific memory, they in turn serve as shaping latent content. The inexact relation of this content to the referent opens greater leeway in selecting manifest symbols and in shaping the interpretation of reality. Dynamic psychotherapies target these distortions, when connecting the distorting influence of the sense of reality on reality testing. At the earliest these functions are working together by twenty-six months. (Sarnoff 1970).

“Primary Creativity” is a concept introduced by Winnicott. He (1953) saw “Primary creativity” as the ability, developed in the first year of life by which one can create a fantasy object in a transitional zone between memory and reality. The object is called a “transitional object”. The zone can be understood to be a precursor of the area of creativity in which sublimative fantasy, symbols and transference are generated by the mature ego.

Winnicott placed Primary creativity at four to twelve months of age. He postulated an intermediate area of experiencing (1958 p 239), which exists in the space between the observing self and reality. Into this zone the child places phantom beings suited to satisfy inner needs. Winnicott postulated that "at some theoretical point early in the development of every human individual, an infant . . . is capable of conceiving of the idea of something which would meet the growing need that rises out of instinctual tension". Through primary creativity, drives can seek gratification from a zone of experience that is neither self nor world. In the small child a very primitive form of transference can be generated. A therapist or other real figure can be interpreted to be the fantasized object. The essence of transference consists of displacement of the identity of the gratifying object from a need answering phantom in the intermediate zone of experiencing, onto a real person who exists on the world side edge of that zone.

In child therapy we meet with a primitive form of this characterological transference. The therapist as protosymbol represents the primary giving object in the intermediate zone. His reality differs from the child's fantasy. This results in the therapist by nature frustrating the child. The child's reaction to this self-generated frustration is given form by the primitive mechanisms of the immature cognitive structures available to the child. These generate crying, whimpering and demanding by the presymbolizing ego. Such expression of felt needs change only in response to corrective object relations and not to interpretations. To achieve hope of success through interpretation by the therapist, the media for communication of infantile expectations, and immature self-concept has to be modified. Infantile psychosexual fantasies must be brought into a zone of concept communication and psychotherapeutic intervention in which verbal interpretation becomes possible. This requires that the therapist encourage the development of the child's ability to replace the presentation of needs through temper, tears, and somatization with verbal concept based communications. In addition the ability to displace wishes and representations of potentially gratifying objects onto objects in the world, must be developed. This ensures that their child perceived estranged nature will hide the true meaning of the wished for fantasy, which if too close to the original may be forbidden or too threatening to express or approach. This means that the ability to symbolize must be encouraged as a therapeutic strategy.

The functions that mediate the presentation to consciousness of instinctual wishes in the form of a displaced manifest representations are two. These are repression, and the function it supports in the third year of life, psychoanalytic symbol formation. These functions create a manifest signifier (the

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psychoanalytic symbol) as gratifying object for instinctual wishes. These signifiers serve as an incognito conduit for drive gratification. This produces lessening of drive need tensions. The psychoanalytic symbol lends itself to being worked into a verbal therapy. The secrets carried by the psychoanalytic symbol can be read by a skilled therapist. It is a substitute object that represents the referent in the real world. The therapist can convey their meaning to consciousness through the creation of a pathway of words for the patient's hidden feelings and wish expressions. They become experienced so intensely through repetition and interpretation that perception of the reality of their existence becomes strong. Such calling of attention to obscure motivations intensifies self-reflective awareness and leads to insight.

SYMBOL FORMATION

Symbol formation is the ability to obliterate awareness of the relationship between what represents and what is represented as a result of displacements to symbolic representations. Obliteration of awareness underlies repression. In all forms of transference, the therapist serves as the substitute or intermediate signifier. Ergo in all forms of transference, the therapist serves as a symbol. This is so even in primal transference. In that circumstance the therapist as primal object serves as a protosymbol (Q.V.I.). Therefore the nature and course of the transference during early childhood, latency, and adolescent psychotherapies can be seen as a process with a development which has parallels to the developmental vicissitudes of symbol formation.

There is an expansion of consciousness at the dawn of the mind. This is made possible by mechanisms that enable delay of response to sensation and affect. Awareness of danger at times only on an interpretive level is shared by all creatures in potentially threatening or nonadaptive situations. In man, capacity for delay permits displacement of attention from the true source of fear to less disrupting representations, such as a therapist. The therapist as symbol absorbs energies which might threaten the primary (parental) objects. Energies absorbed by substitute objects are directed toward them through the displacements, which are part of the symbolizing function. Though dangerous in many circumstances, this process permits the individual to override physiognomic and memory-based misinterpretations. This introduction of deferral or alteration of response to affects or threat provides free energy and time for reflective self-awareness and reality testing to occur.

PROTOSYMBOLS

A protosymbol is a representation in which full self-object differentiation has not taken place. Here we focus on organs and affects that represent other organs and affects. (Additional discussion of protosymbols will be found in Volume 2, Chapter 5, and Volume 1, Chapter 5 page 130.). Protosymbol is here used to represent primitive symbolic forms. Pertinent among these is the process by which the apparatus of awareness responds to bodily sensations displaced from their original organs of origin to a different organ within the body boundary. (See Sarnoff 1989) Such phenomena as painful anospasm in place of sexual arousal, tearing of the eyes representing an affect of sadness, or encopresis as defiance are examples. Sensation is displaced to an organ that has an unrelated function. These sensations can be worked into drive discharge fantasies, whose total manifestations can be expressed in a mind awareness arena limited to the space within the boundaries of the self. Abraham (1924) described partial object relationships in which objects in reality are related to as though they were body parts or products of the subject. For example the therapist could find himself-misperceived and related to by a child whose need to control has been expressed through anal function, as though the therapist were the child's bowel content. Should the misperceived object be a parent, the process is called a primary object relationship. If the therapist is the first to experience this relationship, the process is called primal transference. The newly perceivable relationship is seen by the child to be as real as the synaesthetically equated world within the self, which existed before self-object differentiation became possible. Differentiation between the inner and outer world is blurred when regression associated with such primitive levels of fantasy activates such an immature sense of reality.

Simple Symbols

When the cognitive capacities of the mind expand to permit appreciation of the fact that sensations originate in the world beyond the boundary of the self, reality perceptions are added to the sensory inputs that lead to response. This occurs first at about eight months. There is little to produce reflection of meaning of these inputs in terms of past and future implications. Recognition for response and later naming is the initial step in this expansion of function. At that point a plaything is a concrete representation conveying no other meaning but itself. At fifteen months, "play symbols" (see Woodward 1965) appear. These may be used for the conscious representation of something known or hoped for.

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Primary transference, the seeking of the therapist to serve as a kindly healer like the parent, can occur and is a manifestation of this early level of development of the symbolizing function. At this time, emphasis on words to represent concepts apart from the concrete manifestation of that which the word describes, becomes a part of the parental training of the child. Storage of these abstractions becomes a part of the working memory of the child. The increased emphasis on verbal conceptual memory produces a rich word web of awarenesses about percepts which can be related to one another and enhance meaning and interpretation of sensations. Extended consciousness is crystallized around these verbal codifications of abstract relationships, which then make possible abstract interpretation of new perceptions in terms of past experience and implications for future planning.

Not all perceptions or affect charged contents of memory are so encoded. Many remain outside the arena of verbally organized memory. One may justifiably say that they are unconscious but not repressed. Verbally conscious elements are at times so rich in uncomfortable affects that it is necessary to avoid thinking about them or being reminded of them. This exclusion from consciousness is achieved through denial, which is supported by a number of different mechanisms of defense. Foremost of these is displacement. Displacement alone produces paranoia.

PSYCHOANALYTIC SYMBOLS

Displacement accompanied by the countercathectic effects of symbol formation produces an exclusion from consciousness, which is called "Repression". The symbols so formed are called Psychoanalytic symbols (See Sarnoff 1970; Secondary Symbols of Piaget (1945)

One of the aspects of the psychoanalytic symbol is the use of visual puns in the selection of substitute representations of words. This type of symbol formation is the basis for oeniric (dream) symbols. Repression is produced by introducing perceptions whose verbal associations are on the surface removed from any percept or concept, which could convey that which is being excluded from consciousness. Such a redirection of conscious attention is called countercathexis. In child therapy the role of substitute is played by toys used in play (called ludic symbols).

Repression becomes strong enough to become clinically effective in producing symbols by 24 to 26

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months. When the therapist is used as such a symbol, the process is called transference proper. As will be discussed in a case to be presented below, such a transference contributed to the therapy of a four-year-old boy with delayed symbol formation. However as a general rule transference proper is not common in therapies of early childhood.

Evocative to Communicative Symbols

The capacity for symbol formation is not necessarily accompanied by the appearance of transference proper. Another vicissitude in the development of psychoanalytic symbols is involved in this. That is the gradual shift of the symbol from the evocative to the communicative pole, which is a characteristic of much more mature ego function than can be expected to be strong before late latency—early adolescence. Symbols that serve drive discharge alone, without being part of a social structure, which encompasses objects and discharge within a context are commonly seen early on. These symbols are said to be operating in the evocative mode (See Sarnoff—(Chapter 3 1987B). As in the cryptic symbols seen in dreams, these symbols have little communicative value. They dominate the play of latency age children. In psychotherapy, fantasy play involving evocative ludic symbols diverts drive energies from the energies available for transference proper. Gradually as children move through late latency into early adolescence, the symbols become more involved in communicating to people. They become more easily interpreted. The child can tell observers what the symbols mean. Such use of symbols places them in the zone of communication. These are called communicative symbols. The closer to the communicative pole a symbol leans, the more is the symbol apt to choose as its representation the therapist rather than a toy. As a result of the shift to the communicative mode, symbol formation is apt to use a therapeutic relationship as a source of manifest symbols. Latent content becomes accessible through the appearance of transference.

Toys and other play symbols tend to provide discharge through the evocative symbol pole. They distract attention from the core problems of instinctual discharge and from reality problems to be solved. This further diminishes the impetus toward object seeking in the playing child and saps strength from the processes that produce transference. Play (ludic) symbols lose their capacity to function in this way at the time (late latency—early adolescence) of ludic demise (see Sarnoff 1987A Pp 94-95). At ludic demise, maturation leaves toys no longer attractive to young teenagers. It is then that the drive energies

turn toward dream symbols and into the search for objects in reality to serve as symbols for the core fantasies. The available reality objects fall into three groups. These are parents, therapists and teachers, and peers. The off putting aspects of a closer tie to the parent that is informed by incest fears, the heightening rage involved in the search for independence from parental authority and the concomitant sense of passivity that pervades the psychic life of early adolescence, diminishes the parental potential to serve as an object of fantasy. The therapist is found to be a relatively benign substitute object (symbol). In such turnings in the way of therapy, the therapist can play two roles. He can be the source of insight through interpretation of tranference (both proper and behavioral) as well as a model for identification.

Early adolescent transferences are neither stable nor dependable. The drive manifesting fantasies that had been removed from parents and play and brought into the therapy continue in their browsing search for an object which can offer a gratification that is more concrete and immediate than the frustration of drive that is inherent in the psychoanalytic therapeutic approach to transference. The transference situation may serve as only a way station on the way to object love, and removal of the instincts from play discharge to fantasy discharge in the form of transference proper, continues to enlist objects to play out roles in their fantasies in the teenage world. As a result of this process, love relationships with peers drain energy from transference and may lead to the abrupt termination of treatment (see Katan (1937) Removal Transference).

Parallel to this process of maturing object choices, there is a transition in the march of persecutory objects used as symbols. The earliest such symbols as objects of fear are plants and most often, animals (i.e. infantile zoophobias). With the onset of latency, amorphous figures, which might break into the home, are feared. At about eight and one half years of age, creatures with human forms are feared, a process which foreshadows the giving up of toys in favor of people that occurs with ludic demise. With the step over the threshold into adolescence, real people are recruited to play out the fantasies. Evocation gives way to communication. Fantasy gives way to object love. The further toward these mature polarities of instinctual expression, a child grows, the greater is the chance in therapy that the child will manifest his forbidden wishes in a transference manifestation. Conversely as real objects become more in evidence in drive discharge phenomena, the real objects more and more vie for the instinctual energies and undermine the transference, much in the way that the presence of parents contributes to the vitiation of the transference during the latency years. Character is established when fixed patterns of drive

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discharge fantasy become involved with real objects. When these fixed patterns are acted in during psychotherapy, characterological patterns of behavior, called transference in common parlance can be identified and interpreted.

Accompanying the loosening of inhibitions and the increased direct use of reality objects for drive discharge, neuroses (see Laughlin) become less in evidence in early adolescence. They return in early adulthood. At that time (by 26 years), an increase in inhibitions in the use of objects in reality for the expression of neurotic needs and social wants occurs. A reshaping and strengthening of the organization of defenses occurs as part of this process of impulse control. The limitations resulting from alloplastic drive discharge and reduction in possible drive discharge objects results in the recathexis of unconscious fantasy life. This phenomenon is associated with an intensification of the use of the therapist as object (if a therapist is made available to encourage the focusing of energies on him as an object.) There is strengthening of transference and the transference neuroses that underlie progress in adult psychotherapies.

Limitations to Transference Manifestations in Preadult Personality Organizations

Economic and emotional dependence on parents who are still actively involved in parenting is a characteristic of the life of children and adolescents. The presence of such primary and permanent objects absorbs drive energies to such an extent that there is little energy left to be used to cathect a sustained transference to a therapist. Transference phenomena that does occur in prelatency children with toddler appropriate ego function is dominated by immature types of transference, with emphasis on primal and primary transferences and bursts of characterological behavior based upon unmitigated demands for care, power and supremacy. Adult ego states reflecting fixations and regressions to these levels of immaturity produce transference reactions akin to these.

The encouragement of a transference to the analyst with gain from abreaction holds less promise for latency age therapy than for the psychoanalysis of adults. Because of the nature of their immature egos, which includes the intensity of their sense of reality (fantasy feels real) and the poor quality of their reality testing, abreaction and resolution of conflicts involving early infantile wishes can be achieved through fantasy play (i.e. the structure of latency). This diverts energy from fantasy involving the analyst.

During the latency years transference proper can and does occur. However throughout latency and adolescence, transference is diminished by the diversion from it of drive energies. These energies discharge through fantasy, play, dreams and the presence, especially in adolescence, of real objects articulated with maturation of those ego functions that mediate the capacity to fall in love coupled with increased drive energies with puberty.

Transference in The Toddler

We now turn to a clinical illustration of the case of a child whose delayed cognitive development resulted in the manifestation of his conflicts in an immature and primitive form of symbol (a protosymbol) and defiant social behavior. Therapy aimed at developing a mature symbolizing function made it possible for him to make his operative fantasy available to interpretation through the transference. The psychotherapeutic strategy used in the following case reveals, in statu nascendi, an aspect of the ontogenesis of transference.

THE BOY WHO WOULD BE KING

Roy Keiser came to therapy for an overt symptom. His symptom was encopresis, defined as stool retention with leakage. Roy had not been fully trained. He held back his stools staining when he could no longer restrain himself. He had temper tantrums that disorganized him and the family. He could tolerate no frustration. He was four years old when therapy began.

When he was two years and nine months of age, a sister was born. There was a change in his personality, any progress in bowel control declined. He became obstinate, overcontrolling, and very personalized in his selection of the time and place of defecation. From the day, his sister was born, he became very active, running from room to room. Increased activity is one of the outlets of a child with impaired or limited use of the symbolizing function. For three months starting at 33 months he was persistently hyperactive. At 36 months, he was sent to nursery school where his pattern of overcontrol and retention of stool with leakage made him a somewhat odoriferous but “apparently toilet trained” three-year-old boy. Stool retention in school evaded detection by his teachers. At home, his soiled clothes told of episodes of loss of control. He could be put on the toilet without product only to lose control when

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his clothes were rearranged. There was no question that he could sense bowel fullness. At three and a half years of age, he had an impaction, which was relieved by enema. This brought his problem to medical attention. Megacolon, Hirschsprung's disease, disorders of colonic innervation, and absence of "anal wink"(sic) were ruled out and psychotherapy recommended.

He was weaned at 18 months. He sucked his thumb constantly. He had a distinct thumb sucker's bump proximal to the first right carpophalangeal joint. He had a security blanket, which he carried with him continually when he was at home.

His mother was a tense self-centered, money occupied woman. After discovering that my time for parent visits were subject to a fee she shifted to frequent telephone calls. She tended to be overweight, which she kept under good control. She could cooperate in changes in patterns of parenting required for the therapy (such as limitation of severe punishments, disengagement from stimulating fecal cleansing activities, neutralizing of parental rage, reinforcement of symbolizing function (i.e. through reading fantasy material, inquiring about dreams, and discussions of enhanced cultural experiences such as movies and plays for children and encouragement of play with passively conceived Ludic Symbols.). She performed by rote with little grasp of dynamic balances within psychological ecologies, such as mutual influences and balances that characterize early child development and that inform therapeutic endeavors undertaken for people of that tender age.

Roy was a handsome, sturdy, very cooperative, verbal four and one half year old patient. In the evaluation of the symbolizing function in this toddler it was found that his mental status was within normal limits except for deficiencies in fantasy forming functions. When asked about sleeping habits, he responded that "Sometimes I can't sleep—I think of having ice cream." He reports that he has never had a scary dream and doesn't make up stories.

When I began to make something with Play-Doh, he saw it as a snake, but could not put it into a story context or elaborate on the snake form. I concluded that he was capable of symbolic play, first seen in the 15 month old (Piaget 1945), but not of producing true Ludic Psychoanalytic play symbols. There seemed to be a limit to his ability to create fantasy symbols and fantasies, which would have provided him with a more socially acceptable displaced outlet through which he could have resolved conflicts.

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We now digress to discuss the evaluation of the symbolizing function in the four-year-old. Note that above I said a limit. I did not say that the symbolizing function was totally absent. When it comes to the evaluation of the viability of the symbolizing function in the service of fantasy in children, one must conceptualize the process within a context of an evolving complimentary series, remnants of each part of which may still be manifest after later stages have developed.

Relative health is determined by identifying the number and maturity of the symbolic forms available as well as the quality of the specific symbolic form that is utilized primarily in the production of manifest fantasy and behavior. If the reaction of the child aimed at adjustment to stress utilizes a manifest symbol selected from within the body boundary (in this regard see Sarnoff 1990), we deal with a symbolic form expressing reaction utilizing a body organ or product (a protosymbol). This is a precursor for what will in later life be called a psychosomatic symptom, which is a truly evocative symbol with little in the way of a communicative pole. Were a child able to express his reaction through an external ludic (play object) symbol whose meaning is hidden from the therapist, we would say that we are dealing with a manifest symbol whose evocative pole is being emphasized. (external and evoking, but not in the service of communication). At the more mature end of the complimentary series is the psychoanalyic symbol used in the communicative mode. Here fantasy play contexts consist of symbol groupings, which contain enough meaning detectable to the observer for the underlying unconscious meaning of the fantasy to be detected. With such symbols, conscious discussion, interpretation and working through of the roots of represented problems can be introduced.

Roy's symbolic forms were limited to simple verbalizations, non-distortion dreaming and the use of body functions for a regressed, evocative resolution of affect and conflict. This developmental cognitive impairment resulted in immature symbol formation, and permitted the persistence of fecal retention, which was his manifestation of anal phase problems. A treatment strategy was devised to counter this. First the symbolizing function of the ego had to be improved so that the interaction between therapist and patient could be conducted in a zone that would permit self-aware communication and interaction between the two. This step opened the way for the appearance of transference. Then the conflict and misunderstandings underlying the transference could be interpreted, identified and worked through. There follows a description of Roy's treatment.

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TREATMENT

Roy’s initial way of solving problems in sessions gave the impression of superior intelligence. He was neat and asked questions about the objects in the playroom. As he became more comfortable, however he began disorganized messing. Little was planned. There was also little in the way of organized fantasy. Attempts at painting which dominated his activities always resulted in mixed colors put on the paper in such large amounts that the table bore almost as much pigment as the paper. Early attempts at work with clay produced pizza, snakes without fantasy contexts, “duty” and a lot of clay on the floor and our shoes. If he dropped something, he asked or ordered me to pick it up, (a manifestation of characterological behavior). He ordered me to pick it up so often, that we resolved his demands by drawing a line on the floor. Things that fell on my side, I picked up. Things that fell on his side, he picked up, sometimes.

There was poorly developed symbolizing function. His defensive resources were dominated by drive expression using primitive protosymbolic forms such as body parts and products. This shaped his behavior. When called upon in situations of stress, these primitive defenses produced ego dissolution, increased messing, anxiety, and loss of control instead of the comfort to be derived from age appropriate fantasy formation. Mastery and discharge through the use of fantasy which employs symbols sufficiently removed from the latent content to obscure its meaning and its associated affects were not available to him. Because of this, I had recommended that the mother introduce the passive use of symbols through reading and story telling. In addition, I introduced activities during the sessions that were aimed at enhancement of cognition and symbolizing function. The clay molding technique, which is described in my book “Latency” (Sarnoff 1976) was introduced. I molded small clay figures of amorphous form asking him to guess what I was making. Whatever he guessed, I made. Once completed, these figures of his own creation, were permitted to dry. Once dried, the figures could be used to introduce the use of ludic symbols in fantasy. I asked questions which required the use of the figures in a story. I introduced use of his own symbols in fantasy stories.

In the twelfth month of treatment, I went out to welcome Roy in the waiting room. He rose from his seat slowly and having the sense that he had left something behind turned back for an instant, further slowing his progress toward the door of my office and playroom. His mother jumped up from her seat,

and shoved him forward, pushing the base of his neck with such force that his head whiplashed backward. As she pushed him, she said, “Go faster, you’re wasting money.” Two elements were added to the therapy as a result of her action. In a thrice, one could see an identification with mother’s harsh controlling demands as one source of his characterological choice of bossiness. In addition, this situation provided an important inroad therapeutically. His mother’s rejecting behavior turned his dependency needs toward a substitute object (the therapist). Removal of the primary object encouraged primary transference. Roy was so overwhelmed by feelings that he could not maintain his cold distance from me. Tears streaming from his eyes, he cried to me, “Do you see that? Did you see what she did? She does that all the time.” I had become his confidant. In turning to me, Roy had begun to live through or abreact his primary “transference wish” to be nurtured and cared for. In response to his mother’s failure in this instance to give comfort he turned to the analyst as a substitute object. In this way he overcame some of his resistances and defense against relating dependently and began to undo the stilted nature of his object relations. This corrective object relationship experience apparently was followed by a move toward mobilization of the communicative pole in the formation of symbols. He marched from my consulting room into the playroom. Tears gave way to anger. The anger too resolved as he began the first of a series of fantasies played out in the playroom. He took small gummed labels and began to past them on every toy in the room. On each he marked a value. He declared himself the owner of a store. He invited me to come in and buy. The play was awkward, without a medium of exchange. After a few sessions, this lack was responded to by the introduction of an industrial process that required my help because of its complexity. He organized the manufacture of coins to be used in his store. This included cardboard coins, gold foil covered coins, and even fabricated Olympic commemorative coins. A final stage in this play activity, which lasted for months, was the production of gold credit cards.

While working on the credit cards, he dropped a piece of gold foil paper on his side of the line. He looked at me briefly and then curtly ordered me to pick up the scrap of paper. I pointed out its location. He cocked back his head, looked down his nose, and while pointing with haughty demeanor, commanded me to pick up the paper.

I looked straight back at him, while he continued his demands and bid me coolly to obey again and again. He had focused his characterological behavior in the therapy. He drove towards converting me in the transference into an object external to his body boundaries, into a symbol of the stool he controlled at

will.

Then I said, “Who do you think you are?

“I am a king.”, said he.

I was a little surprised. I realized at that moment that he had chosen a word, with a meaning, which we could share to describe the sense of self that he demanded be recognized in his desperate need to undo the inferiority and narcissistic vulnerability that formed the core of his self-image. This demand, aimed at me, was a transference. Finding a name (KING) could make it possible for us to share, look at, discuss, come back to, and make this barely conscious concept that had been used as defense and had become transference, available to the system consciousness. McClone (1991) has described how “Naming something makes it stand out more clearly from the surrounding background.” (p110) Luria (1968) pp 120-123, speaks of “the forms of reflection which are realized through speech”. And Sacks, (1989) speaks of “the acquisition of conceptualizing and systematizing power with language.” (p43) In a person who is fearful of harm from loved ones, some concepts have too much affect to be spelled out in words. In this case a symbolic substitute in the shape of the therapist as transference object was invoked. It was sufficiently removed from the original to hide meaning. The more fearful or autistic the child, the less can such symbols be used in a communicative mode. Interpretation is needed to bring their true meaning into consciousness.

Insight and the possibility of working through occurred when we shared the aftermath of the reality situation in the waiting room. At that point Roy was able to represent drives through symbols that though masking had a communicative aspect that could be used for interpretation and expansion of consciousness to include explanations of previously inexplicable transference behavior. In response to his declaration, my thoughts dwelled on the possibility of approaching insight through the symbol he had introduced (a King). He needed to be a king, I thought because he felt so unimportant. I suspected that pursuit of the king symbol could provide knowledge with enough distance to be psychotherapeutically workable. However it soon became clear that such working through would have to wait for another day for he began to cut a long strip of cardboard creating a saw-toothed edge. He glued gold paper to the cardboard and then pasted on brightly colored play-doh “jewels”. He twisted the strip

into a loop large enough to circle his head and then, placing it upon his brow, marked the end of the session by marching proudly from the room wearing a symbol of the king, a Golden Crown.

In subsequent sessions, we pursued his idea that he was a king. Logically he could not be a king because a king's father is always a king. He had got the concept of king from the fairy tale books his parents had read to him and in his experience, kings were the sons of kings. He was easily able to put aside naming himself a king. The underlying concept needed more attention. I pointed out the linkage of his kingship to his encopresis. I said, "When you thought you were a king, you could make a duty any place you want to". "And anytime I want to", said he. From that session forth his encopretic withholding came under control.

This insight was not enough to modify his character traits. There was left to be worked through the reason that he needed to feel he was something special with special rules like a king. We embarked on an investigation of his sense of humiliation when scolded by his mother and his feeling that money was more important to her than he was. He also had feelings of jealousy for his sibling who was seen to be held in more value than he. The working through of these important areas were averted when his mother, encouraged by the subsidence of the encopresis and with a lack of psychological mindedness that caused her to see treatment results as the product of a sort of magic, withdrew the child from treatment.

Discussion of the "Boy Who Would Be King"

Verbal Representation and Mental Content in the Toddler

Roy's anal sadistic drives were expressed through body organ based protosymbols when he came to treatment and so were not available at first for an understanding which could be productive of verbal interpretation and influence.

A transition from affectomotor memory to verbal concept memory which Roy had only partially completed before he came for therapy left much that was encoded in the affectomotor memory system and unavailable to the awareness system to which psychotherapy is geared. That awareness system detects verbalizations primarily. Not every event or experience in the child's world finds a word. Roy was slow in this area, especially when it came to the cushioning effect of the symbolizing function, which

makes representation possible, albeit in masked form. Roy had no words for what his anger expressed or meant to him, when he started therapy. This is a form of repression that works by exclusion through an absence of a conduit to verbally organized consciousness. (Schachtel 1949). Cognitive structures for use in producing symbolic or verbal communication were not yet adequately mature for utilization. Rather than through the use of symbols and fantasies, compensatory narcissism, generated in response to his mother's ease to anger and the birth of a sib, was manifested in messing, stool witholding, and demanding controlling behavior on his part (transference) in the therapy. Therapeutic goals included verbalized insight. This required techniques to encourage more mature symbolic forms. This goal was achieved through the introduction of psychoanalytic symbols using words and concepts derived from the zone of experience beyond the boundary of the self. This raised the level of instinctual expression to the point at which communication and interpretation became possible. The verbalization and identification of an age available form of transference were then realized.

Developmentally, the acquisition of the capacity to utilize psychoanalytic symbols in a communicative mode is a turning point with many implications. The development of latency with its importance for civilization begins. The introduction of communicative symbols and words to interpret them to enhance verbalized insight and aid in the resolution of conflict was necessary. When early infantile wishes or the memory residua of trauma can be symbolized communicatively, speech can be used in resolving transference. This entails working through of and disenabling of the contents of the core and masturbation fantasies, which are the precursors of adult transferences, characterology, fate neuroses and neurotic symptoms. Communicative discharge and confrontation are enabled by the development of speech and the evolving of decipherable cryptic symbols. These permit the organization and expression of fantasy informed infantile sexual wishes on increasingly more mature, socially acceptable and sublimated levels.

Organ protosymbols sidetrack this trend. The symbols are too primitive and evocative. Adjustment is interfered with as in the case of Roy whose use of control of his stools expressed his anger and control needs. Psychoanalytic symbols in the communicative mode serve compromise formation and permit discharge under more socialized conditions. Through the interpretation of such symbols, otherwise irretrievable transferences based on early infantile wishes or the memory residua of trauma can be converted from that which is only acted or felt to that which can be expressed in symbols, which can be

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interpreted into verbal concepts that can be worked through or associated to, confronted or challenged.

In Roy's case, a developmental step in symbol usage was introduced to the therapy so that interpretation of transference behavior could bring unconscious motivation into consciousness. (Further discussion of this case begins on page 234.) Verbalization in children enhances the working through of and disenabling of contents that are destined to underlie transference wishes in adults. Communicative discharge and confrontation followed upon the development of speech and the evolving of decipherable cryptic symbols. This permitted the organization and expression of infantile sexual wish informed fantasy, which can be interpreted in child therapy. This results in controlled reparative mastery, working through and the confrontation of the "sense of reality" with "reality testing".

The effective interpretation of transference results in a self-reflective awareness. This awareness places the content of past events and future effects, attitudes, and behavior within reach during the therapy session. The patient expands his consciousness creating a lucid image by expanding the view he has of himself to include that which had formerly been repressed or left unconscious. In this way, the person becomes aware of behavior and motivation, and can recognize that which makes the behavior inappropriate. This brings into focus, with the therapist's help, reasons for stopping the behavior.

The evolution of consciousness is the evolution of self-reflexive verbal thought. This should be differentiated from other awarenesses such as awareness of reflex signals and the responses and awareness that accompany semifacultative "automatic" responses that have been learned or have become second nature as in dancing or athletics.

A major transition in a child's awareness occurs when word memory representing abstract concepts become associated with percepts and affects and other experiences of the moment that had previously only called for reflex responses. Words that represent abstractions can be recalled and remembered. Such recall of abstractions opens the way to past and future, and expands awareness to encompass a view of life that adds insight and a sustained longitudinal history of meaning to experience. The role of interpretation is to expand this memory resonance.

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Notes

[1] This differentiation was early elaborated by Dr. Max Stern in an unpublished paper.

[2] This concept was introduced en passant by Peter Neubauer M.D.(1962) during a training seminar.

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