Freud Teaches Psychotherapy

Special Clinical Problems

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Love. In 1918 Freud brought together three of his earlier papers under the title of "Contributions to the Psychology of Love" (Freud 1910H;11:164-176, 1912D;11:178-190, 1918A;11:192-208). The first of these papers is very well known and deals with a special type of object-choice made by men in which the love object must be a woman to whom another man can claim the right of possession, who is in some way or other of sexually questionable repute, and which leads to jealousy on the part of the lover. A long series of passionate attachments to women of this type is formed and pursued with compulsive intensity; such attachments especially involve the urge to rescue the woman loved. The psychodynamics of this syndrome are traced to the infantile sexual conflicts.

In current psychotherapeutic practice the type of problems described in the second and third papers—impotence and frigidity—are much more common and, in spite of the exaggerated claims of behavior therapists and sex therapists, such patients continue to present themselves in the hope of relief through intensive psychotherapy, often after having tried numerous simpler and briefer techniques and innumerable pharmacologic agents to no avail. The second paper has not received sufficient attention from clinicians, which is unfortunate because Freud points out how aware the clinician must be in uncovering situations of *relative* impotence. Patients will freely complain if

they have a serious problem with sexual impotence and in fact this is often a presenting complaint in the desire for psychotherapy. However, patients with a relative degree of impotence do not volunteer this information or may even be unaware that a problem exists—they push the issue into the twilight of the preconscious.

In the clinical paper (1912D;11:178-190), Freud points out that a completely normal attitude in love requires a combination of what he calls the *affectionate* and the *sensual* currents. The affectionate current, which always carries with it contributions from the sexual instincts, refers to the child's primary object choice; these affectionate fixations of the child are joined at the age of puberty by the powerful sensual current which has a clear and primary sexual aim. The task of puberty is to pass away from objects that are prohibited by the barrier of incest and which are therefore unsuitable in reality, and to find a way to other extraneous objects with which a real sexual life may be carried on. “These new objects will still be chosen on the model (imago) of the infantile ones, but in the course of time they will attract to themselves the affection that was tied to the earlier ones" (p. 181).

Obviously, in the case of infantile sexual conflicts or fixations, the fusion of the affectionate and sensual currents cannot take place. In the masturbation fantasies of the patient, part of the sensual current—or all of it— may be discharged in the state of fantasy and connected in the usual disguised

fashion to the original infantile sexual objects. The genital sexual activity of such people is impaired and, as Freud writes, "shows the clearest signs, however, that it has not the whole psychical driving force of the instinct behind it. It is capricious, easily disturbed, often not properly carried out, and not accompanied by much pleasure" (p. 182). These unfortunate individuals are in the paradoxical position of not being able to desire where they love and not being able to love where they desire.

Freud thinks that the very process of civilization and education interferes with the fusing of the currents of affection and sensuality. Thus a man is "assured of complete sexual pleasure only when he can devote himself unreservedly to obtaining satisfaction, which with his well-brought-up wife, for instance, he does not dare to do" (p. 185). Thus the man can achieve only full gratification of sexual activity either in masturbation fantasies or with a debased sexual object toward which he feels free to allow "the entrance of perverse components into his sexual aims," which he does not venture to satisfy with a woman he respects.

Freud does *not* draw the conclusion from this that total sexual unrestricted freedom on the part of both sexes—the so-called sexual revolution—will solve the problem. He insists that an obstacle is required in order to heighten, the libido; and he points out that "where natural resistances to satisfaction have not been sufficient men have at all times

erected conventional ones so as to be able to enjoy love" (p. 187). He tries to explain this on the basis of the complex developmental vicissitudes and the many components of the sexual instincts. Rather than advocating sexual revolution Freud rather pessimistically concludes that the cost of civilization will inevitably have to be a certain dampening of sexual enjoyment.

For the clinician the important point is that a careful exploration of the details of the patient's sex life and fantasy life can serve as a map of his or her affectionate and sensual currents, and a guideline to conflictual and fixation points. This is true even in patients who do not present sexual complaints; the psychoanalytically informed psychotherapist always takes a very careful and detailed history of all aspects of sexuality *when the patient is comfortable enough to talk freely.* A preliminary phase of establishing a relationship may be necessary before this is possible, especially with those patients who deny any sort of sexual difficulty. If the initial phase of psychotherapy has been successful this material usually presents by itself at the opportune time, for somewhere in the patient's preconscious mind is the realization that not all is as successful as he or she would like to think.

The third paper (Freud 1918A;11:192-208) can be thought of as an appendage to Freud's *Totem and Taboo* (1912X;13:1ff). From the clinician's point of view its importance lies in Freud's emphasis on the hostile element that in many cases underlies frigidity. Freud tries to explain this hostility on

the basis of the fact that the man who deflowers the woman is not the longed-for father, but a substitute. Often this leads to disappointment on the wedding night and the requirement of "quite a long time and frequent repetition of the sexual act before she too begins to find satisfaction in it" (p. 201).

Freud describes a spectrum or "unbroken series," from cases of mere initial frigidity which—sometimes with the help of sex therapy—can be overcome—"up to the cheerless phenomenon of permanent and obstinate frigidity which no tender efforts on the part of the husband can overcome" (p. 201). These latter cases are very important in the practice of intensive psychotherapy and often involve, in my experience, not only infantile sexual conflicts and fixations but also serious narcissistic difficulties. The importance of defloration has changed in our day, with its early and widespread sexual activity among teenage girls, and cultural attitudes toward the whole subject are markedly different than in Freud's time. Still, Freud was right when he said, "We may sum up by saying that a woman's *immature sexuality* is discharged on to the man who first makes her acquainted with the sexual act" (p. 206). The vicissitudes of this immature sexuality can take many forms, from the repetitive adolescent sexual acting-out, to a woman shifting her psychological attitude toward her husband during the course of a long marriage when she "discovers" in middle age that the object for the discharge of her immature sexuality is not the same object that is suitable for mature sexual relations. I believe this to be an important factor in our time of a higher

incidence of divorces among people who were apparently satisfactorily married.

Freud reports that in an uncommonly large number of cases the woman remains frigid and unhappy in the first marriage and after a divorce and re-marriage she is able to become a tender wife to her second husband. "The archaic reaction has, so to speak, exhausted itself on the first object." I am not convinced from clinical experience that an uncommonly large number of second marriages work out better than the first. The notion of an archaic reaction exhausting itself in practice however, finally allowing the sensual and affectionate currents to come together, could form an important explanation in the success of the sex therapies. In cases seen for intensive psychotherapy however, the archaic reaction does not disappear in practice but must be worked through in the transference. The danger always persists that after this archaic reaction is worked through, the woman's choice of object will change and the marriage will dissolve. The compassionate psychotherapist keeps in mind the agonies and anxieties of the husband during such a psychotherapy; if the need arises, he or she often must feel called upon to send the husband for psychological help, and the therapist should explore with the woman from time to time the reaction that she notices in her husband under the influence of her increasing maturity. Thus the maturation of his wife may represent a serious psychological blow and a profound loss for the husband, and this may lead to many complications. The

same approach is correct if the patient is the husband.

Visual Disturbances. Freud's brief paper on psychogenic disturbance of vision (1910I;11:210-218) is an important clinical gem. He clearly delineates those cases of visual disturbances in which, so to speak, the ego throws away the baby with the bath, from other forms of disturbance of vision. In the former cases, which are a manifestation of hysteria and not very common today, looking becomes invested within intense erotic content and the prohibition not to look as well as the punishment for the wish to look results in a visual disturbance.

Freud carefully explains that "Psychoanalysts never forget that the mental is based on the organic, although their work can only carry them as far as this basis and not beyond it. Thus psychoanalysis is ready to admit, and indeed to postulate, that not all disturbances of vision need be psychogenic, like those that are evoked by the repression of erotic scoptophilia" (p. 217). I have illustrated elsewhere (Chessick 1972) the extreme complexity of psychosomatic disturbances of vision. I describe the psychotherapy of a borderline patient during which the patient developed angiospastic retinopathy and indicated how careful the therapist must be in dismissing any visual disturbance complaint as "hysterical blindness." The appearance of any visual disturbances in psychotherapy should call for immediate ophthalmologic examination, for serious and permanent damage to the organ

may occur if these cases are denied proper medical treatment. This is true regardless of how clear the psychodynamics involved seem to be, for we must always remember that mental phenomena are ultimately based on physical ones. All organic symptomatology arising in psychotherapy must be approached by a combination of vigorous medical investigation and treatment as well as psychotherapeutic process.

Depression. Freud's final paper in the series on metapsychology, "Mourning and Melancholia" (1917E;14:239ff), sets forth a number of ideas and implications that are still being followed and investigated by his followers. The two most important lines of investigation are in the field of depression and in the field of narcissism. “Mourning and Melancholia” may be considered an extension of Freud's paper "On Narcissism" (1914C;14:69ff). The former begins with a caveat sometimes overlooked by critics of Freud—that depression or melancholia "whose definition fluctuates even in descriptive psychiatry, takes on various clinical forms the grouping together of which into a single unity does not seem to be established with certainty; and some of these forms suggest somatic rather than psychogenic affections" (p. 243). He thus drops all claim to general validity for his statements about melancholia and accepts the fact he may be speaking only of a small group within what might be called the group of melancholias.

Freud offers a general clinical distinction between mourning and melan-

cholia based on the fact that the features are the same except for the profound disturbance of self-esteem which is characteristic of melancholia and absent in mourning. Since mourning is a reaction to the loss of a loved person, Freud suspects that a similar kind of influence may be at work in the production of melancholia if there is a pathological predisposition, and he sets out to investigate this pathological predisposition.

Goldberg (1975), beginning with Freud's views presents an excellent review of the history of psychoanalytic concepts of depression, and he points out that certain key concepts seem to occur over and over. These are (1) the persistent connection of depression with the mother-child unit in the oral phase of development; (2) narcissistic issues are always raised in the description of object relations of the depressed patient, centering around identification and the regulation of self-esteem; and (3) a regular association of depression with aggression or hostility, superego, and resultant guilt.

"Mourning and Melancholia" would get high marks as a philosophical paper and it represents in essence Freud reasoning out loud on the subject. The cornerstone of his reasoning is the clinical impression that the various self-accusations of the melancholic usually fit someone whom the patient loves, or has loved, or should love. Thus Freud considers the key to the clinical picture the perception that the self-reproaches are reproaches against a loved object which have been shifted away from the object onto the

patient's own ego. He adds that in both obsessive compulsive disorders and melancholia such patients succeed by the circuitous path of self-punishment "in taking revenge on the original object and in tormenting their loved one through their illness, having resorted to it in order to avoid the need to express their hostility to him openly" (p. 251). He mentions that the person who precipitated the patient's emotional disorder is usually to be found in the patient's immediate environment— psychotherapists take note.

This reasoning led to many later investigations of the psychodynamics of depression and also led Freud to the issue of narcissistic object choice and narcissism. Goldberg (1975) underlines the definition of narcissism as psychologic investment in the self and points out that:

> The narcissistic object is one that either is like the self (looks like the self) or is an extension of the self (is experienced as a part of the self). Thus the narcissistic object can be separate from *or* a functional part of the self. The "regression of object cathexis to narcissism" indicates an increase of feeling or interest in the self: what we would call a heightened self-centeredness. This follows upon object loss and may result in the object being internalized. Therefore, the lost object can be replaced by another one or replaced through an identification. Depending on how such a loss is handled, one may experience depression or merely a shift in object interest (p. 127).

There is a fuzziness of the concepts of internalization, identification, and introjection, a confusion which tends to creep into the literature even today. I (1993) suggest that we reserve the term "introjection" for a massive

internalization of the object—setting up, so to speak, a massive representation of the object in the ego; "identification" could be used to represent an internalization of parts or selective aspects of the object and could represent a relatively later mechanism of defense typical in adolescence; "internalization" could be used to represent either of the above. Furthermore, Kohut's (1971) notion of transmuting microinternalizations, where aspects of the soothing function of the mother are internalized and form an important part of the ego structure and the self-regulating systems, is very important. Freud did not make these distinctions. He usually used the term "identification" for all of the above and occasionally used the term "introjection," by which he generally meant a massive internalization. Other authors gave to introjection the cannibalistic or incorporative aspect of the oral phase. Although Freud does mention in this paper a cannibalistic phase to libidinal development, more emphasis on this aspect of internalization is found in the work of his follower Karl Abraham (1954). The basic principle is that melancholia is a pathological state "involving narcissistic blows to the ego experienced as losses and involving more wholesale or traumatic internalization of the offending object" (Goldberg 1975, p. 128). As Freud points out, the predisposition to fall ill of melancholia then lies in the predominance of the narcissistic type of object choice in the patient's psychic functioning.

Jealousy. One of the most common clinical presenting complaints of

patients is that of jealousy, discussed by Freud in "Some Neurotic Mechanisms in Jealousy, Paranoia, and Homosexuality" (1922;18:222ff), a paper which remains a basic classic on the subject. Freud described three layers or grades of jealousy: competitive, projected, and delusional. The practicing psychotherapist is often called upon to decide which layer or grade of jealousy he or she is dealing with and in addition, to determine—when several layers are present—which is closer to the patient's consciousness and what is repressed.

Normal jealousy is essentially *competitive* and occurs when a successful rival has inflicted a narcissistic wound and a loved object is lost. The jealousy of the second layer, *projected* jealousy, rests on the fact that it is so difficult in marriage to maintain fidelity in the face of continual temptations. A patient attempting to deny these temptations in himself or herself may feel the pressure so strongly that the patient makes use of an unconscious mechanism to alleviate the situation. The patient projects his or her own impulses to faithlessness onto the partner to whom the patient owes faith—thus the partner is seen as being unfaithful and the patient feels without guilt, or at least notes that the partner is not any better than he or she is. This jealousy may seem at times to have an almost delusional character, but it is primarily based on hidden fantasies of the patient's own infidelity or wishes to be unfaithful.

The more ominous layer of jealousy is the true *delusional* type. In these cases the unconscious repressed wishes are also toward unfaithfulness but the object is a member of the same sex. "Delusional jealousy is what is left of a homosexuality that has run its course, and it rightly takes its position among the classical forms of paranoia" (p. 225). Thus if the patient for example is a man, it is as if he is saying, I do not love a certain man— my wife loves him! This is described in detail in the case of Schreber (see chapter 8). Freud points out that in paranoia, delusions of persecution as well as delusions of jealousy serve as a defense against unconscious homosexuality. In delusions of persecution, the enmity which the persecuted paranoiac sees in others is the reflection of his or her own hostile impulses against them (see chapter 9). When there is a focus on one individual of the same sex as the persecutor, the ambivalence of the unconscious love as well as the nonfulfillment of the claim for love produces the rage, which is then projected onto the persecutor.

Finally, Freud reminds us of typical mechanisms in homosexual object choice. In one type of case there is fixation on the mother and an identification with her which enables the son to keep true to her at the price of becoming a homosexual. In a second type of case there is a withdrawal from women out of horror derived from the early discovery that women have no penis. Another motivation toward homosexual object choice can involve either regard for the father or fear of him. Freud then adds a fourth dynamic in which an exceedingly hostile and aggressive attitude toward rival siblings

of the same sex is transformed under repression into the opposite, and a homosexual love object is chosen. In the first of these mechanisms notice that the man (for example) identifies with his mother and chooses a love object in whom he rediscovers himself, and whom he might love as his mother loved him. In this situation the love object is a narcissistic selfobject (Kohut 1971).

Masochism. The problem of masochism gained increasing importance to Freud in the final years of his life. His major paper, "The Economic Problem of Masochism" (1924C;19:157ff), presents his definitive statement on the subject, based on his notion of the death instinct. This paper ties together a number of theoretical and clinical loose ends and is therefore difficult to review adequately. In some ways it is an extension of his earlier major theoretical work, *Beyond the Pleasure Principle* (1920G;18:3ff). The paper begins by straightening out the distinction between three principles introduced and discussed in the earlier work. The *nirvana principle* is defined as the endeavor on the part of the mental apparatus to keep the quantity of excitation present in it as low as possible, or at least to keep it constant. The *pleasure principle* is defined as a regulating principle that causes mental events to take a direction such that the final outcome coincides with at least an avoidance of unpleasure or a production of pleasure. At first Freud assumed these two principles to be either correlated or identical, but he realized in "The Economic Problem of Masochism" that they are not, since there are unquestionably states of increasing tension, such as sexual

excitement, which are pleasurable. In *Beyond the Pleasure Principle* he had already suggested that the rhythm or temporal characteristics of the changes and excitations might determine the pleasurable or unpleasurable quality of a state. He defines the nirvana principle as attributable to the death instinct and the pleasure principle to the influence of the life instinct. The *reality principle* represents in turn a modification of the pleasure principle under the influence of the external world.

Freud then turns to the clinical distinction of three kinds of masochism. One kind—*erotogenic masochism*, or pleasure in pain—lies at the bottom of the other two of these. *Moral masochism* refers to the profound unconscious sense of guilt discovered in neurotic patients by psychoanalytic clinical work. *Feminine masochism* has to do with the form of perversion in which secret fantasies place the subject in a feminine situation of being castrated, copulated with, or giving birth to a baby. Feminine masochism, which underlies masochistic perverted performances, represents pleasure in pain and as such is "entirely based on the primary, erotogenic masochism—which, of course, he believed to have its basis in the death instinct.

Thus "a very extensive fusion and amalgamation, in varying proportions, of the two classes of instincts take place" and "corresponding to a fusion of instincts of this kind, there may, as a result of certain influences, be a *de*fusion of them" (p. 164). This corresponds to the remarkable concept of the

taming (*Båndigung*) of one instinct by another—the action by which the libido can make the death instinct innocuous. In a later paper (Freud 1937C;23:225) he defines this process as: "The instinct is brought completely into the harmony of the ego, becomes accessible to all the influences of the other trends in the ego and no longer seeks to go its independent way to satisfaction. If we are asked by what methods and means this result is achieved, it is not easy to find an answer."

Translated into clinical experience, I believe this description emphasizes one of the most serious problems in the intensive psychotherapy of the borderline patient (Chessick 1977). Dealing with the raw aggression pouring out of the patient—an aggression which seems to represent the consequence of a regressive defusion in the patient's instinctual life—and also somehow, in Freud's sense, "taming" this aggressive output, seems to be a crucial task that determines whether the treatment will succeed or fail. In my clinical experience there is no doubt that this self-destructive aggression does carry with it *a form of gratification* which the patient is required to renounce in the interest of obtaining maturity and mental health. In some cases this gratification seems so intense that the patient is unable to make the renunciation and the treatment fails. It is not necessary to postulate a death instinct to explain this phenomenon. We know that the unbridled, massive discharge of sexual desire can be intensely pleasurable; the unbridled discharge of aggression can also have gratification attached to it. The self-

destructive aspect could be understood here as a secondary phenomenon, part of the price the patient pays for the pleasure. This remains an unresolved clinical issue (see chapter 21).

In moral masochism (described above) the direct connection with sexuality has been loosened, as Freud points out. Here the pleasure is not in having physical pain inflicted, but in humiliation and mental torture. Freud designates as a clinical sign of such patients that they have a negative therapeutic reaction. That is, they need to remain sick and to endure pain and suffering, which constitutes a most powerful serious resistance to successful treatment. Recent work makes it clear that not all situations of negative therapeutic reaction are based on moral masochism; the narcissistic blow of discovering that the therapist knows something that the patient does not may contribute to a rage and even a departure from treatment that appears to be a negative therapeutic reaction (Chessick 1974).

Freud believed that moral masochism or the unconscious sense of guilt rests on a wish for punishment at the hands of the father. This is a regressive distortion of the wish to have a passive or feminine sexual relationship with the father. A case in point is the early behavior disturbance of the Wolf-Man (see chapter 7) in which the young boy's misbehavior clearly was designed to invoke a beating from the father, resting in turn on a passive feminine attitude toward the father.

In "Dostoevsky and Parricide" (1928B;21:175ff) Freud gives an interesting clinical example of his notion of masochism. Dostoevsky's very strong destructive instinct, especially his aggression toward his father— which might easily have made him a criminal—was instead directed mainly against his own person "and thus finds expression as masochism and a sense of guilt." Freud regards Dostoevsky's epilepsy as hystero-epilepsy, not a true organic epilepsy.[v] This reaction is at the disposal of the neurosis and attempts by somatic means to get rid of amounts of excitation which it cannot deal with psychically. Dostoevsky's affective epilepsy began with feelings of impending death, which Freud regards as punishment for his death wish to his father and identification with the hopefully dead father. This in turn is seen as a secondary to Dostoevsky's fear of his feminine attitude toward his father. The seizures, which were punishment for the death wish, stopped in Siberia when the Czar administered the unconsciously needed punishment. This analysis also explains Dostoevsky's masochistic identification with criminals and his need to ruin himself by compulsive gambling. The gambling further represents a manifestation of his urge to masturbate, an urge connected with his latent sexual wishes toward his father, says Freud.

Feminine Psychology. I have already dealt at length with the unsolved problem of feminine psychology in chapter 14 of *Great Ideas in Psychotherapy* (1977a) and elsewhere (1988); therefore, my discussion of Freud's views on this subject will be brief. The interested reader is referred to my writings and

to a thorough review of the subject by Eissler (1977). The paper "Some Psychological Consequences of the Anatomical Distinction Between the Sexes" (1925J;19:243ff) contains Freud's reassessment of the entire subject, written when he was 69, and contains the germs of all his later work on the topic. (A complete review of his views with appropriate references is found in the editor's introduction to Freud’s paper.) In this work Freud clearly states that the woman's discovery that she has no penis is a wound to her narcissism, which leads to a certain sense of inferiority, jealousy, and the loosening of the girl's relationship to the mother as love-object. Thus "Whereas in boys the Oedipus complex is destroyed by the castration complex, in girls it is made possible and led up to by the castration complex" (p. 256). The little girl turns to the father for a baby instead. This leads Freud to the logical conclusion that the Oedipus complex in girls escapes the fate it meets with in boys—in girls it may be slowly abandoned or dealt with by repression. Here Freud is led to some disparaging remarks about women.

A very important warning must be added here for the practice of intensive psychotherapy. *Freud’s unfortunate, disparaging remarks about women must be separated from his depiction of the vicissitudes of the Oedipus complex in women*. Clearly his attitude about women is a reflection of his age and his culture and perhaps his personal experiences and idiosyncrasies. The practicing psychotherapist should not be misled by these prejudicial remarks into ignoring Freud's basic description of female sexuality. The little girl *is*

disappointed by the narcissistic blow that she has no penis; she turns out of this disappointment to the father in order to obtain a baby from him, which in a way substitutes for the lost penis. As Freud explains, a wave of repression of this narcissistic wound (and the corresponding wish for a penis) occurs at puberty, an event which has the function of doing away "with a large amount of the girl's masculine sexuality in order to make room for the development of her femininity." Along with the blossoming of the feminine orientation, there is a shift in the narcissistic focus on the genitals from the clitoris to the vagina. The existence of this clitoral-vaginal transfer has not been refuted by experimental work on the physiology of the female orgasm, since the transfer is primarily a normal psychological shift in narcissistic emphasis as a function of the development of femininity. If it has not occurred, a miscarriage of female adult sexuality has taken place. This is a matter of the greatest clinical significance and must be watched for in the assessment of the psychodynamic structure of female patients.

Freud's second important paper on the psychology of women (1931B; 21:223ff) further emphasizes the intensity and long duration of the little girl's preoedipal attachment to her mother. This paper is a restatement of the finding of the previous paper (discussed above) six years earlier and is continued a year later in Lecture 33 of the *New Introductory Lectures* (1933A;22:3ff). This paper represents Freud's final answer to Karen Homey, a famous psychoanalyst who disputed his views on female sexuality. Freud

essentially saw the little girl beginning as a little man, whereas Horney argued that feminine Oedipal feeling develops spontaneously in the girl, who then temporarily takes flight in the phallic narcissistic position. Freud's writing on female sexuality contains what for him is an unusual addition—some criticisms of a number of other authors' papers. Strachey writes, "It is a curious thing that he seems to treat them as though these papers had arisen spontaneously and not, as was clearly the case, as a reaction to his own somewhat revolutionary paper of 1925" (Freud 1931B;21:223). Freud points out that where a woman's attachment to her father was particularly intense, analysis showed the attachment to have been preceded by a phase of exclusive, equally intense and passionate attachment to her mother. This is an important clinical point. For example, Freud notes that certain women who seem to have chosen a husband on the model of their father repeat toward the husband in their married life their bad relationship with the mother. Thus the husband of such a woman was meant to inherit the relation to the father, but actually inherited the relation to the mother. Here we have the important clinical point: "With many women we have the impression that their years of maturity are occupied by a struggle with their husband, just as their youth was spent in a struggle with their mother" (p. 231). Boys are more easily able to keep intact their attachment to their mother because they are able to deal with the ambivalent feelings for their mother by directing all their hostility onto their father.

In his review of the literature, Freud oddly makes no reference to his own previous major paper (1925J as discussed above). Against Horney and perhaps even Jones he approves the views of his three "pioneers in feminine psychology." This was Freud's phrase, according to Deutsch (1973), to depict the early female psychoanalysts Ruth Mack-Brunswick, Jeanne Lampl-de Groot, and Helene Deutsch. I (1977a) discussed these views of Freud's "pioneers" elsewhere. They are falling increasingly into disrepute, but they do offer some very interesting ideas for the psychotherapist to ponder.

In Lecture 33 of the *New Introductory Lectures on Psychoanalysis* (1933A;22:112-135) Freud reviews this same material in a less technical way and ends with an unbelievably disparaging discussion of adult women. At the same time an important clinical point is made in Freud's opinion that a mother is only brought unlimited satisfaction by her relationship to a son; he considers it to be the most perfect and free from ambivalence of all human relationships. According to Freud, a mother can transfer to her son the ambition which she has been obliged to suppress in herself, and she can expect from him the satisfaction of all that has been left over in her of her masculinity complex. In the light of the disparaging comments about women that follow this paragraph, one wonders if Freud is talking about his own life history. Is Freud's narcissistic rage showing here? Was he stirred to achieving greatness by an attempt to live out his mother's ambitions?

Freud's attitude toward women continued to the end of his life. In the posthumous *Outline of Psychoanalysis* (l940A;23:141ff) he points out that it does little harm to a woman if she remains with her feminine Oedipus attitude unresolved: "She will in that case choose her husband for his paternal characteristics and be ready to recognize his authority" (p. 194).

[v] Scholars today generally agree that the story of the "murder" of Dostoyevsky's father, on which Freud's argument for this diagnosis rests, is at best unproven; most scholars agree that the father died of apoplexy (Snow 1978).

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