

THE TECHNIQUE OF PSYCHOTHERAPY

THE UNCOVERING OF
**UNCONSCIOUS
MATERIAL**

LEWIS R. WOLBERG M.D.

The Uncovering of Unconscious Material

Lewis R. Wolberg, M.D.

e-Book 2016 International Psychotherapy Institute

From *The Technique of Psychotherapy* Lewis R. Wolberg

Copyright © 1988 by Lewis R. Wolberg

All Rights Reserved

Created in the United States of America

Table of Contents

The Uncovering of Unconscious Material

THE SYMBOLISM OF THE UNCONSCIOUS

NUCLEAR CONFLICTS

DERIVATIVE CONFLICTS AND THEIR MANAGEMENT

Figure 44-1 Personality Mechanisms

FORGOTTEN MEMORIES AND EXPERIENCES

HYPNOTIC RECALL OF FORGOTTEN MEMORIES

THE HANDLING OF UNCONSCIOUS MATERIAL

ILLUSTRATIVE CASES

The Uncovering of Unconscious Material

Where our goal in therapy is purely symptom relief or problem-solving there is no need, as a general rule, to delve into the depths of the unconscious. Treatment planning is focused on biochemical, neurophysiological, conditioning, manifest interpersonal, and social-environmental issues. The use of pharmacological, behavioral, persuasive and other supportive and reeducative interventions usually will suffice to achieve our objectives. It is only where symptoms and behavioral abnormalities are generated by intrapsychic pathology, or where such pathology acts as resistance to our effective employment of symptom-oriented and problem-solving methods that we may have to focus our sights on some areas beyond the zone of awareness. Our hope here is that the mobilization of sufficient insight into unconscious saboteurs will liberate the individual from their obstructive influence.

Illuminating certain aspects of unconscious conflict, however, is an integral part of our therapy where our goal is personality reconstruction. The roots of the disturbance that we seek to eliminate are buried so deeply that the employment of an uncovering process is desirable if not mandatory. This process, oriented around development of insight, is depreciated by many non-analysts who regard it as an unnecessary and even obstructive formality. More rapid and effective relearning can be achieved, they claim, through other cognitive and conditioning procedures. While insight in itself has been grossly exaggerated as a curative force [“as every experienced therapist knows some patients change in therapy without achieving insight and some patients achieve insight without ever changing” (Fierman, 1965)], it is the *sine qua non* to self-understanding. Cognitive restructuring, however, does not follow in the wake of insight; rather it is a consequence of the working through of this knowledge toward an acquisition of new modes of thinking, feeling, and behaving.

The “depth” of exploration of repressed conflictual foci will vary according to the needs of the patient. It is doubtful that a total divulgence of unconscious material is ever required. Nor is it possible, through the use of any of the techniques known today—focused interviewing, free association, dream and fantasy interpretation, exploration of transference, hypnoanalysis, narcoanalysis, art therapy, play therapy, etc.—to uncover the unconscious completely. There are some repressions that seem to remain

insoluble in the face of the most skilled therapeutic handling. Fortunately, however, most people may be helped sufficiently through the gaining of insight into merely some of their unconscious conflicts.

Among repressed and repudiated aspects of psychic activity are fears and fantasies associated with the various bodily functions, particularly eating, excretion, and sexuality. There are hostile and destructive impulses directed toward other persons and toward the self. There are traumatic memories and experiences too painful to be recalled in consciousness. There are incestuous desires and other unresolved sexualized elements. There are impulses toward sadism, masochism, voyeurism, exhibitionism, and repudiated homosexuality. There are such normal strivings as desires for love, companionship, recognition, self-esteem, independence, and creative self-fulfillment, which have developed incompletely or, for anxiety reasons, been abandoned. There are, in addition, rejected neurotic drives for affection, dependence, superiority, dominance, ambition, power and detachment as well as the conflicts that these drives initiate.

Efforts to banish from mind certain painful needs and conflicts may temporarily mask the merciless hold they have on the individual. There may be awareness of some character drives, for example how dependent one is in a relationship. Dependency however, may not be recognized as a key motif in one's life that undermines self-esteem, nurtures helplessness, and kindles hostility and anxiety.

The specific psychic elements that are repressed are a product of the unique experiences of the individual. Any aspect of feeling or thinking or behaving may be subject to repression if it conflicts with social standards, as transmitted to the patient by the parent through disciplines. These injunctions, incorporated into the superego, continue to exert pressure on the person. In our culture such impulses as sexuality, hostility, and assertiveness are particularly subject to repression. Also commonly repudiated are impulses toward dependency and passivity as well as compulsive drives for power and independence.

In spite of deflection from the mainstream of the individual's thinking, repressed material may gain access to awareness in the form of highly symbolized and distorted derivatives. It is through detection and translation of such derivatives that awareness of the deeper content becomes possible.

THE SYMBOLISM OF THE UNCONSCIOUS

Thus, the patient's dreams, fantasies, free associations, symptoms, and behavioral tendencies may reflect unbelievably primitive or childish symbols. Often, expression is couched in terms of various organ functions. Simple activities, such as sucking, eating, excreting, and sexual functioning, may represent a host of attitudes and strivings. *The form of expression may seem bizarre, senseless, and without rational design.* A need for security and dependency may thus appear as a desire to suck the breast, penis, or nipple. All parts of the body, including the genital organs, may be implemented in this sucking process. Dependency may also be expressed by fantasies of cannibalistic incorporation of a real or nonexistent person. The amalgamation may be achieved by other means, as by entering the body of the person through any of the various orifices, by sexual intercourse, or by changing into a phallus and being sucked up into the vagina and womb. There may be a peculiar extension in which the person on whom the subject wishes to depend is identified with the fecal mass, with resultant overevaluation of excretory products and activities.

Hostile attitudes toward women may be represented by the biting and destroying of a female figure, or of a woman's body contents, breast, or nipple, or of a fantasied penis within her abdomen. This attack may be attempted with the mouth, anus, or penis or with excretory products. Destructive feelings toward males may be symbolized by impulses to castrate, or to devour or incorporate the penis or the body conceived as a penis. Fantasies of eating or expelling loved or hated persons in the form of feces may occur.

Guilt feelings and fears of retaliation may be symbolized by fantasies of being eaten or castrated by devouring animals, ghouls, monsters, or witches, of being absorbed into a vagina for purposes of destruction, of being attacked by a male sexual organ, a female organ, or an imagined intravaginal penis. There may be fears of being penetrated anally by the penis of a strong man or of being injured and killed by feces. A loss of aggressiveness and intactness may be designated by a fear of castration; this may be accompanied in males by reparative attempts and in females by a denial of the fact that there is no penis or by frenzied attempts to secure one in fantasy from a paternal, fraternal, or maternal person in whose body a penis may be imagined to exist.

Phallic symbolism is extraordinarily common in unconscious ideation. Some persons are more

prone than others to use it to express basic needs and attitudes. Sexuality here becomes a magical shortcut to close relationships with people and the nucleus around which the individual's thoughts and symptoms are oriented.

The clinical importance of sexual symbolism lies in its projection and displacement onto seemingly unrelated objects, the complete dynamics of which cannot be understood until the sources in the unconscious are divulged. Possession of an intact male organ is frequently utilized to represent a sense of aggressiveness and power. Strivings for strength, activity, and dominance may thus be symbolized unconsciously by a desire for a penis in a female, who may believe that possession of a penis is a magical solution for all of her problems, including the fear of functioning as a female. Compulsive vomiting may have its origin in need to disgorge a fantasied devoured penis, or it may represent a denial of the desire to incorporate the penis through swallowing. Anorexia nervosa may connote a persistence of the childish fantasy that pregnancy comes about through eating. Phallic overvaluation may also bring about a wish for a larger and more powerful penis in a male. Submission, passivity, and subordination may be signified in a woman by the lack of a penis and in a man by desires for breast, castration, and homosexuality. Where security is sought through dependency and subordination, castration may also be a goal that is usually countered by a desire for activity and a fear of castration.

Unconscious symbolism is so incompatible with rational thinking that its very existence may be denied, even by professionals who are dealing with some of its manifestations. Rarely do unconscious symbols break through directly, except perhaps in dreams or under the influence of psychotomimetic drugs like LSD. During psychotic breaks also, symbolisms of nuclear conflicts may appear in more or less direct form.

NUCLEAR CONFLICTS

There is imbedded in the psyche of each person products of the inevitable clash of maturing needs and reality restrictions, the mastery of which constitutes one of the primary tasks of psychosocial development. It must be emphasized that these conflicts are universal qualitatively, though quantitatively differing in all persons as a result of constitutional and conditioning variations and the integrity of the existing defenses.

The earliest nuclear conflicts are organized in relationship to the parents. For instance, the infant's association of the presence of mother with satisfaction of his or her needs (hunger, thirst, freedom from discomfort and pain, demand for stimulation) results in her becoming affiliated with gratification of these needs, with pleasure and the relief of tension. At the same time the absence of mother becomes linked to discomfort, distress, and pain. During the last part of the first year the child reacts with what is probably a primordial type of anxiety to separation from the mother, and with rage at her turning away from him or her toward anybody else, child or adult. This blended gratification-deprivation image of mother is probably the precursor of later ambivalencies, powering sibling rivalry and the rivalries during the oedipal period. It also gives rise to motivations to control, appease, and win favors from mother and mother figures, to vanquish, eliminate, or destroy competitors for her interest and attention, and to punish mother and mother figures for actual or fancied deprivations. The mother symbol becomes symbolically linked to later sources of gratification or deprivation. Moreover, if a disruption of homeostatic equilibrium occurs at any time later on in life or if for any reason anxiety erupts with a shattering of the sense of mastery, the primordial anxiety imprints may be revived, activating separation fears and mother-invoking tendencies along lines pursued by the individual as an infant.

The gratification-deprivation, separation-anxiety constellations, laid down during phases of development early in the period of personality growth will tend to operate outside the zone of conscious awareness. Whenever habitual coping mechanisms fail the individual and anxiety is experienced, the individual may feel the helplessness and manifest the behavior of an infant, and may seek out, against all logic, a mother figure or her symbolic substitute (such as food in compulsive eating activities). It is little wonder that mothers, and their later representatives (protectors, authorities), come to possess symbolic reward (pleasure) values along with symbolic abandonment (pain, anxiety) potentials. This conflict, deeply imbedded in the unconscious, acts as compost for the fertilization of a host of derivative attitudes, impulses, and drives that remain with the individual throughout life. Other conflicts develop in the child's relationships with the world that are superimposed on the conflicts associated with the demand for magic and for the constant presence of the mother figure.

The actual experiences of infants during the first years of life, the degree of need gratifications they achieve, the relative freedom from deprivation, their learning to tolerate some frustration and to accept temporary separation from their mothers provide them with coping devices to control their nuclear

conflicts, which, nonetheless, irrespective of how satisfying and wholesome their upbringing may have been, are still operative (albeit successfully repressed), waiting to break out in later life should the psychological homeostasis collapse.

Nuclear conflicts, to repeat, are inherent in the growing-up process irrespective of the character of the environment. This is not to say that a depriving or destructive environment will not exaggerate the effect of conflict or keep it alive beyond the time when it should have subsided; a wholesome environment will tend to keep in check operations of conflict, helping to resolve it satisfactorily. *Nuclear conflicts are in part ordained by biological elements and in part are aspects of the culture. We should expect their appearance in minor or major degree in all persons. Their importance is contained in the fact that they give rise to reaction tendencies that, welded into the personality structure, may later interfere with a proper adaptation.* Of clinical consequence, too, is their tendency to stir from dormancy into open expression when anxiety breaks down the ramparts of the existent defensive fortifications.

The exposure of repressed nuclear conflicts *that are creating problems* constitutes a task of dynamically oriented therapy, the object being to determine the distortions they produce in the character structure, their affiliation with current conflicts, and the subversive role they play in symptom formation. It may be possible even in short-term therapy—especially in dreams, transference, acting-out behavior, and certain symptoms—to observe how an important nuclear conflict is continuing to disturb the present adjustment of the patient.

DERIVATIVE CONFLICTS AND THEIR MANAGEMENT

In contrast to nuclear conflicts that are relegated to unconscious oblivion, many derivative conflicts issue from these conflicts and become part of the character structure.¹ A remarkably uniform arrangement of traits occurs in all people, distinguishing features being fashioned by the unique developmental experiences and by the subculture. These traits are not necessarily handicapping except when they become exaggerated and interfere with relationships with people and when they contribute to a defective self-image.

At the core of many problems are *excessive dependency needs* that had not been adequately resolved

in childhood. A healthy balance between dependency and independence is essential for emotional well-being. Where it does not exist, problems ensue. Most likely the average person's childhood yearnings for nurture and affection were not optimally met, leaving a residue of unmet needs that tend to express themselves intensely when the pressures of life mount. Or dependency was pathologically encouraged by a mother who utilized the child as a vehicle for her own unfulfilled demands, hampering the child's growth and strivings for independence. *Unresolved dependency is a ubiquitous fountainhead of troubles. It stems from what is perhaps the most common conflict burdening human kind—inadequate separation-individuation.* And people are apt to blame their troubles on the world: the revolt of youth, governmental corruption, inflation, communism, capitalism, or the atom bomb. Most people, however, somehow muddle through, working out their troubles in one way or another. It is only where separation-individuation is too incomplete and dependency needs too intense that solutions will not be found.

People with powerful dependency needs will often cast about for individuals who demonstrate stronger qualities than they themselves possess. When a swimmer tires, he or she looks about for something or someone on whom to lean or with which to grapple. A dependent person can be likened to a tired swimmer, who wants to find someone or something who can do for one what one feels cannot be done for oneself. What the person generally looks for is a *perfect* parent, an ideal that exists only in a personal fancy. Actually, there are no perfect parental figures who are able or willing to mother or father another adult. So our dependent person is continually being frustrated because his or her hopes and expectations are not met by someone else. A man who weds expecting an all-giving mother figure for a wife is bound to be disappointed. Further, if he does find a person who fits in with his design and who treats him like a helpless individual, he will begin to feel that he is being swallowed up, that he is losing his individuality, that he is trapped. Consequently, he will want to escape from the relationship. Also, as he senses his dependency, he will feel that he is being passive like a child. And this is frightening because he knows that he is not being manly; he may actually have homosexual doubts and fears since masculinity is associated with activity and independence. Women are no less victimized by dependency than are men. And their reactions are quite similar in that they are apt to regard both males and females on whom they get dependent as potential nurturing mother figures.

A second consequence that inevitably accompanies the first is *resentment* (hostility). Resentment invariably fires off because either one must find a perfect parent who will take care of everything or feel

trapped when someone does take care of matters thus prompting feelings of passivity and helplessness. Resentment breeds guilt because people just are not supposed to be hateful. Even guilt does not always keep the hostility hidden. Sometimes when a man has had too much to drink or when he is very frustrated about something, his hate feelings leak or pour out. That in itself can be terribly upsetting because he may fear he is getting out of control; or the mere awareness of his inner angry condition can make him despise himself. *Sadism* and sadistic behavior may be directed at the object of his dependency, who he believes is trapping him or who fails to live up to expectations. It may be drained off on scapegoats: blacks, Chicanos, Jews, communists, capitalists, and so on. Self-hate complicates his existence because it sponsors tension and depression. Hatred directed outward and then turned in results in *masochism*, in the form of major and minor self-punishments. These may range from fouling up a business deal to inability to accept success, to dangerous accident proneness, to physical illness, to foolish, outrageous, or embarrassing behavior.

Dependency and resentment are two sides of the same coin. The picture is not complete, however, without a third consequence, *low independence*, which is an invariable counterpart of high dependence. Low independence is a feeling that one cannot gain, by one's own reason or strength, the desirable prizes of our culture—whether they be love and justice or wine, women, and song. A spin-off of low independence is a *feeling of inferiority*, a lack of proficiency on achieving desirable goals. Part and parcel of inferiority feelings is the uncertainty about being manly and masculine. Self-doubts about one's sexual integrity are torturous; the usual sequel is to try to compensate by being the quintessence of everything powerful: overly aggressive, overly competitive, and overly dominating. Proving himself with women may lead to satyriasis and Don Juanism. Our man may have fantasies and images in his mind of strong men (often symbolized by their possessing large penises) and may be particularly attracted to them because of their strength. But his awareness of how much he thinks about men may cause him to wonder if he is homosexual and to fear the very things that he admires. He may actually on occasion be sexually attracted to idealized male figures, and he may fantasize incorporating their penises into himself. This may produce consternation and guilt feelings.

Interestingly, low independence feelings in women lead to the same self-doubt and compensations as in men. Some women will try to repair the fancied damage to themselves by trying to acquire the characteristics of men (penis envy) through the outer trappings of masculinity (e.g., acting aggressively,

swaggering, and wearing male apparel, etc.) that in our culture are symbolically equated with independence. They will compete with and try to vanquish and even figuratively castrate males. In its exaggerated and pathological form, they will act toward other females as if they themselves are males, dominating and homosexually seducing them.

The constant reverberating of these three traits will leave our man feeling spiteful toward himself in the form of a devaluated self-image. He feels he is miserably incompetent, undesirable, and unworthy. Everywhere he sees evidence of his insignificance: he is not tall enough, he has developed a paunch, women do not seem to pay attention to him, his hair is thinning, his job is not outstanding; his car, his house, his wife—nothing is perfect. He may even think his penis is of inadequate proportions. He feels like a damaged person. These feelings torment him, and he vows to prove that he is not as devalued as he feels. He commits himself to the task of being all-powerful, ambitious, perfect so as to repair his devalued self-image. Then he imagines he can surely respect himself. If he can live without a single misstep, all will be well. He tries to boost himself on his own to the point where others will have to approve of him. He may only daydream all this, or he may, if events are fortuitous, accomplish many of his overcompensatory goals.

If he climbs high, he will most likely resent those below who now lean on him and make demands on him. To those who exhibit weakness, he will show his anger. While he may be able to be giving on his own terms, an unexpected appeal from someone else will be regarded as a vulgar imposition. He actually wants for himself someone on whom to lean and be dependent. However, giving in to such a desire speeds up his doubts and makes him feel even worse. He may pursue just the reverse course from his original dependency drive by competing with any strong figure on whom he might want to lean. He shows the pseudo-independence reminiscent of the adolescent who disagrees on principle with whatever the parents say. And he may compensate for his devalued self-image by exploiting all the cultural symbols of being a worthy person, such as being perfectionistic, compulsively ambitious, and power driven. These compensatory drives may preoccupy him mercilessly, and he may organize his life around them. One failure means more to him than twenty successes, since it is an affirmation of his lowly status.

These difficulties are compounded by the way they interact with our man's sexual needs. When

one's dependency needs are being gratified, there is often a pervasive feeling of well-being that floods one's whole body. Upon awakening following surgery, for example, the confident, smiling face of a nurse can suffuse a man with grateful, loving feelings, at least part of which may be sexual. The sexual feeling is not that of adult male to adult female but rather that of a helpless child toward a warm mother. Such a feeling is tantamount to an incestuous surge and may bring with it great conflict and guilt. Should this dependency be the nature of a husband's continuing relationship to his wife, he may be unable to function sexually with her since he is virtually involved in a mother-son relationship. On the other hand, if the nurturing figure is a man, homosexual fears and feelings may arise with equating of the host's penis with a nipple. For women the dependency situation does just the reverse. A nurturing mother figure calls up in her fears and feelings of homosexuality which may or may not be acted out in passive homosexuality with yearnings for the breast. Moreover, low feelings of independence may, as has been indicated, inspire ideas of defective masculinity in males with impulses to identify with muscle men. Fantasies of homosexuality or direct acting-out of homosexual impulses may follow. In women, feelings of defective independence may inspire a rejection of the feminine role and fantasies of possessing a penis, the symbol in our culture of power and independence. Sadism and masochism may also be acted out in sexual activities in both men and women.

The reverberation of all these traits calls for strenuous efforts on the part of our subject. Dependency, activated resentment, together with its components of aggression, guilt, and masochism threw into gear low feelings of independence, which in turn fueled self-devaluation with its many defenses and overcompensations.

Where can a man turn next to gain some sense of composure? He often turns to a fifth characteristic, *detachment*. Detachment is an attempt at escaping from life's messy problems. Our man by now is fed up with the rat race and wants to get out. He says, "No more committees, no more parties, no more responsibilities, no more extras of any kind, no more involvement with people" He wants an island fortress, or at least a castle with a moat around it, and he would pull up the drawbridge and say no to everything and everyone. He is sure that this is the solution; he decides not to become rich and famous.

But it does not work. People need people. Life is not satisfying alone. Our man finds loneliness to be a worse state than what he was enduring before. He realizes that people constitute one of life's richest

gratifications. So, he plunges in again. By now his dependency is really driving him. And if he is desperate enough, he may attach himself all over again to a figure who holds out some promise of being the perfect parent. Then the neurotic cycle is on its way again: power, hostility, low feeling of independence, devalued self-esteem, and detachment.

These drives are never entirely quiescent. In the average person outlets are invariably present to keep them going. There is no one whose dependency needs were perfectly met early in life. This hunger lives on, and with this hunger, the mechanism of dependency is continually operative. In our culture, in this generation, the unmet dependency needs set in motion the successive traits just described. As long as outlets of expression are controlled, the individual may manage to keep going, switching from one or the other and turning them off if they threaten to carry one away. To some extent all people are victims of these derivative conflicts—to a minor degree at least.

Dependency inevitably breeds resentment in our culture. If outlets for the resentment are not available and if compensations for a devalued self-image cannot be pursued—in other words, if the individual cannot readily switch from one satisfaction to another—then conflict and stress reach proportions where one feels catastrophically overwhelmed. When tension mounts excessively and there seems to be no way of escape, anxiety strikes with frightening fears of helplessness and dissolution. Operations to defend against anxiety may then be instituted, but the defense is often ineffective or more burdensome than the condition it was designated to combat.

Sometimes I draw a sketch on a blank paper showing high dependence, low dependence, devalued self-image, resentment-guilt-masochism, and detachment, and repeat the story of their interrelationship. I then ask the patient to figure out and study aspects that apply. If a general description of dynamics is given the patient, along the lines indicated above, a little insight may be inculcated that can serve as a fulcrum for greater self-understanding. The insight may be temporarily reassuring at first; then it seemingly is forgotten with a resurgence of symptoms. A review of what has occurred to stimulate the upset may consolidate the insight and solidify better control. This will have to be done over and over again. An important tool here is self-observation, which the therapist should try to encourage and which will help the working through process, without which insight can have little effect.

I once treated a patient whom we shall call Roger.² At the initial interview a well-groomed gentleman

presented himself with an expression of depression and bewilderment. The problem, he said, started while discussing seemingly casual matters with his best friend and partner during a lunch hour. He was overwhelmed with a feeling of panic, with violent heart palpitations and choking sensations, which forced him to excuse himself on the basis of a sudden indisposition. Back at work, he recovered partly, but a sensation of danger enveloped him—a confounding agonizing sensation, the source of which eluded all attempts at understanding. Upon returning home, he poured himself two extra jiggers of whiskey. His fear slowly vanished so that at dinner time he had almost completely recovered his composure. The next morning, however, he approached his work with a sense of foreboding, a feeling that became stronger and stronger as the days and weeks passed.

Roger had obviously experienced an anxiety attack the source of which became somewhat clearer as he continued his story.

The most upsetting thing to Roger was the discovery that his symptoms became most violent while at work. He found himself constantly obsessed at the office with ways of returning home to his wife. Weekends brought temporary surcease; but even anticipating returning to his desk on Monday was enough to fill him with foreboding. He was unable to avoid coming late mornings, and, more and more often he excused himself from appearing at work on the basis of a current physical illness. Because he realized fully how his work was deteriorating, he was not surprised when his friend took him to task for his deficiency. Forcing himself to go to work became easier after Roger had consumed several drinks, but he found that he required more and more alcohol during the day to subdue his tension. At night he needed barbituate sedation to insure even minimal sleep.

The surmise that I made at this point was that something in the work situation was triggering off his anxiety. I felt that Roger had attempted to gain surcease from anxiety by implementing mechanisms of control (first-line defenses, see p. 518) such as trying to avoid the stress situations of work and deadening his feelings with alcohol and sedatives. These gestures seemed not too successful since he was obliged to remain in the work situation no matter how much he wanted to avoid it.

Continuing his story, Roger said that wild, unprovoked feelings of panic were not confined to his work. Even at home, his habitual haven of comfort and safety, he experienced bouts of anxiety, which burst forth at irregular intervals. His sleep, too, was interrupted by nightmarish fears, which forced him to seek refuge in his wife's bed. A pervasive sense of helplessness soon complicated Roger's life. Fear of being alone and fear of the dark developed. Other fears then occurred, such as fear of heights, of open windows, of crowds, and of subways and buses. In the presence of his wife, however, these fears subsided or disappeared. Roger consequently arranged matters so that his wife was available as often as possible. For a while she seemed to relish this new closeness, for she had resented what she had complained about for a long time—his coldness and detachment from her.

What apparently had happened was that not being able to escape from the anxiety-provoking situation at work, and being unable to develop adequate first-line defenses to control or neutralize his anxiety, Roger was retreating to and sought safety in a dependent relationship with his wife (second-line defenses) that paralleled that of a small child with a mother. Various fears of the dark and of being alone were indicative of his childlike helplessness. This kind of adaptation obviously had to fail.

Not long after this, Roger continued, he developed fantasies of getting into accidents and having his body cut up and mutilated. When Roger confided to his wife that he was greatly upset by these occurring fantasies, she enjoined him to consult a doctor. He rejected this advice, contending that he was merely overworked, and he promised to take a winter vacation, which he was sure would restore his mental calm. Fearful thoughts continued to plague Roger. He became frightened whenever he heard stories of violence, and he avoided reading new accounts of suicides or murders. Soon he was obsessed with thoughts of pointed objects. Knives terrified him so that he insisted that his wife conceal them from him.

The return to a childish dependent position apparently mobilized fears that in too close association with a mother figure he would be subjected to smothering and destruction. Sexual feelings toward his wife were equated with forbidden incestuous feelings for which the penalty was fierce and bloody. Fantasies of accidents and bloodshed could be reflections of Roger's mutilation fears. The repetition of the oedipal drama thus could follow a shattering of Roger's repressive system. Attempting to reinforce repression by repressive measures (third-level defenses, see Fig. 37-1), Roger employed phobia formation striving to remove himself from symbols of mutilation such as knives and other cutting instruments.

When asked if he had other symptoms or fantasies, Roger, in an embarrassed way, confided that in the presence of forceful or strong men, he experienced a peculiar fear, which he tried to conceal. Sometimes he was aware of a desire to throw his arms around men and to kiss them in a filial way. This impulse disturbed Roger greatly, as did fantasies of nude men with huge genital organs. His sexual life continued to deteriorate. While he had never been an ardent lover, he had prided himself on his potency. His sexual powers now seemed to be disappearing; when he approached his wife, he was impotent or had premature ejaculations. This upset Roger and created fears that he never again would function well sexually. To disprove this, he forced himself compulsively to attempt intercourse, only to be rewarded by further failures. Anticipatory anxiety soon made sexual relations a source of pain, and when his wife suggested that they abstain, he agreed, but he was frightened that she would leave him for another man.

The fear Roger manifested of strong males, the desire to act in an affectionate way with them, the terror of homosexual assaults by nude men with huge genital organs were, if we follow our previous line of reasoning, the products of his fear of attack by father figures irate at his appropriation of the maternal object. A disintegration of Roger's sexual life was inevitable because he was relating to his wife not as a husband but as a child. Abandonment of a male role with his wife was, therefore, necessary to avoid anxiety. While serving as a spurious protective device, his sexual inhibition obviously further undermined his self-esteem.

In attempting to make a tentative diagnosis of Roger's condition at this point, I was confronted with the contemporary contradictions that plague our attempts at classification. All emotional difficulties

spread themselves over a wide pathological area, involving every aspect of the person's functioning—intellectual, emotional, physical, and behavioral. Based as they are on presenting complaints and symptoms, systems of nosology often lose sight of the fact that the entire human being is embraced in any emotional upheaval. The particular classification into which a patient fits then may depend merely upon the relative emphasis the diagnostic agent (i.e., the therapist) or the patient puts upon selected symptoms.

This may be illustrated in the case of Roger. His complaints were those of tension, irritability, explosiveness, anxiety, depression, psychosomatic symptoms, phobias, and obsessive thoughts. In addition, he exhibited a character disturbance in such manifestations as excessive submissiveness and dependency. Were Roger chiefly concerned with his physical ailments—his headaches, dyspepsia, listlessness, fatigue, failing health, or impotence—we would be inclined to regard him as a person suffering from physical disorders of psychological origin, that is, a type of somatoform reaction. Should his anxiety attacks have caused him greatest concern and were he to have focused his attention on his anxiety, we might classify him as “anxiety disorder.” In the event his depression was of prime interest, a diagnosis of “dysthymia” (psychoneurotic or reactive depression) might be entertained. If emphasis had been put on his obsessive concern with bloody amputations, death, and pointed objects, this might be called “obsessive disorder.” His fear of heights, subways, buses, crowds, and of solitude and the dark are those often found in “phobic disorders.” Finally, had his submissiveness, passivity, and other character defects been considered his most significant problem, he might be labeled as a “personality disorder.” The matter of diagnosis, then, would be essentially a matter of what seemed immediately important. Actually, we might say that Roger suffered from a mixed psychoneurotic disorder with anxiety, depressive, psycho-physiologic, obsessive, phobic, and distorted personality manifestations. This diagnostic potpourri is not surprising when we consider that every individual whose homeostasis has broken down exploits dynamisms characteristics of all levels of defense in addition to displaying manifestations, psychological and physiological, of homeostatic imbalance and adaptational collapse.

When Roger was asked what he believed had precipitated his anxiety originally, he was unsure, but he hazarded that it might have been related to a change in his position at work. Not long after his tenth wedding anniversary, at age 33, Roger was promoted to senior member of the firm. His elation at this was short-lived as he became conscious of a sudden depressed feeling, which progressively deepened. Inertia, boredom, and withdrawal from his ordinary sources of pleasure followed. Even his work, to which he had felt himself devoted, became a chore. Always eager to cooperate, he experienced, during work hours, a vague dread of something

about to happen which he could not define. He could not understand why he would react to a promotion that he wanted by getting upset.

Should a therapist not be interested in pursuing the patient's symptoms further to determine their origin in early past experience or in unconscious conflict, in other words, avoiding a dynamic approach, an abbreviated approach aimed at symptom reduction might now be selected without further probing into history.

First, an effort may be made to treat the symptoms through medicaments, like sedatives or tranquilizers for anxiety, and energizers for depression. Roger may be enjoined to slow down in his activities and to detach himself as much as possible. He might be requested to take a vacation, engage in hobbies and recreations in order to divert his mind off his difficulties.

Another way of handling the problem might be to assume the source of the difficulty to be Roger's work situation and to get him to change his job to one that did not impose too great a responsibility on him. He would be encouraged to try to detach himself more from his wife and slowly to begin functioning again on the basis of the customary distances that he once put between himself and others. Active guidance and reassurance may make it possible for Roger to return to his own bedroom and to assume indifference to his wife that might enable him to function without anxiety.

On another level, the therapist might utilize behavior modification methods to desensitize the patient to his anxieties as well as to institute assertive training to promote greater self-sufficiency and independence. Approaches such as these understandably would not correct any basic character problems that lay at the heart of Roger's distress. Yet they might make it possible for him to get along perhaps as well as he had ever done prior to the outbreak of his neurosis.

Since my approach was a dynamic form of short-term therapy aimed at some personality rectification, I proceeded to explore as completely as I could his past life through interviewing and to probe for more unconscious motivational elements through exploration of dreams and fantasies and through observation of the transference.

Roger was the younger of two brothers. He was reared by a domineering mother who was resentful of her role as housewife, which had halted a successful career as a fashion designer. Unhappy in her love life with her husband, she transferred her affection to her younger son, ministering to his every whim and smothering him

with cloying adulation. Roger's brother, George, bitterly contested this situation, but getting nowhere, he subjected his sibling to cruel reprisal. Roger's father, recoiling from the not too well concealed hostility of his wife, removed himself from the family as much as he could manage and had very little contact with his sons.

The dynamics in Roger's case became apparent during therapy. Basic to his problem was a disturbed relationship with his parents, particularly his mother. The yielding of her unmarried professional status to assume the role of housewife apparently had created in the mother resentment toward her husband and rejection of her children. This inspired a "reaction formation" in the form of overprotection, particularly toward her younger child, Roger. Frustrated and unfulfilled, she used Roger as a target for her own needs and ambitions with the following effects: (1) in Roger, encouragement of overdependence and passivity, strangling of assertiveness and independence, and stimulation of excessive sexual feelings toward the mother, and (2) in George, hostility displayed directly toward Roger as aggression, and (3) in her husband, detachment.

Overprotected by his maternal parent, neglected by his father, and abused by his brother, Roger took refuge in the relationship offered him by his mother. His dependency on her nurtured submissiveness and passivity, with alternative strivings of rebelliousness and fierce resentment which he repressed because they threatened the security he managed to derive through compliant behavior. Roger both cherished and loathed the crushing attentiveness of his mother. Toward his father and brother he felt a smothering fear, which he masked under a cloak of admiration and compliance.

The withdrawal of his father made it difficult for Roger to achieve the identification with a masculine object necessary for a virile conception of himself. Roger turned to his mother for protection. He revolted, however, against too great dependency on her, fearing that excessive closeness would rob him of assertiveness and that his aroused sexual feelings would bring on him disapproval from his mother as well as punishment from his father and brother. Repudiating competitiveness with the other male members of the family, he attempted to win their approval by a submissive, ingratiating attitude.

During adolescence Roger emerged as a quiet, detached lad, never permitting himself to be drawn into very intimate relationships. He was an excellent and conscientious student, and he was well-liked for his fairness and amiability. At college he was retiring, but he had a number of friends who sought his companionship because he was so easy to get along with. His romantic attachments were superficial, and the young women he squired to parties admitted that he was attractive but complained that it was difficult to get to know him.

Adopting detachment as a defense against a dependent involvement, and compliance as a means of avoiding physical hurt, Roger evolved a character structure that enabled him to function at home and at school, although at the expense of completely gratifying relationships with people.

Upon leaving college, he entered a business firm, arrangements for this having been made by his father. He resisted for two years the exhortations of his mother to marry the daughter of one of her best friends; but finally he succumbed, and he seemed satisfied and happy in his choice. The young couple lived in harmony, and he was considered by his group to be an ideal example of an attentive husband and, after his son was born, of a devoted father. His steadfast application to his work soon elevated his position, until he became a junior member of the firm. His best friend and confidant was one of the senior members, toward whom Roger bore the greatest respect and admiration.

His work and marital life, which were more or less arranged for him by his parents, turned out to be successful since he was able to employ in them his compliance and detachment mechanisms. Toward his best friend and other senior firm members, Roger related passively as he had related previously toward his father and brother. Toward his wife he expressed conventional devotion, keeping himself sufficiently distant to avoid the trap of a tempting dependent relationship that would threaten the independent assertive role he was struggling to maintain.

The only distressing element in Roger's life was his failing health. Constantly fatigued, he evidenced a pallor and listlessness that inspired many solicitous inquiries. Dyspeptic attacks and severe migrainous headaches incapacitated him from time to time. In addition to his physical symptoms was a pervasive tension, which could be relieved only by recreational and social distractions.

Inner conflict between dependency, submissiveness, compliance, detachment, and aggression, however, constantly compromised Roger's adjustment, producing a disruption of homeostasis with tension and psychosomatic symptoms. His failing health, fatigue, pallor, listlessness, dyspeptic attacks, and migrainous headaches were evidences of adaptive imbalance. What inspired this imbalance was an invasion of his capacity to detach, produced by the demands made on him by his wife and associates. In addition, his submissive and compliant behavior, while protecting him from imagined hurt, engendered in him overpowering hostility, which probably drained itself off through his automatic nervous system producing physical symptoms.

As might be expected, Roger's affability and needs to please won for him the praise of his superiors at work, and he was advanced and finally offered a senior position.

Had Roger at this point refused to accept senior membership in the firm, he might have escaped the catastrophe that finally struck him. His legitimate desires for advancement, however, enjoined him to accept. His conflict became more and more accentuated until finally he no longer was able to marshal further defenses. Collapse in adaptation with helplessness and expectations of injury announced themselves in an anxiety attack during luncheon with his friend.

As long as he had been able to satisfy to a reasonable degree his needs for security, assertion, satisfaction in work and play, and creative self-fulfillment, Roger was able to make a tolerable adjustment even with his psychosomatic symptoms. The precipitating factor that had brought about the undermining of Roger's capacities for adaptation was his promotion to senior membership in the firm. While Roger had ardently desired this promotion, for reasons of both status and economics, actually being put in a position of parity with his friend violated his defense of passivity, compliance, and subordination and threatened him with the very hurt he had anticipated as a child in relationship to his father and brother. To accept the promotion meant that he would be challenging of and perhaps triumphant over father and brother figures. This touched off fears of injury and destruction at the hands of a powerful and punitive force he could neither control nor vanquish. Yet Roger's desire for advancement, inspired by realistic concerns, made it impossible for him to give up that which he considered his due. Since he was aware neither of how fearfully he regarded authority nor of how he was operating with childish attitudes, he was nonplussed by his reactions.

A dream revealed during one psychotherapy session will illustrate some of our patient's maneuvers that became operative and apparent in therapy (see Fig. 44-1).

Pt. I had a dream last night that upset me. I am in bed with this big woman, big wonderful breasts. She's my wife, but she changes into a negress. She strokes and touches me all over, and I feel completely loved and accepted. I awoke from the dream with a strong homosexual feeling that upset me. [Here Roger symbolizes in dream structure his dependency impulses, his repulsion against his dependency, his incestuous desire, and the resultant homosexual residue and defense.]

Th. Yes, what do you make of this?

Pt. I don't know. The woman was comforting and seductive. I always like big-breasted women. Exciting. But my wife isn't as stacked as I'd like her, or as she was in the dream. (pause)

Th. How about the negress?

Pt. I never liked the idea of sleeping with a colored woman. Makes me feel creepy. Colored people make me feel creepy. I know I shouldn't feel that way. Last time I was here I noticed you had a tan like you had been in the sun. I said, "Maybe he's got negro blood." I know I shouldn't care if you did or not, but the idea scared me for some reason.

Th. Sounds like the woman in your dream was partly me. [This interpretation was proffered in the hope of stirring up some tension to facilitate associations.]

Pt. (pause) The idea scares me. Why should I want you to make love to me? (pause) By God, maybe I want you to

mother me, be giving, kind.

Th. How do you feel about me?

Pt. I want you to be perfect like a God; to be accepting and loving; to be wise and strong. I realize I'm dependent [motor one], I resent my need to be dependent on you [motor two]. When you show any weakness, I am furious. I feel guilty and upset about my feelings. I feel like killing anybody who controls me. I know I must face responsibility, but I feel too weak and unmasculine [motor three], I feel like a shit [motor four] and hate myself. I am a nothing and I'd like to be a somebody, but I can't.

Th. Apparently it scares you to be a somebody. When you were promoted, you started getting upset.

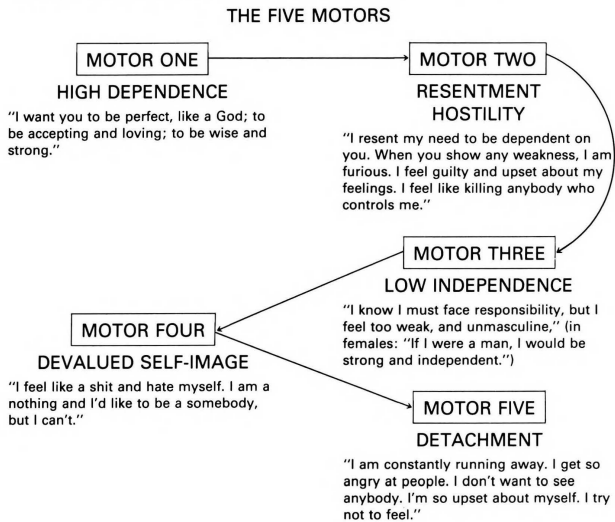
Pt. Why should I? I suppose I feel like I'm stepping out of my depth. Like I'm not man enough. The whole thing puzzles and frightens me.

Th. So what do you do?

Pt. I am constantly running away [motor five], I get so angry at people. I don't want to see anybody. I'm so upset about myself I try not to feel. But I can't seem to make it on my own. [The reinstating of motor one]

Figure 44-1 Personality Mechanisms

Fig. 44-1. Personality Mechanisms. From Wolberg LR, Kildahl J: The Dynamics of Personality. Orlando, FL, Grune & Stratton, 1970. p. 215, with permission.



FORGOTTEN MEMORIES AND EXPERIENCES

In the course of exploring the unconscious, experiences in the past that have been traumatic are apt to be revived by the patient. Forgotten memories may be remembered of which the patient may have been relatively or completely unaware. The importance of this material constantly comes up for appraisal.

There are those who believe that the recall of forgotten traumatic incidents in the developmental history is essential for cure in reconstructive therapy, since repressed memories are fountainheads of conflict. A criterion of cure set by Freud was a removal of the amnesia of the third and fourth years and a recovery of memories during this period that are associated with the patient's neurosis. There are other authorities who tend to disagree with this standard, believing that therapy, focused on immediate interpersonal relationships, can change personality without the need for probing into the past. This, it is avowed, is because the past is always repeating itself in the present and can be better managed when it becomes freshly apparent in contemporary behavior. Actually we are more concerned with a patient's *ideas* about his past rather than what actually happened in the past. The patient's *interpretations* about parental attitudes and behavior can be more important than the actual reality. One may observe this within some families when a parent behaves toward a child in what seems on the surface to be loving and giving, yet the child reacts as if being maltreated and tortured. A prejudiced child advocate might say that the child penetrates the facade of lovingness and recognizes that the parent is merely concealing maliciousness and rejection. But the advocate could be wrong in that it is the child who anticipates and even desires malicious treatment. Parents can communicate destructive designs to their children, wishfully anticipating that their offspring will act out fantasies that they themselves cannot openly express. Children are not entirely helpless pawns, however, and they do act out their own selfish promptings. Do we have to expose all past happenings before a person can get well? It is credibly established clinically that an individual in many ways relives the past in present behaviors, thoughts and feelings, and it is usually through working with present-day distortions that we can rectify the effect of past troubles rather than the other way around.

The mechanism associated with the repression of early experiences is organized around the need to avoid anxiety. In early childhood, inimical happenings are extremely traumatic. One reason for this is that the child feels relatively helpless in a world, the manifestations of which are a constant source of

mystery. Relations between cause and effect are indeterminate, and in this world there are many inscrutable menacing events over which the child has no control. One way of coping with childhood anxieties is to project them in the form of phobias. Another way of dealing with anxiety that threatens to overwhelm the immature ego is through processes of repression and dissociation. These phobic and repressive defenses continue to function far beyond the period of childhood, and the ego reacts to the original traumatic events as if it still were too weak and too vulnerable to deal with them. This is possibly the reason why many adults feel that there is something buried deep within themselves so terrifying that they cannot bear to bring it up.

An important question is whether early traumatic experiences are universally damaging. It is difficult to provide a complete answer to this question. All children undergo traumatic experiences of one sort or another during the period of socialization. A cataclysmic happening, however, can bring the effects of minor experiences to a head and can embody the accumulated emotions of all past inimical events.

Traumatic experiences in early childhood thus act upon a sensitized soil at a time when ego resources are relatively limited. Often these experiences, when uncovered, appear so insignificant that one might doubt their potency in evoking such disproportionate emotional responses. Yet, if one considers that the traumatic experience is a condensation of a series of damaging events and that it comes to stand symbolically for all of them, one may appreciate that it can be greatly overvalued.

As a general rule, early traumatic experiences are of two types. In one type the events are so devastating or destructive that no child could be expected to cope with them. This occurs where the child is severely injured physically or witnesses an incident so horrible that the experience takes away security. The other type of traumatic experience can in no way be considered extraordinary since it is a part of the normal growth process. Growing up involves the capacity to abandon narcissistic and omnipotent strivings, to tolerate frustration, to channelize aggression into socially accepted outlets, to control sexual impulses, and to develop independence and self-assertiveness. In the course of development, the child is subjected to many frustrations that involve abandonment of selfish strivings in favor of those that will bring cooperative relationships with others. Most children are capable of handling such frustrations without too great difficulty. However, an insecure child, and particularly one who has

been rejected and denied legitimate demands for love and support, will be so overwhelmed by feelings of helplessness that the child will be unable to tolerate frustration and to withstand traumatic experiences that are a usual component of growing up. Such an individual is likely to react catastrophically to relatively normal hardships such as are imposed on every child. Certain events, like the birth of a sibling, the discovery of the genital difference between the sexes, the witnessing of parental intercourse (“primal scene”), or exposure to any bloodshed and cruelty, may mobilize inordinate anxiety.

The insecure child may feel so threatened by rejection or punishment that the child will find it necessary to repress such impulses as hostility toward parents and siblings, masturbatory desires, sexual curiosities, and strivings for mastery, independence, and self-assertion. The repression of these impulses involves much experiment. The child for a long time defies the parents, even at the risk of incurring retaliatory punishment. Gradually, however, the child may yield to parental discipline. Frequently repression occurs dramatically following a particularly traumatic incident that convinces the child that danger can be real. For instance, an insecure child who retains certain rebellious tendencies may witness the flogging of a dog that has done something to offend its master. The child may be frightened by this brutal treatment and may unconsciously identify with the animal, fearing injury in the same way if he or she persists in defying the parents. The result may be a phobia in regard to dogs, the dynamic purpose of which is to be insulated against fear of aggressive impulses. The event comes to constitute a traumatic experience that may be repressed in an effort to avoid any reminder of pain. The dog phobia will, nevertheless, persist, aiding the repressive process.

During later life, too, even in adulthood, intensely traumatic experiences may shock the organism into a revival of the mechanism of repression. This move is motivated by a need to ward off a threat to the self. There are no better examples of this than those seen in the neuroses of war in which traumatic incidents may be blotted from the mind.

In the course of therapy the recovery of repressed traumatic experiences may ameliorate or dissipate certain symptoms, especially those that serve the function of keeping these memories repressed. Many compulsions, obsessions, and conversion symptoms fall into this category. The most dramatic results occur in simple conditioned fears and in amnesias of recent origin, such as hysterical amnesias, trauma of the skull, and exposure to unbearable stresses like those during disasters and war.

Where the personality is relatively intact and the individual has, prior to the traumatic event, functioned satisfactorily in interpersonal relationships, the recall of forgotten events may restore the previous status.

Theoretically, all symptoms have an historical origin. It may be argued that were we capable of probing deeply enough into the past, of penetrating the myriad conditionings, of reviewing every stimulus that ever invaded the senses and every idea that entered the mind, of peering into all influences, pleasurable and inimical that have impinged on patients, we might be able to demonstrate to them how each of their symptoms came into being. This task, however, is impossible, for many vital early experiences that have molded the personality are not accessible to recall, having occurred prior to the phase of mnemonic accessibility, or having been subjected to a practically impenetrable sealing-off process of repression. In spite of a most extensive analysis one is able to recapture only a fragment of the total of life experiences. Even where we have not laid out for ourselves so ambitious a task and are satisfied with reviewing the most important experiences in the patient's development, we find these so numerous as to defy recapitulation.

However, to indulge our imagination, we may conjure up a situation in which we track down the origin of each of the patient's symptoms. Having done this, we should probably find, in most cases, that the symptoms themselves would not vanish. The expectation that recovery of traumatic experiences will invariably produce an amelioration or cure of the patient's neurosis is founded on a faulty theoretic premise. Even though the individual's character structure is in a large measure developed from the bedrock of past experiences and conditionings, and even though damage of personality has resulted from untoward happenings in early interpersonal relationships, it does not follow that a recall of these experiences will correct the existing condition.

As an analogy, we may consider a focus of infection that operates insidiously over a period of years. The original source of the individual's physical disability is this infective focus, but by the time it is discovered, it has already influenced other bodily structures. It may have produced kidney damage or acted as a stimulus of secondary foci of infection. The removal of the primary focus will leave the body still suffering from the effects of the original infection, and it will be essential to cure these secondary effects before the patient can be pronounced cured. A single catastrophic experience or a series of harmful experiences can likewise act as a focus, engendering in an insecure person the conviction that

the world is menacing and that the people in it are not to be trusted. The experience may influence the individual in forming decisive attitudes and reaction patterns. By the time of adulthood, however, the manner of dealing with the conflicts will have been structuralized into behavior so ingrained that the recall of the original trauma will have little effect upon habitual responses. Therapy will involve tedious reeducation and reconditioning long after the recall of the initial traumatic memories.

Often during therapy a patient may recover the memory of a forgotten traumatic happening and through this recall may experience considerable abreaction. The patient may even be liberated from certain associated symptoms. However, the essential difficulty will probably remain. The patient will still be insecure. The circumstances that sensitized the patient to the original traumatic scene will continue to plague him or her in daily interpersonal relationships. The essential task in therapy, therefore, would seem to lie not only in recovery of early traumatic experiences, but also in ascertaining the reasons why the experiences became so catastrophic as to necessitate repression. Ultimately, a remodeling of behavior will be mandatory before we can pronounce our objective as successful.

It must always be remembered that a neurosis is not a fortuitous happening, dependent exclusively upon early traumatic events. It is rather a form of adaptation to, and defense against, a world that is regarded by the child and later by the adult as potentially hostile and menacing. Current reaction patterns and attitudes, while derived from past experiences, are not an automatic repetition of infantile modes in an adult setting. They are forms of behavior motivated by a desire to escape helplessness, to gratify vital needs, and to allay tension, anxiety, and hostility. The individual reacts to the present with characterologic machinery that is rooted in past experiences; but present-day problems are the immediate results of conflicts deriving from demands, fears, and resentments that arise also from current interpersonal relationships.

Overemphasis on the part played by the past may produce certain unfortunate effects during therapy. The patient may utilize inimical childhood experiences as a justification for neurosis and for resistance to change. Therapy may bog down in a compulsive historical review of the patient's past, a definite cleavage developing to isolate it from the present. Some patients who have familiarized themselves with early theories of psychoanalysis are led to believe that awareness of their past conditionings will magically dissolve their problems and reintegrate them in their dealings with the

world. Consequently, the analysis becomes a stereotyped search for an illusory pot of gold at the end of a mnemonic rainbow.

While an exclusive preoccupation with the past imposes definite limitations in therapy, one must not be won over to the fallacious notion that the historical experience can be entirely meaningless. Tendencies in this direction are apparent in certain current insight therapies, and they foster a concentration on relatively recent material. There is in this approach a dichotomization of the personality, as though the individual had two parts—an important present and a past that has little bearing upon prevailing attitudes, values, and goals.

Knowledge of the historical roots of a disorder is in itself not sufficient to produce cure, but it is of tremendous value in establishing continuity in the individual's life, from infancy to adulthood. It points to weakness and sensitivity of the ego at the time of a particularly traumatic experience. It shows how some repetitive happenings in the present are a reflection of the same problems that existed in childhood. Of particular therapeutic benefit is the ability of the ego to withstand the emotions liberated by the recall of early traumatic incidents. The neurotic individual often has little self-respect because of the constant necessity of yielding to the fear of the past. To be able to master this fear, and to tolerate the anxiety that previously caused the individual to cringe, has an enhancing effect on ego strength.

The relationship with the therapist acts as an important tool in the recall of buried memories. In the transference the patient will be stirred up emotionally and will experience attitudes and impulses that have a potent effect in reviving mnemonic prototypes of what he or she is undergoing in the present. The transference will frequently touch off patterns that cannot be uprooted by any other method.

During therapy, however, some patients may be incapable of remembering any traumatic experiences. This failure need not necessarily block the therapeutic process, and important changes in the dynamic structure of the personality can occur with little recall of the past. Interpretation of the transference and the establishing of an unambivalent relationship with the therapist may enable the individual to function on better terms with himself or herself and with others. It is possible also that the individual may give up infantile defenses without recalling the specific traumatic memories or experiences that inspired them.

On the other hand, analysis of the transference and interpretation of dreams, free associations, and material elicited through interviewing may, in themselves, fail to elicit memories. The patient seems to be stymied by a stubborn amnesia relating to vast segments of childhood or later life. The inability to recall vital situations of the past may represent resistance to accepting the implications of certain drives and defenses as they reveal themselves in the relationship with the therapist.

Obdurate resistance to recall frequently constitutes a means of avoiding anxiety of a sort that initially fostered the repression. In some patients it serves to retain the secondary gain inherent in their neurosis. The amnesia affecting recall may be so stubborn that even the most concerted effort will fail to bring the repressed material to the surface. Where, with extensive probing the patient is unable to recover damaging traumatic experiences—although one is reasonably certain that such experiences have occurred—it is probable that the amnesia protects the ego from anxiety that it would be unable to handle if the experiences were recalled. Here the reasonable ego is still too weak to absorb anxiety and to reconsider the experience in a factual light. The ability to recall early traumatic experiences, and to reevaluate them, requires considerable ego strength. In a number of conditions—for example, conversion reactions—sufficient ego intactness exists so as to make possible the handling of fears and conflicts associated with an inimical past. In these ailments the recovery of repressed experiences may suffice to produce a cure of specific symptoms.

In other conditions, however, such as certain personality disorders and psychoses, the ego is so vulnerable and weak that it cannot tolerate either the repressed memories or their implications. Therapy may fail to break down the resistances to recall, or the traumatic experience may be remembered with a peculiar dissociation of its emotional content. The forgotten event may be remembered as a vague experience without emotional implications, what is recalled being enough to satisfy the rational demands of the individual. The damaging emotions and the significance of the experience itself are, however, repressed. The individual reacts to devastating childhood incidents or fantasies in an apathetic manner, as if they were somehow detached. There is no abreactive process. It is almost as though the patient, by recall, seeks to fulfill a dual purpose: first, to retain the good will of the therapist by remembering things and, second, to hold on to his or her resistance by repressing the emotional meaning of the traumatic event.

Failure to uncover buried memories may be due to the fact that therapy has not bolstered the ego to a point where it can absorb the anxiety liberated by the recall of early experiences.

HYPNOTIC RECALL OF FORGOTTEN MEMORIES

In some cases hypnosis may uproot unconscious memories. One may question the efficacy of such a process, for it is axiomatic that a premature confrontation of the ego with unconscious material merely serves to create anxiety and to enhance resistance. Yet hypnosis need not have this effect, providing the recall is adroitly handled. Instead of battering down resistances by forcing memory of things, it is best to give full freedom to recall when the patient feels capable of dealing with such memories. During hypnosis the patient may be told that there are certain experiences and memories that are quite important and that, because of their painful nature, they have been forgotten. Assurance may be given that it is not necessary to remember all details of such memories at once, but that the patient will be able to reveal and to tolerate isolated fragments of these memories and experiences as time goes on. Under the influence of such suggestions the patient will bring out those elements of a forgotten memory or experience that can be tolerated, and as the patient becomes stronger and realizes that he or she is not injured by the recall, more and more material will be available, until finally the fragments can be reconstructed into a consistent whole.

Piecemeal recovery of a forgotten memory or conflict may be furthered by employing such techniques as dream induction, automatic writing, regression and revivification, drawing, and mirror gazing (Wolberg, LR, 1964a). The evidence elicited by all these procedures may make the meaning of the experience increasingly clear to the patient. As a general rule, the implications of the memory will not be accepted until the patient realizes its importance and presents a recapitulation as a product of personal efforts and conviction. Reconstructing the patient's memory in the waking state, from material uncovered during hypnosis, may rob the recall of its therapeutic effect.

One of the best methods of handling material that is recalled in hypnosis is to instruct the patient to forget a revived memory until he or she feels convinced of the truth of the memory and understands it thoroughly. It may be weeks before the patient is capable of bringing up portions of the material spontaneously, with corresponding insight. Even where the patient recalls in the waking state memories

recovered in a recent hypnotic session, the patient will usually be unable to integrate their meaning until the ego has had time to prepare itself. The authenticity of the memory may, of course, be in question since fantasies are common in the process of recall. But fantasies are creative constructs and dealing with them may also have a therapeutic effect. Indeed, sometimes fantasies are more potent sources of conflict than actual past traumatic happening.

THE HANDLING OF UNCONSCIOUS MATERIAL

The actual handling of derivatives of the unconscious depends on the projected goals in treatment. In supportive therapy one may totally disregard unconscious outpourings. In reeducative therapy the most manifest eruptions are selected for exploration. Thus, immediate character distortions and the surface conflicts these initiate may be a chief focus. The less manifest, more repressed aspects of the unconscious are usually deliberately avoided. In reconstructive therapy various strata may be explored, from topical spontaneous unconscious manifestations to those that are so deeply repressed that they require mobilization through the dissolution of repressive barriers.

Among the techniques in reconstructive therapy exploited to stir up unconscious activity and to remove repression are employing a passive role in the therapeutic relationship; focusing on dreams, fantasies, past experiences, and early relationships with parents; increasing the frequency of sessions; and using the couch position and free association. These activities may lead to a transference neurosis. Sometimes narcoanalysis, hypnoanalysis, art analysis, and play analysis are utilized as adjuncts for the probing of unconscious material. Of all measures, the provocation of a transference neurosis is perhaps most effective.

Unless the therapist is trained to do reconstructive psychotherapy, it is unwise and even dangerous to stir up unconscious material. Explosive forces may be liberated by a lifting of repressions with which the untrained therapist may be incapable of coping. Where, in the course of supportive or reeducative therapy, disturbing unconscious material spontaneously appears, the therapist may strive to help repression by avoiding discussion of the material, by dealing with it reassuringly, by focusing the interview on reality matters, and by the use of greater activity in the relationship.

There are a number of ways in which unconscious feelings and attitudes can be expediently brought to the patient's attention. Some activities employed during interviewing are restating, reflecting, and interpreting whenever the therapist recognizes an unconscious trend in the patient's verbalizations, dreams, fantasies, slips of speech, free associations, or transference reactions. These activities at first register themselves only minimally on the patient's mind since acknowledgment of unconscious trends is laden with much anxiety. Incredulity or polite acceptance without conviction may mark the first reactions of the patient to the disclosures.

As has been indicated, a patient may be helped to accept repudiated aspects of the psyche by the recollection of early traumatic experiences and memories. The realization that traumatic memories were being repressed, and the understanding of their symbolic significance may provide the patient with a wedge with which he or she can penetrate into unconscious conflicts and gain insight into their significance.

When interpretations are presented to the patient, it may be important to recast the wording of early memories or experiences in the very terms utilized by the patient, even though these parallel the expressions used as a child.

ILLUSTRATIVE CASES

Example 1

The following excerpt illustrates the verbalization in transference of unconscious sexual impulses on the part of a male patient toward his father. The material was expressed explosively with great anxiety, following a prolonged period of silence. This is from a session in which free association was employed.

Pt. My God. I feel I'm in love with you. I can't break away from you, but I want to come. I want to come here every day.

Th. Every day?

Pt. I'm afraid of you. You are so high and I am so low. I'm afraid of my feelings for you. Oh, God, as I talk I think of your penis. It's in my mouth. Oh, oh ...it makes me afraid. It makes me so afraid ... oh, oh. [*The patient seems to be in a transference upheaval.*]

Th. Why?

Pt. You're so big and I'm so little. I'm down on the floor. Oh God, I'm frightened ... oh, oh, I'm afraid you'll stick it up. This is awful. Please don't. I have to do what you want me to do. I want you to put me down on the floor. I want you to be powerful like my father. I want you to tell me what to do. I want to love you, and I want you to love me. I don't want you to hurt me or kill me.

Th. You feel I may hurt you?

Pt. I know this isn't real, but I have a feeling you are my father. I want to reach out and grab my father. He is sitting there, gentle and strong. I want to scream and cry. I want you to come to me. Father, come to me! Please come to me! I want you to kiss me and hold me close. Everything is whirling around. I can't stand it. I see myself nude. You are standing over me. Oh, God, please give it to me.

Th. What is it that you want?

Pt. Don't get near. Oh God, don't kill me. I'll do anything you say. I feel so little when I talk. I'm afraid to be big. I can't be the same as you. I don't want to, I don't want to. (*cries*) I don't want to ... no, no, no. (*cries*)

Th. Why don't you want to?

Pt. I don't want to grow up. I can't fight like the other boys. I never could. I love you. I want to wear your suit, but I can't wear it. I can't touch it, anything you wear, (*continues crying and then begins to act more cheerful*)

Th. Well, how do you feel now?

Pt. God, that was a horrible experience. It was like I was a little boy again. I can't understand why I said the things I said. I remember father. He never let me do anything. I always thought I hated him and was afraid to do anything, not even shovel the snow. He acted like he always had to be the boss. Kind of hard on me, I can see it now. I always felt that I never wanted to grow up; I wanted to be a little boy. Maybe I wanted to be punished because I felt guilty about not liking my father. Even now, when I am near him. I am afraid he will hit me. He goes into such a rage. I wonder what would happen if I hit him back. I felt the same way about you, but I never realized these sexual feelings. It scares me to think about that, (*pause*)

Th. It scares you?

Pt. It's funny I never wanted you to touch me. It scares me. It scared me suddenly to realize I want you to treat me like a woman. On the other hand, I want you to touch me. I was afraid for father to touch me. Maybe I felt the same way toward him as toward you. This whole thing must be some way connected with my fear of homosexuality.

Th. And with fantasies about your father.

Pt. I just remembered a dream I had last night. I'm at home, the house we had when I was little. There is a bed against the wall. Father is there in the room. He is undressing. I wonder if he is approaching me. I'm in bed. There is a funny excitement, repulsion, and fear. His body is big. It has a nauseating smell. His penis is enormous, enormous, big and red, fearful. I feel repelled by his body. I know he wants to stick his penis up my rectum. This I realize will kill me. I grab a gun and shoot at him, but it doesn't go off. I keep firing, but the bullets shoot out a couple of inches and fall on the floor. Father comes closer. I want to scream and can't. I then woke up

screaming and found I had an ejaculation.

Th. What do you think this means?

Pt. It must be connected with what we've been talking about—my fear of women, my fear that they'll reject me. I must be scared of being rejected or even killed for my interest.

Example 2

The following interview illustrates the use of hypnosis in recovering the memory of a traumatic incident, in the form of a “primal scene,” which engendered an hysterical conversion symptom.

The patient, a woman of 28, came to therapy because of anxiety that was so severe that it absorbed all of her attention and energy. It had its inception in a particularly violent quarrel with her boyfriend, with whom she had expressed growing dissatisfaction. The imminence of a rupture in her relationship with her friend caused the patient to respond with panic, since she was devoted to the man and marriage had been contemplated in the near future. She was aware of the fact that she was repeating a pattern, because all of her relationships with men had terminated in the same kind of violent disagreement. During one interview, while working on her sexual attitudes, the patient complained of a blurring of vision. She confided that this symptom had appeared on certain occasions when she looked into a mirror. She then searched the room intently with her eyes, and asked if a mirror were present.

The following is an excerpt of the recorded interview, during which the meaning of her eye symptom becomes apparent. The patient is in a waking state at the start of the session.

Pt. (panic in voice) I have that funny feeling again about a mirror—looking at it, *(pause)* and everything is blurred.

Th. You act somewhat upset by this.

Pt. Everything is upside down.

Th. Upside down?

Pt. Not really, but it seems like it. *(pause)* Do you have a mirror here? I don't see one, but it feels like it.

Th. What does it feel like?

Pt. I . . . don't . . . know . . . An upside down feeling . . . I'm doing something with a mirror reflection . . . a reflection.

Th. Tell me about it.

Pt. It's like last night. The same thing happened. I was at a friend's house, thinking of coming here. There was a mirror table in front of the sofa, when I was sitting there . . . I looked in the mirror, and everything I saw in the mirror began to look more real than the women in the room. And I thought, that's strange, and it looked like I could walk right into the room . . . the mirror room.

Th. Almost as if it were a different world?

Pt. Well . . . well, it didn't seem to be upsetting anyhow, *(pause)* It looked very inviting.

Th. You were not afraid to walk into that mirror room?

Pt. Now, it looks very frightening, but I have been dreaming about a mirror, *(pause)*

Th. Tell me more.

Pt. Upside down, backward, and all the letters and all . . . *(pause)* everything you say— everything has to be read backward. I used to do mirror writing when I was little.

Th. What about your writing; you say it was mirror writing?

Pt. Oh! I wrote quite a lot.

Th. What did you write?

Pt. Oh, just the way I felt and whatever I did when I was a child. I sometimes would doodle something about a mirror. A mirror of some kind seemed to be on my mind.

Th. You did write about a mirror?

Pt. Well, sometimes.

Th. Do you remember seeing anything unusual in a mirror?

Pt. I can't think . . . I can't remember.

Th. Maybe I will put a pen in your hand, and we'll see. Let your hand just do what it wants. *[I try to induce automatic writing in the waking state, which may be possible in patients suffering from hysterical reactions. This may reveal repressed material.]*

Pt. I use the typewriter.

Th. You can write freehand pretty well, can't you?

Pt. I guess so.

Th. Just let your hand move along as it wishes. Just let it do as it wishes, and pay no attention to what it writes. Just put

the pen right down, and don't look at it as you talk to me; just let your hand travel along as it wishes. You will notice that it will be almost as if an outside force pushes your hand along without paying any attention to what your hand writes. Just talk to me. You acted a little bit nervous when you walked in here today.

Pt. Yes.

Th. Are you any less panicky than you were?

Pt. Well ... it isn't panic exactly.

Th. What is it then?

Pt. I don't know.

Th. Like something deep down underneath that bothers you?

Pt. Uh huh.

Th. Are you now aware of what that something is?

Pt. Oh! It's disgusting—something I saw, I guess.

Th. Something you saw?

Pt. Uh huh.

Th. What?

Pt. I don't know.

Th. There was something you saw?

Pt. Uh huh.

Th. Put your pen down, and maybe your hand will tell us more about what you saw— what it actually was that you saw. *(The patient's hand scribbles a few words.)* Can I see that? I mean the sheet you wrote on. Your hand seemed to scribble something while we talked. Now let's see what your hand wrote. *[The patient responded to the suggestion to write automatically.]*

Pt. It says, "You used to have a mirror to write in when you were a girl."

Th. You used to write in a mirror?

Pt. Yes, it was a mirror with a barricade in front of it, and when you put the paper down, you couldn't see what you were writing, but you had to look in the mirror and then you could see. That was the mirror writing.

Th. I see. How old were you then?

Pt. I guess around 8, 7 or 8.

Th. Around 7 or 8?

Pt. Uh huh.

Th. It would seem that perhaps around that period of your life something quite significant happened to you.

Pt. Yes, I guess so.

Th. Do you know what that was?

Pt. *(pause)* I can't remember.

Th. Now I would like to have you sit just exactly as you are. *[Hypnosis is induced at this point.]* And I want you today to bring your hands up, this way—clasp them together closely. I want you to watch them—watch your hands. I am going to count from one to five. You are going to notice when I count from one to five that your hands will become pressed together, the muscles will stiffen, your hands will get tighter, tighter, and tighter, so that at the count of five it will be difficult or impossible for you to open them. Keep gazing at them. One. tight; two, tight, tight; three, tighter and tighter; four, as tight as a vise; five, so tight now that when you try to separate them, you cannot. *(pause)*

You notice now that your eyelids will get very heavy, that they close, they shut, they feel as if little steel bands are pulling them together. Your breathing gets deep and automatic, and you go into a deep, deep sleep. You are very, very drowsy; you are very tired—very, very sleepy; you are going to get drowsier, drowsier, and drowsier. You are going to fall asleep now, and you will stay asleep until I give you the command to awaken. You'll stay asleep until I give you the command to awaken. You feel very relaxed. Let your breathing become regular and deep. You feel more comfortable and relaxed. You are very, very sleepy. I am going to unclasp your hands now—just like this. I am going to bring them right down to your sides.

I am going to take this arm and stretch it out in front of you now, and as I do this, the arm is going to get very stiff and rigid. The arm will get stiff and heavy and rigid, heavy and stiff like a board. I am going to count from one to five. At the count of five, the arm will have got so firm, stiff and heavy and rigid, that it will be difficult or impossible to bend it. One, firm; two, heavy; three, firmer and firmer; four, just as firm and stiff and rigid as a board; five, just as firm and stiff and rigid as a board. Notice how stiff it is. The harder you try to bend it, the heavier and stiffer it becomes, until I push it back the other way, and then it loosens up. Bring it down, bring your head down this way. Relax yourself and go to sleep. Go to sleep, deeply asleep, very deeply asleep. Just relax all over, *(pause)*

Now I am going to give you a suggestion that you begin to enter into a deep sleep, so deep that you don't keep anything back from me. I am going to help you to a point where you will be able to see what it is that is behind the mirror. *(pause)* I want you to start getting very, very little. I want you to start feeling very, very little.

Your head is getting smaller; your arms and legs are getting smaller. You are going back, back, back to the time when you had that mirror. You are going right back to the time of the mirror. Your feet are getting tiny, you are shrinking, you are getting little, you are getting very small, you are shrinking, you are getting very, very small, you are getting very tiny. You are very, very small and tiny as if you are little again, just the way you were then. You are little, you are tiny. How old are you? How old are you? *[This is a technique aimed at regression and revivification.]*

Pt. Eight.

Th. You are 8 years old. (*Patient appears to be trembling with fear.*) Are you afraid? You look afraid. Tell me what you are afraid of. What are you afraid of? Tell me.

Pt. (*panicky*) Of myself.

Th. Anything else?

Pt. I don't know. It's a secret.

Th. You are afraid of yourself, afraid of yourself. Now listen carefully to me. I am going to ask you now to make your mind a blank; I am going to ask you now to make your mind a mirror. You are a little girl, and you are looking in a mirror. In your mind you will see a letter that will appear in the mirror. Every time when I clap my hands together, you will see a letter. It will appear in the mirror. The letters all put together, in whatever order they may come, will spell a word. That word holds the secret of what frightens you. One, two, three, four, five—watch the mirror, (*clap*) [This is a technique of circumventing repression.]

Pt. K.

Th. K—one, two, three, four, five—watch the mirror, (*clap*)

Pt. F.

Th. F—one, two, three, four, five—watch the mirror, (*clap*)

Pt. U.

Th. Now, when I clap my hands together, see the entire word.

Pt. F-U-C-K.

Th. F-U-C-K. Now watch that mirror again—watch that mirror, and when I clap my hands together, you will see that secret, you will see that secret. Don't be afraid now ... One. two. three, four, five, (*clap*) (*pause*) Tell me about it.

Pt. Woman up on top of a man. (*Patient is panicky as she talks.*)

Th. Who? (*Patient moans in a distressed manner.*) You see a woman on top of a man. All right now, watch that mirror. Watch that mirror.

I am going to clap my hands together, and then, all of a sudden, the face of the woman in the mirror becomes clear. As soon as I clap my hands together, it will be as if you see the face, you see the features. Watch carefully, (*clap*)

Pt. Mother.

Th. Your mother! Now watch carefully. I am going to clap my hands together. The minute I do, you will be drawn right into the mirror, and the man's face will become clear.

Pt. (*with fright*) My father.

Th. Your father. Are you afraid? What do you think is happening?

Pt. I am afraid.

Th. Now listen carefully. If this is an actual scene—an actual memory—you finally will be able to understand it. Your fear is getting less now; you are beginning to get less and less fearful. Don't be afraid; don't be afraid. Good I want you to sit here for a while, then I'm going to help you start growing up to your present adult age. If you like, you can remember what you saw, remember everything that happened, when you awaken. After that you can talk to me; we can talk this thing out. You would like to be well, completely well and unafraid, wouldn't you?

Pt. Uh huh. (The patient is breathing heavily, sweating, and is obviously shaken.)

Th. Good. In a moment I am going to wake you up. (*pause*) Now listen carefully to me. When you awaken, I want you to begin talking. Try not to be afraid even if you remember an actual memory. If you remember all the details, I want you to remember also the reasons you became afraid and had to forget them. I want you, if you can, to remember your fears, whatever they were. When you talk to me, the thing may come back as it happened, just exactly as it happened with all details. If you remember, tell me exactly how it happened. You have spent your life running away—hiding. You may not want to hide now. I am going to count from one to five, and on the count of five open your eyes suddenly and talk to me rapidly. One, two, three, four, five, (*patient awakens*) How do you feel?

Pt. (*mumbles*)

Th. I can't hear you.

Pt. Very funny.

Th. Tell me all about it.

Pt. I don't know. What shall I do now?

Th. Do you remember what happened here?

Pt. Yes.

Th. What happened?

Pt. (*somewhat fearful*) The mirror writing happened ... and then mother and father vanished.

Th. Did you ever see your mother and father together—intimately?

Pt. I know I did. It's all been in the mirror writing.

Th. Do you recall the incident when you saw your mother and father together?

Pt. Yes.

Th. Are you afraid now?

Pt. My father's dresser with the mirror was next to the door, and that was reflected then. I was outside and I saw it all.
[It would seem that the image inspired such anxiety in the patient that she attempted to repress it. Yet the mirror image also caused great excitement. The consequence of this conflict was mirror writing and blurring of vision.]

Th. I see. So you stood outside there, and you saw the mirror reflection?

Pt. I saw mother on top of father.

Th. So you saw your mother on top of your father?

Pt. I think so.

Th. A child, when she perceives these things, thinks of them in different terms than an adult. What might you have thought as a child, what could have been going through your mind? What do you think was happening? You must have thought something, *(pause)*

Pt. They keep turning around.

Th. Do you see the two of them now?

Pt. Yes, when I close my eyes.

Th. Do they keep turning around:

Pt. Yes.

Th. Describe to me what they do.

Pt. First father is on top, and then mother is on top now. First mother is on top, and then father is on top. *(There is fear and excitement in the patient's voice.)*

Th. Now what's happening?

Pt. Upside down.

Th. Do you remember the first few weeks when you came to see me? You were so upset, you said everything was upside down.

Pt. Uh huh . . . upside down.

Th. Perhaps you were excited by what you saw?

Pt. Yes, yes.

Th. Do you have any thoughts of upside down?

Pt. I don't like it upside down, *(pause)*

Th. Why?

Pt. I feel as if it's been killing me.

Th. You feel what?

Pt. As if it's been killing me.

Th. What's been killing you?

Pt. It isn't real, like in the mirror.

Th. Now keep your eyes closed, and when I count from one to five, you will be asleep. [*Hypnosis is reintroduced here.*]

One, go to sleep; two, sleepier and sleepier; three, go to sleep, deeply; four, deeply asleep; five, deeply asleep.
(*pause*) How did you feel about your mother when you saw that thing? What did you think about your father when you saw a thing like that?

Pt. I don't know. [*It is possible that the patient has repressed some of her feelings in relation to this memory.*]

Th. Now listen carefully. I want you to sit there. I am going to count from one to five, and then clap my hands together.

When I do, you are going to have the same emotion that you had when you looked into that mirror, if you actually did look into that mirror. You won't be able to keep it back. Just let it come out spontaneously. As soon as I clap my hands together, tell me the emotions that you feel. One, two, three, four, five, as soon as I clap my hands together, tell me the emotion, (*clap*)

Pt. Anger. (Patient speaks in a drawl with her fists clenched.)

Th. You feel anger? Listen to me now. When I count from one to five and clap my hands together, you will see who it is that you are angry at. One, two, three, four, five, (*clap*)

Pt. (*pause*) Mother.

Th. Mother. You were angry at mother; at what you saw?

Pt. Yes, but I always try to see backward.

Th. Why?

Pt. I was angry at father, too. She didn't really want him.

Th. She didn't want him?

Pt. No.

Th. Why?

Pt. Mother didn't seem to want to bother with him, I guess.

Th. Did you love your father?

Pt. Yes.

Th. You did love him?

Pt. Uh huh, very much, but I stopped loving him.

Th. What made you stop loving him? How old were you when you stopped loving him?

Pt. I don't know. Maybe I didn't love father because of mother.

Th. Did you feel that you would eventually like to find a man like your father?

Pt. Oh, I did in my teen age, yes. Father is quick—he used to be very clever and funny. Once he got angry with mother, and he didn't speak to her for a long time. He was very jealous. He was very cross with me.

Th. He was very cross with you?

Pt. Yes, father was when I started going out with boys.

Th. He did not like to have you go out with boys?

Pt. He was always . . . *(pause)* jealous.

Th. He was jealous.

Pt. Yes, he was.

Th. What was his name?

Pt. Lewis *(laughs)*

Th. Why did you laugh when you said Lewis?

Pt. 'Cause your name is Lewis.

Th. 'Cause my name is Lewis?

Pt. Uh huh.

Th. Do I in some way resemble your father?

Pt. Not very much. I got awfully upset when I saw that mirror thing.

Th. What sort of person was your father?

Pt. He was very determined.

Th. Determined?

Pt. Uh huh. Maybe I liked him too much.

Th. Most little girls love their father. Little girls often get infuriated with their mother for having father, but they finally decide that they will find a man of their own, that they don't have to have father.

Pt. Mother was always like that, telling me that too.

Th. Did she want you to go out with men?

Pt. Yes, she did (*pause*), oh, yes; but I think she turned me against them.

Th. What did she do to turn you against them?

Pt. Oh, always blazed at me; she's always blazed at me. I think she really hated men.

Th. She really hated men?

Pt. Uh huh.

Th. How did you learn that?

Pt. I . . . I . . . I just felt it.

Th. Now I am going to wake you up. When you feel you understand the meaning of what we have been discussing, you will remember what is necessary. I will count from one to five. At the count of five, open your eyes and wake up. One, two, three, start waking up, four, five.

This excerpt has illustrated the use of hypnosis for the recovering of a traumatic memory or fantasy by hypnoanalytic techniques of regression and revivification, along with a counting procedure. These adjuncts are of aid in circumventing repression. Because repression is sponsored by anxiety that the patient is yet unable to control in the waking state, she is given a suggestion at the end of the session to remember the incident only when she has worked through its implications. In this particular case she was able to understand in a short while the significance of her mirror fixation and eye symptom and she was then able to integrate her reaction to the traumatic scene of childhood. She was also able with further therapy, to resolve her difficulty in her relationships with men.

Notes

¹ Some parts of this section have been adapted from Wolberg LR, Kildahl JP: *The Dynamics of Personality*. Orlando, FL, Grune & Stratton, 1970.

[2](#) This case history is from Wolberg LR: The Handbook of Short-term Psychotherapy. New York, Thieme-Stratton, Inc., 1980. Reprinted with permission.