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INTRODUCTION TO SIMMEL'S SCHLOSS TEGEL

by Heiman van Dam, M.D.

Originally, I had hoped to bring together two papers concerning Ernst Simmel, the founder of our institute: One dealing with his scientific work in Germany and the other with his political activities in that same period. Both, I felt, needed to be read together, because Simmel's psychoanalytic thinking helped shape his politics, and, as the present paper will clearly demonstrate, his political beliefs influenced his scientific thinking and activities before his emigration to this country. Unfortunately, the two papers became separated from each other, not unlike the separation that Simmel experienced in his career and personal life on a much larger scale and in a far more painful and tragic way.

In a way it was a blessing in disguise that the two papers were published separately. I was not given the opportunity to edit the first one. I did, however, edit the present paper, and I believe it became more readable and closer to what the authors had in mind.

The authors are two German psychoanalysts from Berlin. Like many of their colleagues, they have a strong desire to learn about what went on in psychoanalysis before and during the Nazi era. This need to learn more about that period is not limited to psychoanalysis but is quite widespread. It stems in part from the fact that they belong to a generation whose parents were unable or unwilling to speak of their own experiences during that time period, much like the actual surviving victims of the Nazi regime. It is part of the ongoing soul searching of post-war Germany and Europe.

This work on Simmel is part of the much larger project of researching and recording the history of psychoanalysis in Germany. It is also a demonstration of how easy it is to destroy psychoanalysis and how long it takes, and how arduous it is, to rebuild it.

What particularly interested me in this paper was to see the development of Simmel: How he came to discover psychoanalysis for himself through his military experience in World War I with the treatment of traumatic war neuroses. The paper also demonstrates Freud's need for as much

corroboration of his views from as many areas as possible. In this connection, it is interesting that Freud estimated that one year of training could make an analyst out of Simmel. Times have changed somewhat. The paper shows Simmel's commitment to applying psychoanalytic principles to the masses, and also a strong awareness of the differences between psychotherapy and psychoanalysis. His clinical case example of the mechanic can serve today as well as then to demonstrate that psychological problems can interfere with the adherence to a strict medical program.

Another very important aspect of this paper about Simmel is the relationship of psychoanalysis to medicine, physiology and biology. The lack of contact between psychoanalysis and these fields is unfortunately not limited to Germany only. Closer contact could benefit both fields. Shortly, I hope to present some data from pediatrics that will widen our understanding of the development of children, and its implications for theory as well as psychoanalytic technique. It is unfortunate that Simmel's work of linking the biological and psychological did not continue in the way he had visualized it.

The paper also gives us a cross sectional glimpse of psychoanalysis at the end of World War I. How to deal with forms of active abbreviated versions of psychoanalysis; how resistances were viewed and dealt with before ego psychology became part of psychoanalysis; how psychoanalysis helped to understand the forces unleashed by war and revolution. Finally, the paper and its bibliography shows the wide scope of interests that Simmel's papers reflect.

Simmel obviously was a man with a great deal of passion for life. His approach to the war neuroses ran counter to the military establishment. His desire to start a psychoanalytic hospital with a closed ward was almost "Mission Impossible." He made it happen — for a while. It is not surprising that after leaving Germany Simmel used his tremendous creative energy to start two psychoanalytic institutes. Freud was right when he predicted that Simmel was the person who could do it. He apparently gave up his dream of a psychoanalytic hospital. Perhaps it was a sign of the times. As Anne Frank said so eloquently in her diary on July 15, 1944, "[It was] a time, when all ideals are being shattered and destroyed, when people are showing their worst side, and do not know whether to believe in truth and right and in God." This paper, then, is about Simmel, the analyst, before the war.

ERNST SIMMEL'S SCHLOSS TEGEL SANATORIUM ON THE HISTORY AND CONCEPTION OF THE FIRST PSYCHOANALYTIC CLINIC

by U. Schultz and L.M. Hermanns

Translated by David Lee and Britta Bothe

According to Alfred Lorenzer (1986), the history of the relationship between psychoanalysis and psychosomatics has been, not so much a history of rapprochement and deepening encounters between these two fields, but rather one characterized by mutual ignorance or even outright alienation.[1] Moreover, it seems today almost strange that Sigmund Freud wanted to organize his experiences with "hysterical suffering" (1895) completely on the basis of a neurophysiological approach — an approach never completely rejected by Freud. Nevertheless, Freud took an active part in the construction of borders with neurology and neurophysiology. In his view, doctors who apply the psychological events to this illness should "resist the attempt to toy with the ideas of endocrinology and the autonomous nervous system, which means that psychological facts can be understood through psychological hypothesis."[2] In this respect psychoanalysis succeeded in establishing, more or less successfully, the person as subject in psychology; however it failed likewise in respect to establishing the person as subject in medicine as Vicktor von Weizsacker has attempted in different ways.[3] The more psychoanalysis turned toward the "soul" as the laws of suffering and understood itself energetically as a "psychology" — even as a psychology of relationships, the more psychoanalysis became removed from limb and body.

The reverse tendency is also seen: not a few advocates of integrating psychosomatics, such as Vicktor von Weizsacker or Wilhelm Kutemeyer reject the training analysis as part of psychoanalysis, even when they would otherwise not question the value of psychoanalytic methodology and therapeutic theory. It may be dependent upon this specific split development

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— on the one hand a secret fellowship, on the other hand an open split that the, until now growing interest, in the history of the relationship between psychoanalysis and psychosomatic medicine turned toward such bold outsiders as Georg Groddeck or Wilhelm Reich. [4,5]

Ernst Simmel belonged to the small circle of early psychoanalysts who strove with great fascination and with "productive orthodoxy"[6] toward the hospital utilization of psychoanalysis. The opening of the Schloss Tegel sanatorium as the first psychoanalytic hospital marks the first real integrated model of psychosomatic medical care in a hospital practice and educational setting. Only recently have Ernst Simmel's achievements been recognized for the establishment of Sanatorium Schloss Tegel as a historical precursor of inpatient psychosomatic care. Simmel's psychological theories concerning psychosomatic illness developed in this period are also of historical and contemporary importance. [7,8]

Because it interested us as to whether our investigations are generally meaningful, in 1984 we conducted a poll of 30 university professors and directors of psychosomatic hospitals and departments — all of whom were members of the German Society for Psychosomatic Medicine (DKPM) — to whom we asked amongst other things, "Did you know that there was a sanatorium called Schloss Tegel which operated as a psychoanalytic hospital?" Based on a return of 83%, only 12 answered this question positively. None of the answering psychosomatic professionals had, however, based the planning and establishment of their present department on Ernst Simmel's hospital concept.

This lack of familiarity and lack of reference to the first psychoanalytic hospital came as a surprise to us. The quickest and easiest explanation, in our opinion, is bound tightly with the consequences of Nazism: the burying of alternative ideas and approaches in conjunction with the forced emigration of Jewish psychoanalysts had led to a "triumph of conformity"[9] not only in psychoanalysis, but also in psychosomatics. Only the recent and growing interest in the social and scientific history of psychoanalysis and psychosomatics during the Third Reich [10,11] has awakened the interest in reviving productive approaches which had fallen into oblivion and repression.

Ernst Simmel and his development toward hospital psychoanalysis.

The in-patient concept and very idea of a psychoanalytic hospital is most closely bound with the person of Ernst Simmel. The sanatorium Schloss Tegel cannot be understood without presenting Ernst Simmel's biographical and medical development.

Ernst Simmel, "after [Schloss Tegel] had been appropriately remodeled and dedicated as a psychoanalytic hospital,"[12] on April 11, 1927 had just

celebrated his forty-fifth birthday, having been born on April 4, 1882 in Breslau as the youngest of nine children. His father was a merchant and his mother owned an employment service for household help in Berlin. Ernst Simmel had begun, after breaking off his studies, a four-month long apprenticeship as a pharmacist and after making up his final examinations, he began the study of medicine in Berlin in 1902. In 1908 he took his final medical exams and wrote his dissertation which was entitled, "Critical Essay on the Etiology of *dementia praecox*" in Rostock. In this work, which described the clinical courses of four patients, he cited Karl Abraham, Josef Breuer, Sigmund Freud, and Carl Gustav Jung.[13] After his residency at the Rostock university/city hospital for nervous and mental illnesses and an assistanship at both the Pathological Institute of Darmstadt hospital and at the August-Victoria Hospital in Berlin-Schonberg, he set up a private practice in 1913 in Berlin-Baumschulenweg — a working-class district now in East Berlin.[14]

In the same year Ernst Simmel had made a name for himself in the politics of health care. Together with Karl Kollwitz (husband of Kathe Kollwitz) and Ignaz Zadek, he founded the Social Democratic Physician's Union. From the beginning to the end of the First World War he served as a military doctor. From 1916 to 1917 he served as Chief Physician of a military hospital for kidney illnesses. From 1917 to 1919 he was Director of the military hospital for war neuroses in Posen. It was here, as Royal-Prussian Head Physician, that he introduced psychoanalytic principles to the spectrum of therapeutic possibilities which was then dominated by the Kaufmann cure.

The Kaufmann cure which, as Kaufmann himself described it in 1916, consisted of "suggestive preparation," "an application of strong alternating current with the aid of abundant word suggestions," "doing away with military formalities" and "unwavering, consistent enforcement of the healing process in one session," had been used with little long-lasting success accorting to Jellinek in 1918 involving 1.2 million such cases of war neuroses.[15,16]

The special role Simmel's psychoanalytically oriented treatment takes is evidenced, in our opinion, by his later understanding of hospital therapy; it can also be deduced from the strong arguments on the etiology of war neuroses which took place at the eighth annual meeting of the German Neuro-Psychiatrists held in Munich in 1916.

The well-known neurologist Hermann Oppenheim derived his understanding of war neuroses from the mechanistic idea that "raw power of trauma" to the "central organ" generates shocks in the meaning of a "local commotion" ["lokalen commotion"] which causes the symptom.[17] Max Nonne on the other hand, disagreeing with Oppenheim at this congress, was convinced of the psychogenesis of war neuroses and advocated a pragmatic-

suggestive "short psychotherapy" in addition because "the danger of the psychic infection is not to be underestimated."[18]

Sandor Ferenczi, who also directed a special military hospital for war neurotics in Budapest, commented ironically at that time with regard to this conflict: "the experience with war neurotics led little by little toward the discovery of the soul and consequently led neurologists to nearly discover psychoanalysis."[19]

Ernst Simmel recorded his abundant experiences in the psychotherapy of patients with war neurosis in a book which bore the title: "War Neurosis and 'Psychic Trauma.'" Their reciprocal connections were described on the basis of psychoanalytic, hypnotic studies."[20] The book hit the analytic circle like a bomb. It prompted Freud on February 20, 1918 to write an inviting letter to this author who was until then virtually unknown in psychoanalytic circles. In a letter to Karl Abraham, Freud spoke of Simmel in these words: "for the first time here is a German doctor who puts himself on the grounds of psychoanalysis without patronizing condescension. A man who advocates the marvelous utility of psychoanalysis in the therapy of war neuroses and who also verified this with examples. Additionally, he behaves with regard to sexual etiology completely properly. He is, I must admit, not completely adherent to psychoanalysis. Essentially he subscribes to the cathartic point of view, working with hypnosis which by definition must hide resistance and sexual drive forces. He excuses this, however, correctly with the necessity for a quick success and with the massive size of his operation. I believe a year of training would make a good analyst out of this man. His behavior is correct."[21]

Karl Abraham wrote to Freud on October 27, 1918 in a rather reserved fashion: "During the return trip from Budapest and recently in Berlin I got to know Simmel better. He has still not moved away from the Breuer-Freud standpoint and has emphasized — for reasons which he himself has not made clear — his strong resistance to sexuality. Unfortunately he even emphasized this at the Berlin conference [where he stated] that in his experience sexuality plays no essential role in war neurotics and in psychoanalysis. Perhaps he will develop further, but we may under no circumstances overestimate him."[22]

As a consequence of his book, which earned him together with Karl Abraham the *Prix d'honneur* for the best clinical paper, Ernst Simmel was appointed co-reporter of the Fifth Psychoanalytic Congress in Budapest in September 1918, the theme of which was "War Neuroses." According to Jones, this congress in which for the first time official government representatives attended made an impression, "although it did not make an impression on the general medical community, it did do so to the high-ranking military representatives; they talked about creating in different centers psychoanalytic hospitals for the treatment of war neuroses. The first one should be in Budapest.[23]

Freud wrote in the introduction of the congress papers, "Before the execution of these plans could occur the war ended; typically with the conclusion of the war the phenomena evoked by the war conditions also stopped. The opportunity for a thorough research of these conditions was now unfortunately lost. One must add: this opportunity will hopefully not return again soon."[24]

Ernst Simmel turned out to be the only one at this congress who so far had gained experience with the "method of psychocatharsis of war neuroses" of two thousand patients — half of whom he treated himself[25] — which is the reason why he is actually mentioned as the precursor of Focussed Therapy. He developed a "combination of an analytic and cathartic talking cure and dream interpretation — the latter performed while the patient was either awake or in deep hypnosis." These made it possible for him to eliminate war neurotic symptoms in, on average, two or three sessions. With the reduction of the symptoms as far as the present military hospitals are concerned, the treatment of war neuroses must be seen as a finished process. "An analytic cure of the personality as a whole with an abbreviated, combined method will be reserved for the psychoclinic of the future."[26]

The powerful impression of the war neurotic symptoms united psychoanalysts and neurologists despite all differences about therapeutic opinions, at least in the respect that both found it important to recondition the patient for duty as fast as possible. This impression produced in Ernst Simmel a kind of a therapeutic optimism. The cure of the war neuroses which he also called "crippling neuroses" [*"Verschuttungsneurosen"*] he says were "very easy, if they are only battle-generated emotions."[27] The organic illnesses, such as "epilepsy" are "often injustly labelled as incurable."[28]

On the other hand, he warned against "purely somatic treatment" of conversion neurotics "which concentrates on the symptom through massage, electro-therapy and so on in the same way as the predominant emotion itself concentrates on producing the symptoms." "Then the doctor and the emotion operate together as allies in the sense of aggravating the illness." Out of this yields the important practical fact that we have to ignore the symptom if we want to liberate the patient. Because it disappears by itself as soon as the core of the sickness is discovered, the core deserved our complete interest and effort. And therefore the patient must realize from our treatment the secure knowledge that the sickness is an easy one and curable, but that the sick person is to be taken seriously, and difficult [to treat].[29]

Looking at the numerous functional forms of the neurosis, which according to Simmel most frequently represent a "repetition of those defensive movements which the patient made when he felt overwhelmed by the massive trauma," he finds that it is almost always rage against superiors which then furthers anxiety attacks. In hypnosis we see again and again the

sick person in a fight with his highest superior officers. He strikes, bites, stabs, and shoots them, steps on them with terrible curses."[30] Such attacks were viewed by Simmel as aiding the patient's self-esteem and restoring the narcissistic equilibrium, which under the flood of affects had been shattered in order to avoid psychosis. As a "substitute action" they could offer different forms of expression corresponding to the content of each occasion. It is insufficient for the war neurotic to abreact through words because the soldier remains under the suggestion of action: an eye for an eye, a tooth for a tooth. This led Simmel in the short space of time allotted for treatment to introduce into hypnosis a "stuffed phantom," later also called "actual enemy"[31] or "dummy" [English original], and allowing the patient to follow a regressive way of struggling to liberate himself victoriously.[32] This treatment which helped many (for a [complete] cure it is self-understood that a continued and deeper analysis is necessary). It usually resulted in the partial mutilation of this stuffed puppet.

Sigmund Freud had supported Ernst Simmel in the fact that necessary and desired shortening of the therapeutic process can make use of "active procedures" to make possible the psychoanalytic therapy to a broader level in state hospitals.[33] And along these lines Freud spoke at the same congress these words: "We will most probably also be forced to alloy the pure gold of analysis richly with the copper of direct suggestion for the mass utilization of our therapy. No matter what form this psychotherapy for the masses will take, and the elements of which it may consist, the most effective and most important components will certainly remain those which are borrowed from psychoanalysis."[34]

The end of the war had buried the hopes of Sigmund Freud and Ernst Simmel for promised psychoanalytic departments and hospitals. The expected clientele of war neurotics recovered quickly and found themselves — to the surprise of many neurologists — amongst the revolutionary soldiers.[35] The wide-spread style of self-healing — and if one wishes — this spontaneous course of the war neuroses — did not make its way into the literature. Ernst Simmel — presumably disappointed by the destroyed plans for a psychoanalytic hospital — saw now in the "revolutionary neurotics" a new clientele for such a hospital. Consequently he publicly explained in an article to a large daily during the summer of 1919 his plans for a psychoanalytic hospital and polyclinic.[36]

The article ended with reference to Freud with the words: "It may be a long time until the state feels this duty as pressing, but at some time or another it will come to pass. That is, the construction of a 'Training center for psychoanalytic treatment.'" Out of this article came contacts with Prof. Becker (State Minister for Science, Art and national education in Berlin) whom (after many attempts) he revisited again in April 1926 to obtain the public financing for a psychoanalytic hospital.[37]

Next, however, Ernst Simmel, together with Max Eitigon (who made available RM 16,000 yearly from his personal fortune) founded a psychoanalytic polyclinic and teaching facility on Potsdam Street in Berlin in 1920; this was the first such clinic of its kind. Ernst Simmel had committed himself — with reference to Sigmund Freud — for the free treatment of the "neurotic misery of the greater population."[38] To this end he granted that it was at first necessary to give education to the underprivileged, for before the "existence of our polyclinic the poor neurotic was so completely unaware of so-called psychotherapeutic treatment." With what misconceptions in [treating] the "underprivileged" sick Ernst Simmel had to wrestle is illustrated by an anecdote from the infancy of the polyclinic. Once one of the patients walked away "disappointed," Simmel had to turn down her anxious question: "Don't you have a sunlamp?"[39]

In Prof. Becker (who since 1926 was simultaneously the head of the Union of Socialists Doctors and of the German Psychoanalytic Society) Ernst Simmel found a well-educated man. However, because of the negative viewpoint of the medical faculty he could give no promise of financial help but nevertheless welcomed the opening of such a hospital very much and therefore held out the prospect of support.[40] Prof. Gustav von Bergmann (director of the Second Medical Hospital of the Charite) turned down Ernst Simmel's plea for support for his project with these words: "Not my doubts as a member of the faculty are essential, but the conviction that the psychoanalytic comprehension of the sick is as one-sided as the purely somatic one; and if one can see nothing else in psychological phenomena than biological processes, which are also accessible to us in a different form, namely introspective perception, then one cannot agree with the principle of the psychoanalytic hospital as a program, even if you admit that the psychotherapeutic efforts often must be combined with those of internal medicine." (Letter of March 26, 1929).

Ernst Simmel's Concept of a Psychoanalytic Hospital.

Although Ernst Simmel was originally not inclined to construct a psychoanalytic hospital as a private business,[41] he finally founded "Sonatorium Schloss Tegel Inc., Psychoanalytic Hospital." Investors were Dr. Nussbrecher and Dr. Jekels from Vienna, as well as former Minister of State Prof. Julius Hirsch and Ernst Simmel from Berlin.

On November 6, 1926 the owner of the castle, Geheim Regierungsrat Reinhold von Heinz, signed a lease agreement with Ernst Simmel. The contract specified the use of the Schloss as a "sanatorium including doctor's living quarters, a garden, and a park." The festive opening of the hospital on April 10, 1927, was begun with a celebration speech left, unfortunately, only in fragmented form. It was a paper by Simmel on the use of psychoanalysis in a hospital. The entire affair received only one short notice in the daily

newspapers in Berlin.[42] The hospital redesigned by the architect Ernst Freud — son of Sigmund Freud — was done in a Bauhaus style with fifty "large and small" rooms and was licensed for 74 patients. The hospital had served previously as a private sanatorium, at one time directed by the early German follower of Freud, Johannes Marcinowski.

With psychoanalytically trained assistants — as far as is known: Rudolf Bilz, Ludwig Fries, Irene Haenel-Guttmann, Carl Maria Herold, Hellmuth Kaiser, Eva Rosenfeld, Frau Schalit, Edith Weigert-Vowinckel, Moshe Wulff — and a psychoanalytically trained nursing staff under the supervision of Hausmutter Frau Bruentizer, 25-30 patients were treated at a time when fully occupied. One assistant had to take care of "at most eight patients."[43]

The psychotherapeutic concept of Simmel's hospital is nowhere clearly defined. It is possible to reconstruct the concept on the basis of a letter to the medical group of March 22, 1927 and on the basis of a hospital brochure for patients and relatives. Further sources are found in the *Simmel Nachlass* [literary legacy] as published speeches of September 3, 1927 at the 10th International Congress in Innsbruck, the theme of which was "the psychoanalytic treatment in the hospital"[44] and in a celebration speech in honor of Sigmund Freud's 81st birthday which was published in the Bulletin of the Menninger Hospital in 1937.[45]

Mainly such patients were treated who "because of the severity and scope of the symptoms did not allow for ambulatory treatment or where ambulatory treatment proved insufficient to reach the cure within the given time frame."[46] The clientele to be treated by Ernst Simmel in his hospital were very sick neurotics, addicts "of all kinds," including gamblers, children and adolescents with problems in personality development (e.g., kleptomania) patients in acute life crises, and, long-lasting and complicated organically sick individuals (see Table 1). He emphasized that for him it was "self-understood" that only "after a thorough physical exam would a treatment plan be formulated."[47]

TABLE 1:

Range of Patients of the First Psychoanalytic Hospital Schloss Tegel.

Neuroses	Obsessive compulsive neuroses, phobias, hysterias.
Psychosomatic disorders	Neuroses of the respiratory (asthma) and alimentary tracts (anorexia, spasms of the esophagus, hyper- and anacidity, indigestion and obstipation), neuroses of the genito-urinary tract (functional poly- and polakiurea, severe dysmenorrhea).

Organic disorders	(especially chronic and complicated illnesses) dysfunctioning of the glands of internal secretion, especially thyroid; dysfunctioning of the sympathetic and parasympathetic systems (vagotony, sympathicotony, dysfunctioning of the gall bladder and digestive disorders).
Addictions	Morphine, cocaine, alcohol, sleep medication, and gambling.
Personality developmental problems	(especially children and adolescents).
Acute life crises	(marital problems, suicidal attempts, "flight into illness").

Sanatorium Scholss Tegel — so Ernst Simmel hoped — was to become a place of systematic "psychotherapy of organic illnesses" which was supposed to put the "valuable instrument of psychoanalysis, as given to us by Freud, into the service of the most sick — even more comprehensive and more general as was then possible." The sickest people were described as those who "were forced to die while their real lives passed them by."[48]

From that time there are only a few case histories available which elucidate the style of the treatment and the therapeutic concept of the hospital. The first one is about a 50-year-old mechanic who was suffering from a severe cardiac insufficiency with pulmonary edema.[49] Ernst Simmel decided "out of psychoanalytic considerations in this special case not to do an exact psychoanalysis" and he decided to do "hypnosis . . . with certain doubts. Because one does not want to hypnotize a person who could die at any moment. And I must admit that even my heart stood still during the treatment a couple of times when I thought the patient's heart had ceased." Simmel managed to discover that the "heart and lung water stoppage" was actually an unconscious deathwish of the patient to drown himself. This symptom is a compensation for the massive guilt feelings due to the suicide of his first wife. Upon his return from the war he disowned her because she had been unfaithful. She drowned herself in the river across from their apartment. "Coincidentally" the river had the same name as the ship to which the patient as a mechanic was devoted. "His dropsy gave evidence of his tendency of punishing himself with his suicidal punishment as if to reunite with his dead wife in the same way. It contained the wish to annul his divorce postmortem by dying in this same manner."[50]

In the further course of therapy, the patient obviously suffered a psychotic reaction which was "small consolation for the therapist." Simmel treated this with additional suggestive-hypnosis and relieved the patient of his guilt. "In a

manner of speaking I offered myself as a catalyst to release his super-ego tension. I explained to him again the analytic result that through his sickness he tortured his present wife in order to unload that which he had suppressed from his first wife. He may love his wife, not only as a tabu-Madonna, but also as a real wife . . . I pardoned him. The continued purely somatic treatment to the exclusion of any other psychotherapy led to complete restoration of fluid balance. The patient was healed and has been at sea for the last two years."[51]

This case study which was delivered by Ernst Simmel at the Sixth General Physician's Congress for Psychotherapy in Dresden in 1931 left a large impression. Although there should have been many connections between Ernst Simmel and Viktor von Weizsacker since both from time to time spoke at the Psychotherapy Congresses held since 1926 usually in Bad Nauheim, the only published document in which Viktor von Weizsacker referred to Simmel contained the following words: "This noteworthy case study does not stand by itself and it has its cogency especially for those who are eager to satisfy *"ex juantibus"* their desire to find causal connections. Yet the essential is also not the merging of treatment and healing process, instead the crisis-like removal of a repression which is followed by the regulation of the circulation."[52] Further unpublished case histories from the Nachlass cover the area of "forensic psychoanalysis" and the treatment of psychosis which are to be published separately.

Although Ernst Simmel was able to define part of his theoretical psychosomatic works only during his American emigration in the 1940s[53,54,55], he had already taken a view of some kind of an early theory of his treatment of sick families during his psychoanalytic hospital years. The sick person who came to Simmel on his own or some other way "most often only represents through his sufferings partial exposure of a collective sickness" and may be an exponent of a "collective neurosis."[56] Such a neurosis is created through the fact that also the 'significant other' [*Lebenspartner*] develops a complimentary neuroses — even if it is latent — out of a "similar unconscious complex or in reaction to an unconscious content of symptoms which have been present for years." Such family members — about whom Freud himself admitted his complete helplessness[57] — "directed their exaggerated guilt feelings and feelings of empathy in their efforts to assist the psychoanalysis of the patient." In fact, however, their efforts were excuses of all kinds designed to hinder the analysis. Because of that fact a treatment must take place in a psychoanalytic hospital "under more or less strict isolation — controlling human contact." This he formulated in the following way: "We are in need of an introduction to psychic dietetics in order to master such psychoanalytic cures."[58] The isolation also gave guarantee for the protection against [discharge of] inner stimuli which might be necessary because the unconscious of these patients resembles a battlefield.[59]

Organic illnesses have their origin in the fact that "the sick person . . .

transforms part of his psychic and physical inner-world rather than transforming the object-world . . . which he feels unable to change."[60] The physically sick person "acts out" against his own ego his destructive tendency which was originally directed against his object world — his family members. These family members, in reaction to the unconscious of their sick relative, aimed unconsciously for his death. "In the last year I've seen two such sick people dying only because of the overwhelming loving care of the other [partner or family member].[61] These family therapeutic theories are borrowed from a previously articulated consideration (1922) that "physiopathologic and psychologic processes" are in certain ways identical, which is to be seen in the direct continuum from the individual cell to the cell community which form a human being and finally from an individual to a human community.[62]

The psychoanalytic hospital concept rests on the hypothesis that the psychological situation of the sick person regarding the outside world is reflected in his relations inside the hospital. The hospital situation is not just restricted to the relation of the psychoanalyst toward the analysand, "rather the whole hospital is a kind of enlarged person of the analyst as the primal type of the family in general." The *Hausmutter,* the nurses, the doctors, and the other patients are approached at the same time in the role of a replacement for the mother and siblings in order to reactivate the neurotic process. Based on this, the staff must function as an enlarged sense organ of the analyst [*Sinnesorgan des Analytiker*].[63]

A legend which, as do all legends, throws light on the Sanatorium atmosphere is the unproved assertion of Paul Roazen, that "in Simmel's Sanatorium all —the nurses, even the doorman — should be analyzed."[64]

"The premature mobilization of unconscious resistance" of resident patients was [supposed to be] avoided by the fact that during the first days of the hospital stay there was no importance attached towards the beginning of an exact psychoanalytic cure. "I allow the patient to acclimate himself during the first days and to enjoy the calm, conflict-free atmosphere before the work of the transference makes itself felt . . . In contrast to outpatient treatment, we also gain the possibility in the hospital of making the patients who are at first prepared for resistance and who did not want to know anything about such a cure, ready for analysis. Harmless walks in the park with the analyst, casually getting to know other patients whose analytic processes are well underway on the basis of deep transferences. All of this serves partly as a transition to the real psychoanalytic situation especially for those who deny their sickness in the beginning or also swear to a diametrically opposed method. It appears that we start the cure only at the point at which the patient himself wants it. In reality the treatment begins at the patient's first step into the hospital. Neither a prison nor a monastery atmosphere is allowed by which punishment or penitence help numb the guilt-feelings of the patient in spite of their complete remoteness from real life."[65]

Next to the daily, on-going analytic sessions there was occupational and hydro therapy. But there existed no group therapy. Everything must strictly point the sick person "regarding large and small infirmities toward only one solution: the psychoanalytic treatment." Therefore the cure may be oriented against the Pleasure Principle and indeed, in the strictest *Freudian* sense, against all infantile pleasures which originate from Substitute Satisfaction." But the real pleasure of life "we leave untouched in order to avoid unconscious expiation of guilt feelings."[66]

Simmel's scientific work needs to be examined especially with regard to its theoretical implications because, by and large, his work has remained unpublished out of the fear of being in conflict with Freud's dualistic drive theory.

Next to smaller publications, for example, on his son's screen memory *in statu nasendi*[67] in which Simmel peruses the observation that specialized doctors very often fall ill with their own speciality. From the Nachlass one might refer to small publications as well as to the larger ones on alcoholism and addictions[69] and "on the problem of compulsion and addictions"[70] and especially Simmel's lifelong preoccupation with the on-going "effect of the earliest pregenital level of development of the libido, the so-called intestinal-libido."[71,72] He took the hypothetical viewpoint that in the primitive intestinal-libido "ego-libido and object-libido" are mixed with each other without differentiation and are identical with organ-libido. With the libidinal investment of the insides of the body, so to say on the level of representation of the body-scheme, a center is produced in which we might seem from today's perspective an early nucleus of the body-ego, of the body-self or of our bodily subjectivity.[73] Especially the unconscious phantasies about the stomach as acted out in the child's doctor game are important for the formation of the concept of body image and the understanding of the self. Adding to that, Simmel remarked that the early body representation which he conceptualized can be upset by traumatic experiences may become points of fixation for possible later regression.

On account of his wish to treat those most ill, Simmel from the beginning endeavored to add to his hospital a closed ward section for the psychotically ill[74] for which he had received an allowance from the Prussian Welfare and Culture Ministry but not a permit from the Humbolt-Schloss owner. Geheimrat von Heinz told Ernst Simmel as early as 1926 that the proximity of a sanatorium for the insane would devalüe his land holdings and after the termination of the lease there would be the danger that "a closed ward institution owned by a third party would remain a thorn in the financial side of the endeavor."[75] Out of the numerous letters which Ernst Simmel wrote to his domestic and foreign friends with the wish for financial support of his project, it emerges that his lawyer and advisor Dr. Hilb favored very much such an institution also on financial grounds.

Based on the difficult economic situation of 1930/31 Ernst Simmel did not have the privilege of realizing his utopia of a systematic psychotherapy in a way that it could become, as a clinical, educational institution alongside the training analysis, the theoretical education and the treatment under supervision, the proverbial fourth or first "standing leg" of psychoanalytic education. In order to come closer to this aim Ernst Simmel offered, as can be seen in the index of the teaching manuals of the Berlin psychoanalytic institute, during the last two years [of the hospital's existence] a seminar for "practicing analysts" that "two times a month in the psychoanalytic hospital . . . dealt with problems of in-hospital psychoanalytical therapy (indications, prognosis, modifications of the method)."

Sigmund Freud stayed several times at Schloss Tegel for a few weeks when he had to be treated in Berlin for his tongue cancer. He made an appeal in 1929 for the creation of a fund from private resources in order to protect the further operations of the hospital due to the financial difficulties of running such a hospital as a private enterprise. Although he was personally asked to sign the petition the Prussian minister of culture Prof. Becker did not join; but he met Freud in 1930 at the Sanatorium for a conversation to congratulate Freud on his scientific work. Although energetic financial support came from different sources, such as Dorothy T. Burlingham, Raymond de Saussure, René Spitz, and Marie Bonaparte, it was not possible to keep the hospital open for economic reasons and it was closed at the end of August 1931.[76]

In spite of its closure Ernst Simmel stuck to the concept of in-patient analytic treatment. As early as 1927 he pleaded for the creation of a consulting specialist for psychotherapeutic tasks in big hospitals — the first to do so —at a general physician's conference for psychotherapy in Bad Nauheim.[77] In a letter to Freud, to whom he had a hard time telling about the end of the psychoanalytic hospital, he wrote: "the kind-hearted cooperation of Dr. Schlomer, the owner and director of the Westend Healing Institute, made it possible for me to open a psychoanalytic department in the Sanatorium Westend. Here I will continue to treat in the same fashion, with my four-and-a-half years of experience at Tegel and supported by my Tegel assistants, patients whose sufferings make it necessary to treat through an in-patient specific psychotherapeutic (psychoanalytic) treatment."[78]

Eventually the Nazi organization "SA Berlin-Brandenburg" housed relief work in the former psychoanalytic hospital Schloss Tegel.[79] Ernst Simmel who was well-known as a socialist health and social politician was able to escape persecution by the skin of his teeth and arrived in Los Angeles via Belgium and England where he participated in the establishment of the psychoanalytic institute there. From Brussels in 1934 he wrote for the last time to Georg Groddeck, to whom he was very well connected in different respects, but he had to grant: "but it is not possible to imitate Groddeck and the attempt to dare to do this would almost be dangerous."[80] Simmel wrote

that he would, above all, dedicate "his future life in California especially to the digging for gold." He wrote: "My departure from Europe is like quickly removing first aid tape — it leaves me sore and whenever you think it has come loose it is still stuck in another spot. One must always painfully tear off a new piece and such a painful spot you are for me."[81]

In 1947 — being almost 64 years old — Ernst Simmel died of a heart attack. Simmel's expulsion from Germany had the effect of no explicit reference to the present in our country [i.e., Germany] of his hospital-based, psychoanalytically-oriented psychosomatic concepts. In the United States his concept was most similarly taken up by the Menninger Clinic (Topeka, KS). We are not in the position to judge whether there the realization of Simmel's utopia of treating the bodily and psychically most sick people in a psychoanalytic way has succeeded. Max Horkheimer was friendly with Ernst Simmel. In his speech at Ernst Simmel's memorial service he honored his most important theoretical work of self-preservation and the death instinct with the following words: "the meaning of Ernst Simmel is rooted in his productive orthodoxy. His death means the irrevocable loss of this approach. He did not swear to the words of the master. One of the most remarkable characteristics of his lifework is that he tried to expand the doctrine of his teacher in order to overcome the dualism of the libido theory: the distinction of ego-libido and object-libido. This seems to me to be the implication of his theory of incorporation. But his intention was contrary to the fashionable adaptation of psychoanalysis to the necessities of today's organized mass culture. He wanted to come closer to the unconscious sources of our actions to comprehend them where they are identical with biological forces and not to translate them into a language of a rationalistic ego-psychology of common sense. His uncompromising yet subtle, tender viewpoint which originated out of the knowledge of the finiteness and the weakness of the human being made him a real successor in the Freudian sense."[82]

National Socialism, which encouraged the forgetting of Ernst Simmel's pioneering work in the field of psychoanalytic hospitals, was the center of his interest besides his work in Southern California of establishing the psychoanalytic institutes in Los Angeles and San Francisco. He published a symposium-sponsored volume entitled "Anti-Semitism. A Social Disease" (1946) [in English]. After he wrote an article describing his war experiences of the First World War for the U.S. Army, he contributed a paper "Anti-Semitism and mass psychopathology"[83] to the volume on anti-semitism. After he had diagnosed anti-Semitism as a mass psychosis, Simmel looked for practical solutions. "It is time to actively put into action our modern psychoanalytic knowledge in order to influence the process of civilization, the collective formation of personality through a thoughtful international psychohygienic program."[84]

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PSYCHOANALYTIC TRAINING AND THE DEVELOPMENT OF AN ANALYTIC CAREER:

A Proposal for Revising the Structure of Psychoanalytic Education

by Richard P. Fox, M.D.

Psychoanalytic education traditionally has been built upon the tripartite model which begins with the training analysis and is then augmented by didactic and clinical seminars and finally the undertaking of supervised analyses. As currently conducted in most psychoanalytic institutes, this course of training continues well beyond the four years of formal seminars into a post-seminar phase during which the major focus is the supervised analytic work as the didactic teaching and eventually the training analysis itself are left behind. Finally when the candidate and the faculty agree that the candidate has achieved an adequate level of proficiency, he is graduated. The graduate analyst then sets about establishing his analytic career based in his own clinical practice with a greater or lesser degree of involvement with his analytic society, institute and colleagues. A limited number of graduates, after several years, are appointed training and supervising analysts and have their identities as analysts and analytic educators reaffirmed through their analytic and supervisory work with candidates.

There are a number of problems involved with this model of analytic education: in a sense it is both top — and bottom — heavy with an important deficiency in between. The significant rites-of-passage in this developmental sequence have been completion of the four years of formal seminars and appointment to training and supervising analyst; until very recently even graduation was essentially a private event. In between these two milestones there is a vast, largely uncharted area where significant personal and professional development occurs but without the institutional support and recognition granted to candidates and their analyzing/supervising instructors. Group affiliations which had been so important during the seminar years are not-so-gradually dissolved during the post-seminar phase of candidacy and are restored by only a limited number of graduates through their participation in society and faculty activities over a number of years. This organizational and educational structure with its emphasis on the "top"

(training and supervising analyst) and "bottom" (seminar candidate) tends to accentuate and perpetuate the intergenerational conflicts which are inevitable in any organization but which represent an even greater problem in psychoanalytic institutes given the residual transference/ countertransference problems of the training analyses.

Educational opportunities for post-seminar candidates and post-graduate analysts present continuing problems. For the clinical associates, case conferences and electives often seem like an after-thought to the four year curriculum and candidates play little part in establishing their educational program. As a result their post-seminar status remains unrecognized and they are apt to feel infantilized. In addition, their seminar group has been disbanded and their contacts with the institute are lessened and may be limited to dealing with administrative requirements. Graduation further compounds these problems of isolation and disaffiliation. Study groups tend to function outside the society/institute organization and are left to the individual to locate and join or establish individually. Other educational opportunities are relatively poorly organized and there is no acknowledged place for post-graduate "mentoring" or group support.

In terms of analytic opportunities, after the institute supplies an initial clinic case (even this is not always true) the post-seminar candidate and the recent graduate are left on their own to find or develop analytic patients within their own private practice. Difficulties in being able to locate cases frequently becomes the stumbling block resulting in prolonged candidacies and is a source of dissatisfaction among graduates as individuals find themselves doing much less psychoanalysis than they had hoped when they undertook analytic training.

This diminished clinical opportunity significantly interferes with the experience of clinical immersion and when combined with the paucity of institutional support has a very negative effect on the individual's attempt to establish a psychoanalytic identity.* Within our own institute the symptoms of this problem are very evident. The duration of analytic training has grown progressively longer and among post-seminar candidates there is an apparent lack of enthusiasm or interest which is reflected in the poor attendance at case conferences and seminars and in the reluctance to complete the required clinical case reports. Likewise, our graduate analysts have difficulties establishing an analytic practice and hesitate or refuse to apply for certification. I feel that this attitude toward certification can be explained only

*As was pointed out by Dr. D.J. Fisher at a recent Faculty Forum discussion of this subject, the problems involved in establishing an analytic identity are further compounded by the fact that we tend to define an analyst solely in terms of clinical practice and exclude other significant activities such as teaching, writing and research.

in part by the problems with the American and its certification procedures; at this point I think it is doubtful whether the number applying would increase significantly even if the process were vastly improved. I sense that at least some of the animosity directed at the American is a reflection of feelings of disappointment and disaffiliation experienced at the completion of analytic training.

As I approach my tenure as Director of Education, I feel that a reorientation of our vision of psychoanalytic education may prove helpful in addressing these problems and in developing a more relevant career pathway for psychoanalysts of the future. The proposed modification which I would like to offer is based upon the idea that psychoanalytic education *begins* during candidacy but continues in very meaningful ways after graduation and in essence is career-long. If this vision became the cornerstone of our model of psychoanalytic education, it would broaden the scope of a psychoanalytic institute's functions and, in important ways, modify the analytic community which it encompasses.

To highlight the need and emphasize the importance of such a change, I reviewed the records of our fifteen most recent graduates and found that the duration of analytic training has lengthened to a surprising degree. The average length of training for this group of fifteen was 10.2 years; the shortest term was six years, the longest fifteen! In part, this is in keeping with a recent survey by C.O.P.E. which indicated that the duration of analytic training is approximately two years shorter (7 vs. 9 years) in those institutes which have an expected time frame for training. In addition, however, it may also be a reflection of the sense that there is not a meaningful and exciting career phase to move onto after graduation.

In suggesting a modification in our training plan, I would begin by proposing that psychoanalytic candidacy be shortened significantly, perhaps to six or seven years for almost all graduates. This would not necessarily mean that the training analysis nor the supervised analyses would be completed within this period. Graduation would reflect the fact that a candidate had completed his required course work, had passed a colloquim, had completed the requisite number of hours of supervision and had demonstrated the capacity to undertake unsupervised work. The would-be graduate would be expected to continue his supervision on his requisite control cases including work on termination (in extended analyses the supervision might be interrupted until the termination phase was reached). During the fifth and subsequent years of candidacy the clinical associate would begin to take elective seminars, seek out study group opportunities and begin considering teaching opportunities within the extension division, the psychotherapy training program and within the institute itself. These activities would continue into the post-graduation phase in such a way that the post-seminar candidate would already be on his way toward becoming a post-graduate analyst.

In considering such a reorientation, we must be careful not to compromise our current training program; nevertheless a great deal of thought and planning should be directed to developing a post-seminar and a post-graduate educational program which would be meaningful and stimulating for all concerned. For example, study groups might be organized by recent graduates, post-seminar candidates and members of the society and institute. Our most experienced members of the faculty might co-lead such groups along with more junior colleagues thereby creating greater opportunities for intergenerational communication as well as providing visability and access to those on the next rungs of the analytic developmental ladder. Such an arrangement would tend to blur some of the distinctions between institute and society and perhaps provide a greater feeling of continuity for the individual and of unity within the organization.

In terms of analytic development, the probability that the American Psychoanalytic Association will sever the linkage between certification and full membership is of great importance. Full membership should be available upon graduation to confirm the psychoanalytic identity of an institute graduate. In addition, the certification process, if it is revised and made a meaningful educational opportunity (rather than an odious obstacle) could represent a significant milestone in an analyst's post-graduate career.

Finally, and perhaps most important, the problem of developing opportunities for doing psychoanalysis needs to be addressed. The single, most important reason for delayed graduations is the lag in developing suitable analytic cases to meet graduation requirements. This problem, however, is not limited to clinical associates. From our recent survey of the institute faculty and society members, it was clear that very few members felt they had sufficient analytic patients. Since an analytic identity hinges upon the opportunities to do psychoanalysis this must be a major focus both during and after candidacy. For example, case finding and conversion of psychotherapy cases should become topics for symposia, classes, study groups and research activity. As awareness of this issue begins to take center stage, it is possible that we will find more patients to analyze. In addition, we should spend more of our time as faculty members and graduate analysts discussing our clinical cases and working together on the problems involved in the psychoanalytic process.

THE PSYCHOANALYTIC STUDY OF LITERATURE: THE SEMINAR

by Leslie M. Kirschenbaum, M.D.

I had been reminded recently about the problems that the politicization of the institute had caused for my candidate group. The formality of the political, organizational, and the idealogical struggles of the institute, as I remember it, had intruded on some of the enthusiasm that perhaps we might have had about learning and studying and sharing what we were learning about. I began to remember once again the seminar in which I participated for a number of years, the seminar on psychoanalysis and literature led by Milton Bronstein, that was really a refuge from those organizational problems.

The idea for the seminar came from my candidate group. I have been looking back through the institute's files for communications about that particular seminar. It seems that the curriculum committee supported the arrangements of the seminar in September 1974. There was a distribution, at that time, to Drs. Ackerman, Baker, Block, Cowan, Fox, Kirschenbaum, Kondratief, Leiken, Schreiber, Sogher, Weiler, and Wilson. We were fifth-year clinical associates at that time. Although the seminar was part of the curriculum, the attendance was voluntary. There was no credit associated with it, no evaluation, etc. We were doing it because we wanted to and because we were interested. The first book that we read was *The Brothers Karamazov,* and we spent a number of sessions over a period of several months on that particular book. The seminar continued until at least 1985. I stopped perhaps a year or so before the seminar stopped. The make up of the seminar changed. A few stayed with it through many years.

The seminar came to have some official credit within the institute, but there never was an evaluation process. It came to be equivalent to the continuous case seminars for post-seminar candidates. There were different groups in the seminar through the years although a number of people: myself, Richard Baker, and several others formed the core of a stable group. The seminar was joined by candidates from the Southern California Psychoanalytic. We met every month and took a different book each month.

On looking back, I am surprised by the number of books we read and also at the number of seminars that I missed. Among the books discussed, in no particular chronological order, were *A Memoir of Fathers and Sons; Home Before Dark* by Susan Cheever; *Humbolt's Gift* by Saul Bellow; *The Deptford Trilogy* by Robertson Davies; *Growing Up* by Russell Baker; *The Little Drummer Girl; F. Scott Fitzgerald, the Biography; The Memoirs of a Viennese Psychoanalyst; The House of Seven Gables; Billy Budd; Beck is Back; Last Rites* by Aram Saroyan; *The Chosen; Richard III; King Lear; Huckleberry Finn; The Great Gatsby; The World According to Garp; Madam Bovary; A Tale of Two Cities; The Stranger; Coriolanus; The Wasteland; Spoon River Anthology; Brideshead Revisited;* and *Look Homeward Angel.* There was a range in the types of books that were selected.

Although there was probably some motivation for people to come to the seminar, they got credit for the continuing seminars, the original motivation, as I remember it, was preserved. We first decided we wanted the seminar, I think, because we wanted to read great and good books and to add to the psychoanalytic reading that we were doing, because we wanted to share ideas and share ourselves with one another in a setting different from the seminars. Maybe we wanted to escape from being evaluated, evaluating ourselves, and evaluating our colleagues. Perhaps, we were looking for some kind of material that we could talk about together without being angry or critical or judgmental of one another. Perhaps we wanted to nurture ourselves to try to make-up for what we felt was missing.

Throughout the seminar it did not seem like people were coming because they had to, or to meet a requirement or an obligation. It seemed as though they were coming out of excitement and interest. It took place in Milt Bronstein's home. The fact that it lasted for so many years, I think is extraordinary. It went on through the period of greatest turmoil in the institute and among the candidates. There were ideological battles leading up to the moratorium and then there was the period of the moratorium. It was difficult for candidates of different ideological persuasions and from different camps and backgrounds and analysts to sit and talk with one another without being verbally angry or so guarded that there was a limit on spontaneous communication.

We got along in my candidate group, and for the most part, liked one another. Some of us became good friends. I think we enjoyed and profited from the seminars. There did hang over the climate of the institute an atmosphere of heaviness, of judgement, of rancor, and of disappointment. I think one of the sources of my own bitterness was that the people within the institute could not talk to one another, and I must have hoped for parental figures who could talk freely with one another and support one another.

Candidates within the institute have complained about a lack of, or

insufficiant, nurturance. The feeling about the "Literature" seminar, at least in my memory, was one of richness, and a sense of hospitality. We met in Milt's home. The rooms were very comfortable. There was always brandy or soft drinks or cake.

As I remember the seminar, there was sustained hospitality by Milt and an atmosphere of tolerance, generosity, and respect. He was very accepting of what each person had to offer, and the seminar members, I believe, identified with the acceptance. Milt always gave us something in the way of background about a book or an author, but it was not final or didactic. He gave a lot along with the authors and along with the seminar members. What he said set the stage, helped to create a background, did not intrude, and was not too much.

There was no particular formula in the choice of books and no particular style or period that guided our selections. The seminar members would say what books they wanted to read, what came to mind. There would be a little debate. Sometimes there would be a bit of a struggle about the choice. Milt would finally approve of a particular book. He was a benevolent authority. There were occasional candidates who knew a lot about psychoanalysis and literature who felt that the pattern we were following did not have a great deal of sophistication. From time to time, I would agree and argue that the seminar ought to be more focused on a particular author or style. This way we would be learning more and getting more from reading in a concerted and organized way. My discontent would surge forward every now and then.

I think in retrospect that the way we selected books was really good and had a quality of free association, a kind of play in the selections of books. It was not entirely free; it was managed in some way, but it went along with the atmosphere of tolerance that permeated the seminar. It was tolerance along with exploration. We were going in new and sometimes surprising directions, probably with some of the appeal and some of the excitement and also perhaps with some of the apprehension that led me to miss a number of the seminars, as I look back, as well as to attend for so long. Appreciation, tolerance, and respect are words I think I have used before in talking about the seminar. I realize that these words sound like words from a boy scout's oath, but they really apply in a very serious way.

A group of psychoanalysts, or candidates to become psychoanalysts, could easily have slipped into certain not-very-productive postures in reading works of literature together. We could have identified with the writers, the creative people, and begun to think of ourselves as critics, litterateurs, etc. We could have hidden behind analysis of the writers . . . We never did. We went together beneath the surface of the books we read and our own immediate interpretations, a kind of association without role playing, without jargon, without psychologizing. We seemed to find within ourselves the Coriolanus, the King Lear, the Gatsby, the Billy Budd, the Richard III. It was not pretentious. It flowed.

It happened in a way that was not happening a lot within the institute. It was, perhaps, the way it should be. People listened not uncritically but came with a kind of reverence of the experience and perhaps of the creative powers of others. People were at their best. We came to levels of understanding and articulateness and depth that was perhaps new to us. Maybe there was a connection to a certain kind of analytic hour wherein one came, hoped to be treated with respect, and to rise to new levels and find things within oneself and be listened to well.

In addition to my own periodic efforts to take over the seminar by dictating what the format should be and emphasizing that we ought to be focusing in more on a particular body of literature, in addition to my own efforts to be a favorite son and have my book chosen, I was periodically wanting to free myself and grow up and go on and leave the seminar. I sometimes resented reading for a group and felt that I should be choosing books on my own, resentful of the very quality of the group that was special, its endurance over time, and I felt I should be getting on with things. But there was great support, support to discover within ourselves and to discover our own capacities to see and to understand and to articulate.

I think that there was a bond between the people who were in the seminar together. Friends became better and deeper friends. People I did not know before became friends. A few I did not like, I grew to like. It is my idea and fantasy that we shared something good together that was and always will be a bond. I have spoken with only a few of the people who were in the seminar. Richard Baker feels that he came to read through that seminar in a different way and a way that is more creative to him. Nicole Poliquin shared with me over a period of time her interest and appreciation of that particular seminar. Clem Mortashed missed it, as did Ruth Mesquita.

There are many memories of books we read and evenings and colleagues and friends. A few memories that stand out are the ones of Gant, Eugene's father, piling on logs and building huge fires and inundating the family with the fruit of the season, fortifying the reader against the sadness and the ghosts of lost ones in Eugene's life. There is the terrible storm of Lear's narcissistic rage that went on and on until it was finally spent, Lear tended by his gentle, non-judging, and loyal friends. There is the image of the terrible and bitterly unfair destruction of Billy Budd, betrayed by himself, in a fleeting moment. There is the pathetic groping of Gatsby for the past and for what never was or would be.

These moments and memories are the gifts, along with many others, of the writers and of Milt and of all the people who shared the seminar together, but more important I think is the sense of having bolstered one another, supported one another, and having had the courage to look in a new place a little more deeply and clearly and less pretentiously, with more respect, tolerance, and appreciation.

KARL AUGUSTUS MENNINGER, M.D.
JULY 22, 1893 - JULY 18, 1990
THE WAY I REMEMBER HIM

by Rudolf Ekstein, Ph.D.

At the end of 1937 or the beginning of 1938, I discovered a paper by Dr. Karl, entitled: *The Genius of the Jew in Psychiatry* (published in Medical Leaves, Chicago, 1937, 1:127-132). It was an unruly, disturbing, upsetting time for all of us in Austria. The Hitler Germany began to threaten. But there were some small islands, even in fascist Austria, where freedom seemed to still exist at that time. That time was the start of my life at the university and the beginning of my training as a psychoanalytic pedagogue at the Vienna Psychoanalytic Institute. As I read that paper, never having met Dr. Karl, I felt somewhat annoyed and critical. How could Jews, being always under the threat of persecution — how right he was about that — and always being in the minority, always in danger as a group of people — who in order to defend themselves — had learned to watch the faces of people, how could a Jew living in small towns, read in the faces of the Cossacks when they were peaceful and left the Jews alone, or would, at another moment, suddenly fall on them in rage and drive the Jews away, persecute them, kill them? Those who had learned to read the faces, that is to somehow understand the other person, would have an extraordinary talent to develop psychological sensitivity such as those famous Jewish physicians Alfred Adler, Sigmund Freud, Theodor Herzl, Victor Adler, and learn to read the faces of their potential enemies —and turn the psychological defense into the desire to heal, to educate and to improve social conditions.

I had grown up in a time, the greater part of it between the two world wars and for me, at least in Vienna, my existence was fairly peaceful and I, a Jew, had friends of different religious backgrounds in the youth movement. Was Dr. Karl right? I might have enjoyed, at that time, meeting someone who had a special gift, a special talent for psychology, but I did not want that to be based on religion or "race."

Soon the time came, after the invasion of Austria by the forces of Hitler, that we all began to wonder whether we must leave and where we should eventually go. I proceeded to America in December of 1938 and I began to learn American geography and thus to discover the Menninger Foundation in Topeka, Kansas.

My now American family and I lived in Brooklyn and one of these days a letter arrived in early 1947 from Dr. Karl Menninger inviting my discussion on the nature of the issue of causality in psychology. He caused me to inquire more fully about the Menninger Foundation. I was invited to come and I slowly discovered a place, strange for me. There, far away from the East and West coasts, in the midst of the wheat fields of Kansas was their Foundation dedicated to training and research, and above all, the treatment of very ill patients, and also a developing Psychoanalytic Institute. I met Dr. Karl at that Institute and found that most of its members were Europeans, analysts who had escaped from Vienna, from Prague, from Berlin, from many of the European cities where Hitler had driven them out. It truly was a mini-international psychoanalytic association. I admired the Menningers not only for their willingness to help us but also for their foresight in knowing that such a place should be created in the center of the United States, in Topeka, the capital of Kansas. In Europe, I had never heard of Kansas, except having read about the Wizard of Oz.

After the first or second year there, Dr. Karl asked me as to what I thought about the psychotherapy course we offered. Each of the training analysts gave two or three lectures during the spring or summer term. I could speak to him openly and found a sensitive ear. I thought that some of the lecturers often repeated what the others had said before, never gave the students, the psychiatric residents, psychologists, social workers an opportunity to be involved in the group, to form a stronger relationship to the teacher. I felt that kind of teaching needed continuity. I remember how anxious I got when he, Dr. Karl, suggested I take over the full course. I taught that course for many years and I sometimes felt the students taught me more than I taught them. I realized that a didactic course is not enough, that we needed small seminars, and above all, we needed individual supervision and not merely occasional consultation. My European training, my experience with American social work, make me think of supervision not only as a didactic task but rather as a process, a relationship between supervisor and supervisee. This gave me the opportunity to offer to a number of colleagues a seminar on supervision. Dr. Robert Wallerstein, who was one of these people, came to my seminar on supervision, and later wrote with me *The Teaching and Learning of Psychotherapy,* a book that came out about 1958, saw a number of improved editions and was translated into Swedish, Italian and Spanish still in print. The way that Dr. Karl encouraged me is typical of his way of developing talents, giving opportunities for professional growth.

But the same was true for me concerning my work at Southard School, an opportunity again via supervision and consultation and many seminars, to develop new notions in the analytic treatment of psychotic and autistic children, of borderline conditions of childhood and adolescence, and thus the book was born: *Children of Time and Space, of Action and Impulse.* He

inspired many special research projects, not only *Diagnostic Testing* as developed by Rappaport, Gill and Schafer, but also the interview procedures concerning the capacity of psychiatric residents as developed by Holt and Luborsky, and I could go on endlessly.

Sometimes I thought I would want to stay there forever and to always be a part of the Menninger community. But as much as Dr. Karl and his associates encouraged us to grow, to develop, to be creative, I also felt that he sometimes put a stop to the activities we had in mind. It is always true that younger, growing people come to a point where they admire their teachers and their mentors, but they no longer inspire further growth. He could it be otherwise? Each year some of the senior staff might leave, such as the Europeans who wanted to live again in the larger cities, or the residents who had graduated and went out into the psychiatric world, sometimes with ambivalence but somehow they always came back to visit, to contribute, and to feel somehow that they are "Menningerites."

As I look at the writings of the Menningers, I find that the stress of their contributions was on modernizing American psychiatry, while I tried to remain within the inner circle of psychoanalysis. I recall how Anna Freud, who once came to Topeka to visit and to teach, described the place as one that had many circles but that the most inner circle was the one of analytical thinking, the Psychoanalytic Institute; the outer circles were the veterans hospital, the State Hospital, the community clinics, child psychiatry, education and many aspects of social life. It was in these circles that Karl Menninger, our "Dr. Karl," was trying to give each of us an opportunity for creative work.

Once he gave me a ring made by Navajo Indians and I learned later that he had many copies of that ring, giving them to us as a token of his esteem. I recalled the German poet Gotthold Ephraim Lessing, who wrote about a man who lived in the distant east and as he came near to his death told each of his sons, each of them separately, that he thought well of him and gave him a special ring that he possessed, a ring of inestimable value. However, he had copies made of that ring and each son then believed that he had the true ring, that he was the chosen son. Lessing was to refer to the Mosaic, the Christian and Moslem religions. Let each think that God has chosen him, but better remember that the rings that the two other brothers had was to prepare them for unity.

Freud gave seven rings to his early collaborators in order to maintain the unity of the group. I think then of the ring that Dr. Karl gave me in the same way. Of course, I am often curious and want to find out who else received the ring. I know a few, and I know, having the gift, permits me to maintain the link to the Menninger Foundation that we inherited from Dr. Karl. Will we maintain the spirit that is connected with his name? Will the analysts

maintain the spirit that connected them to Freud? One uses the teacher, and when in the field one can retain him only if one internalizes his work, his goals, his devotion to the science, to patients, and his devotion to teaching and research.

Now, as I revisit the Menninger Foundation, I see, of course, that many of the Europeans are gone and that many colleagues, having had similar experiences as we who came from Europe, now come from South America and other parts of the world. What a creative refuge the Menningers have built there in the midst of the wheat fields. That is why it is for those of us who have taught there, have been trained there, feel a need to visit our professional home of many a year, find strength for further work, and thus have "Dr. Karl" go on living in our hearts and minds.

THOUGHTS OF AN ANALYST WATCHING THE BERLIN WALL CRUMBLE AND FALL

by Martin Grotjahn, M.D.

When I saw the Berlin Wall coming down, on television here in Beverly Hills, I and my wife spent hours fascinated watching the spectacle. Very much in contrast to my usual behavior, I was deeply moved.

We saw the Brandenburg Tor and the great space from there to the Reichstag. This had been where we lived when we were medical students, since the Brandenburg Tor is located between the Charite where I worked and the Gynecological Clinic where my wife worked.

I remembered the times until we could escape in September 1936, fifty-three years ago. We lived in fear, terror, anxiety, rage and wild fantasies of hatred, revenge, and bloody vengeance as a reaction to what we had to suffer then.

I remembered how I once raced for my life out of a police ambush in which I had stumbled, and thought: You wait! We will come and kill every one of you bastards who want to kill us now.

And now the fascists had gone, the Russians had followed, and we have become foreigners to our own country.

Reaction to threat of murder is thought of as a reactive rage leading to more murder.

I remembered our first visit to Germany after the war. We discussed a possible new, nuclear war. I was interrupted by a German Jew who had lived through the whole war right there in Berlin. He said with surprise: "Martin — it seems to me you are still afraid of death?!" Of course I was afraid and did not deny it. Was not everybody? No. No more. Time has changed. After nightly bombings, fires, finally fighting; after persecution, tortures and prison; after destruction of the bunker — there were people indifferent to death.

Thirty years later I was in an intensive care unit, trying to recover from a coronary attack. My friend, the analyst Gottfried Bloch, who had lived with death for years in German prisons, bent over my bed to me and said: "Why are you afraid to die? Right now you live! Try to make the best of that, and worry about tomorrow, tomorrow."

And then I saw people climbing the wall, the very real representative of terror and unfreedom. There were no heroes. There was no fighting. They were Berliners on a *Volksfest,* a festive family outing. There was beer, there was ice cream cones and sticks, there were young fathers helping their sons and daughters climb on top of the wall, which was now a heap of stones. There were embraces and laughter and joy; there were more men than women, and there were hardly any old people visible, sitting on the fringe and seemingly asking: "Is that it? Where are the terrorists? The Secret Police? The torturers, the prison guards; where are the damned Nazis singing the *Horst Wessel Lied?*

The answer to newly won freedom was not murder.

The answer to freedom regained was freedom enjoyed.

The answer was joy, laughter, high spirits, and good will toward mankind.

My colleagues who had become Nazis had been killed in the war or died in the 45 years since then.

My friends who had not become Nazis and could not escape were also dead.

I do not want to be the last man to hate. I want to be one of those people who are free and happy, and free even of rape and vengeance — people who were survivors but not victors or victims.

I saw the wall fall. It may not be the end. Let us hope the future will not be limited to unification of two Germanies. It should be leading to the birth of a united Europe, which includes two Germanies.

As far as I am concerned, let me remain what I am: An old-fashioned man afraid to die — or at least not willing to stop watching the show today.

A SAD LESSON: CURSE GOD AND LIVE

by Bruno Bettelheim, Ph.D.

Editor's introduction: The following introduction by Bruno Bettelheim to Alvin Rosenfeld's *A Dissenter in the House of God* may be the last piece Bettelheim wrote before his death. The themes and subtext are particularly poignant. It first appeared in *The Forward*, August 10, 1990, page 9.

No survivor of the German extermination camps escaped the most severe traumatization. If in addition to their horrible experiences there they lost those who were closest and dearest to them (as was true for most extermination camp survivors), they will never be able to fully recuperate from experiences which had shattered their lives. While during their stay in the camps, many prisoners expected that if by some good luck they survived and were liberated they would be overcome by joy and happiness; this was, often to their great surprise, not the case. As Primo Levi describes, they felt shame and guilt that they were the lucky ones when so many like them were murdered. As much as Levi tried to cope with his terrible experience through writing about it, and as successful as he was a writer, in the end he committed suicide, as had before him the great German poet Paul Celan, and so had others.

Even persons such as Saul Friedlander, who never was in a camp but survived because a French Catholic family raised him as their son — when as a young man he learned that his parents had died in Auschwitz, this shattered his life. As he writes in his book *When Memory Comes*, "I now preserve, in the depth of myself, incompatible fragments of existence . . . like those shards of steel the survivors of great battles sometimes carry about inside their bodies."

When other children who survived in France were interviewed by Claudine Vegh, who was one of them, most had not spoken about their experience, which had shattered their lives, for twenty or more years, because they could not afford to recall their sufferings. All these were real people. Having studied their fate for many years and having published a book and articles on it, I was deeply moved by this fictional account of the fate of a survivor, so true to life is this story of Hyman Schwartz.

In creating the hero of this novel, the author, Dr. Alvin Rosenfeld, has clearly drawn on his experience as a psychiatrist. But this alone would never have sufficed. I do not know on what other personal experience with utter dejection and depression he was able to draw to create this story, but it shows an amazing insight into and empathy with the fate of an extermination camp survivor who has lost everything he cared for and lived for.

It is this novel, more than any other writing that I can think of, which permits the reader a true understanding of the utter despair and emptiness of a survivor, feelings which have taken the place of an all-consuming rage against what fate has done to him. Not being able to permit himself to feel this rage prevents any positive relationship to others or to life and makes Hyman in essence a living corpse. While at first a ray of hope that by some miracle his wife and son had survived and that the family would soon be reunited gives him the strength to go on, the disappointment of this hope extinguishes all desire to live. So for some ten years he continues a totally empty and to him meaningless life in New York. There, he vegetated, dead in all feelings and devoid of any human contacts which he utterly rejects, as if they were a betrayal of those he loved and had lost.

He had amazing mathematical abilities, which had saved his life because they were useful to his Nazi masters. It is this very ability which he now uses to blot out all life and feelings. Whenever there seems to be a chance for their reawakening, he uses computations and mathematical speculations to blot them out.

This living a non-life continues for some 10 years after liberation until late in 1955. The first sign that his spirit was reawakening took place on Yom Kippur, the holiest day of the year, when Hyman Schwartz went to synagogue for the first time since the war's end. In a moving scene he screams accusations against the God he had learned to believe in as a child. In his rage, he tried to take God to account for what He had done to him and to the Jews of Europe. Although this outbreak led to his being ejected from the synagogue, Hyman's rage against God was the first time in ten years that true feeling had come to the fore. As so often in real life, it is only after the extreme despair and intense rage have been felt that the chance for some more positive feeling to emerge has been created.

No reader will remain untouched by the deep concern Dr. Rosenfeld has with those who lost everything in the Holocaust. How can a person learn to "accept" the terrible way he was robbed of all he held dear? Losing a beloved wife and son in gas chambers fellow men have built can hardly be viewed as the way of all flesh. But the story told in this book and the questions it addresses have a broader significance. I suspect that everyone who reads this book, regardless of his religion, will become one with the universal human experience of irrevocable loss. As Hyman struggles to have a second life in

spite of his anguish, most readers will reflect on their own personal losses, on the times when the pain seemed so intense that they wanted life to stop. In the end, the reader will reach a deeper level of acceptance and a realistic, yet hopeful, vision of one man's chance for renewal, for a second life.

Dr. Rosenfeld's insight into the process of healing combines his psychiatric knowledge and his empathy for a man who has suffered. He shows us that when feeling returns, relationships may begin. For after his outbreak of rage, by chance Hyman is approached by a young man who wants to apprentice himself to him. And therein lies the tale.

But I do not want to tell more because this would cheat the reader of the interest in reading the story in which Dr. Rosenfeld asks what kind of a new life a person can have after so massive a trauma, and what would make that life worth living. He looks at the importance of a man's relationship to his father, the way this influences the type of father he becomes and the sacrifices parents make so their children can have a better life. He explores the way a good enough parent tries not to burden his child with his own problems but to let him become his own person.

The writing itself is succinct, straightforward and easy to read. Dr. Rosenfeld exhibits consummate skill in describing both Hyman's withdrawal from life and his eventual reawakening to it. He reveals a sensitive understanding of the depth of the existential despair of a man who has lost everything and of what it takes to make him accept life despite his deep disappointments. I am glad to introduce this fine book to its readers. I hope they gain from it as much as I have.

THE SCREENING FUNCTION OF POST-TRAUMATIC NIGHTMARES

reviewed by Regina Pally, M.D.

In his paper "The Screening Function of Posttraumatic Nightmares" (presented at LAPSI on October 1989) Dr. Melvin Lansky makes two major points. The first point, which comprises the major portion of the paper, is that chronic posttraumatic nightmares are not purely the result of stress but have psychological meaning reflecting long standing emotional conflicts. To illustrate this, he points to the factors promoting the chronicity of these dreams, as well as, evidence of secondary revision and screening of childhood memories. The second point is that posttraumatic nightmares fit in with Freud's original model for dreams as expressing unconscious wishes as fulfilled.

A historical review surprisingly reveals that both the psychoanalytic and non-psychoanalytic literature views posttraumatic dreams as essentially an exact replay of the traumatic event. These nightmares are viewed as a stress response to the trauma rather than having psychological meaning. It is this aspect of the paper that I found most valuable since its conclusions are useful for a wide range of patients, both analytic and non-analytic. I also found it refreshing for Dr. Lansky to take a strong stand on a controversial political and societal issue. Perhaps this is not controversial to a psychoanalytic audience but it is to community based psychotherapy. In recent years the issue of the role played by early childhood experiences in the psychological impact of trauma has become almost a taboo subject. As a result of the influence of victims groups, there has been a disturbing tendency to view the psychological effects of trauma in a very narrow scope, having to do solely with the direct effects of the trauma itself. I have a personal, clinical, interest in this controversy related to my work with sexual assault victims. What I have seen is that the experience of being victimized, although universal in some ways, (i.e., Anyone would feel terrified by a rapist) is also experienced in very personal ways which are influenced by early childhood experience. Therefore to treat the psychological response to the trauma one must, almost from the beginning, include issues related to childhood experiences within the family. The significant issues for sexual assault victims relate to the handling of strong affects and the feelings of shame which occur in the face of helplessness, much the same kinds of issues Dr. Lansky found with his patients.

Using a sample population of psychiatric inpatients at the Brentwood VA Hospital, Dr. Lansky studied chronic posttraumatic nightmares. The information for this study was gathered by an open-ended questionnaire, an individual interview, as well as clinical knowledge of the patient while on the ward. The collected data included information about the nightmare, the traumatic event, childhood experiences and family constellation. In all cases there was gross family dysfunction both during childhood as well as the current family situation. Chronic posttraumatic nightmares were defined as any nightmare occuring more than two years after the initial trauma and identified by the dreamer as being *about* the traumatic experience. The body of the paper consists of numerous clinical vignettes of patients and their nightmares which illustrate Dr. Lansky's points about the psychological meaning and function of these dreams.

Secondary revision was prevalent in these nightmares. Dr. Lansky expalains that secondary revision consists of an assessment in the dream work itself, used when other attempts at dream work defense are insufficient to reduce the disturbing aspects of the dream. Freud's phrase, "It is only a dream," becomes in these cases, "It's a replay of what happened to me," during the war. The patients reported that they experienced these dreams as flashbacks or simple memories of *actual* traumatic events. In fact, the dreams not only contained many non-battlefield situations both from childhood and current life, but some patients who had never had combat experience reported "post traumatic" nightmares of the battlefield! These patients were genuinely surprised to realize how much imagination played a role in constructing their dreams. In one case a Vietnmam veteran, a cocaine addict with many prison sentences, reported a recurrent nightmare which he claimed was about an actual event in the war. In his dream he is tortured as a prisoner of war. Upon questioning in the interview session, he admitted he had never been in prison in the war. His family background revealed a violent father who beat and whipped the children, while the mother made no efforts to protect them. The torture of his childhood becomes, "It's only a replay of what happened during the war," illustrating the use of secondary revision as a last line of defense.

In addressing the chronicity of these dreams, Dr. Lansky points out that many post traumatic nightmares eventually become diluted with other material and eventually disappear as nightmares. What contributes to making some nightmares continue in this repetitive chronic fashion, Dr. Lansky feels, is the contribution of coexistant trauma from early life. The dreams provide a screening function, as a defense against awareness of unconscious conflicts from childhood. Dr. Lansky uses the term "screening" in much the same way as Freud applied this term to unusually vivid memories from childhood, screen memories. One patient, who felt rageful at the government for not compensating him for damages done to him in Vietnam, reported a recurrent nightmare in which he is being shot at by the Viet Cong and is scared of being

killed. Like others in this study, the man experienced beatings from his father in the presence of an unprotective mother. Consciously he could feel rage at the government and express his feelings of fear in relation to the Viet Cong. The nightmare, according to Dr. Lansky, served to "concretize the helplessness and terror" of his childhood — thereby screening these childhood memories.

Dr. Lansky gives many dream vignettes with themes of fear, shame, aggression, and guilt in which the dream serves as a defense. He concludes that the helplessness and fear of attack on the battlefield resonate with childhood emotional traumas. Although these dreams involve terror on the battlefield, they serve to diminish awareness of feelings of rage, terror and shame originating within the family both in childhood and in their current family situation with spouse and children. The setting of the battlefield serves as a defense against these unacknowledged feelings. In one example, a patient reported a dream in which he is a Marine fighting in his home town against some gang member. A 17 year old "baby" is shot. The patient feels important because he once again is in the military, but feels angry and guilty that this boy was shot and that he hadn't prevented it. This man had a highly traumatic childhood involving physical abuse. His mother had been too afraid to leave the father. In his marriage he ruled like an abusive tyrant. In this dream he relived not only his fear when at 17 he enlisted into military service to escape his home life but also his childhood fear of his father. Unable to acknowledge the fear he felt as a child, he used the military situation to account for it. He could feel fear for someone else, but not himself. He also could not consciously admit his rage at his children because then he would realize he had become just like his own abusive father. In the dream the rage gets projected onto the gang members. The shame and guilt resulting from his childhood and his failure as a father further serve to make him feel undeserving and worthy of the punishment which comes from being under attack on the battlefield.

Yet another example dealing with rage shows how the nightmare sufferer, demanding recompense from the government feels entitled to his rage. This enables him to split off from awareness his early and/or concurrent family conflicts and to focus his attention instead on the government's unfairness to him regarding his combat trauma. For these men, the underlying, unconscious, feelings of uncontrolled rage, shame and guilt, which they cannot manage consciously, serve as the fuel for these defensive dreams.

For me it is more meaningful that these dreams illustrate the psychological meaning of post traumatic nightmares, rather than that they also turn out to be consistent, specifically, with Freud's theory of the function of dreams. I also think Dr. Lansky's illustrations of this point is the more convincing aspect of his study. However, it seems very important to Dr. Lansky that he show how wish fulfillment, so prevalent in regular dreams, also appears in posttraumatic nightmares, and thus are consistent with Freud's original

theory of dreams. He points out that most of the men suffering from posttraumatic nightmares volunteered for combat. The conscious wish to fight, as well as the reappearance of battlefield trauma in dreams, may serve to modulate and keep unconscious feelings of shame, rage and guilt by being projected onto enemies and rationalized by the combat setting. Even such wartime experiences as buddies being killed or girlfriends sending "Dear John" letters, which result in narcissistic wounds, may be more psychologically acceptable as a source of fear, shame and rage than childhood or present day family experiences. In other words, the wish fulfillment aspect is that the dreamer wishes not only to express rage but more importantly wishes that these painful emotions resulted from the less narcissistically wounding battlefield, rather than from within their families. Dr. Leo Rangell was the discussant. Despite the fact that he enthusiastically praised Dr. Lansky's study, I found his discussion somewhat disappointing. Dr. Rangell focussed too much on how Dr. Lansky's work validated classical psychoanalytic theory and less on the significant contribution to working with traumatized patients no matter what the theoretical persuasion of the analyst or therapist. During the discussion with the audience a comment was added by Dr. Robert Pynoos, who has studied children traumatized by being witness to violent death, which added to and broadened Dr. Lansky's findings. Dr. Pynoos has found that even the reporting soon after these violent experiences is already distorted along what seem to be psychologically defensive lines. For example, a child might "remember" the incident as happening further away than it did to reduce the sense of vulnerability in the child.

I was glad to see an analytic audience so welcoming of data derived from non-analytic sources and of use to non-analytic, as well as, analytic patients.

THE SCREENING FUNCTION OF POST-TRAUMATIC NIGHTMARES

Reviewed by Scott Carder, M.D.

This report is based on my impressions from the evening. I did not read the paper ahead of time and have not read the paper. My report is based on the summary presented by Dr. Melvin Landsy and the discussions following.

I was fascinated when Dr. Lansky began to report his summary of data gathered at the V.A. Hospital on interviews on nightmares. He had over 40 patients in his study, which appeared to be a truly scientific study. Nightmares were recorded with some depth interview material, some past material, and current observational data — all done from a psychodynamic, psycho-analytic perspective. This was truly a rare group of data. As the discussant Leo Rangel mentioned, although it was not research on the psychoanalytic process, this was psychoanalytic research, psychoanalytically informed research.

I got several impressions from the material. Dr. Lansky clearly demonstrated that these hospitalized veterans, in their reporting of nightmares, both immediate and chronic, repeating nightmares, did reveal the phenomena of transference as Freud had originally defined it. Freud originally spoke of two different, yet related meanings of transference. In Chapter 7 of *The Interpretation of Dreams*, in discussing the importance of day residue, Freud wrote, "An unconscious idea is such quite incapable of entering the preconscious and . . . can only exercise any effect by establishing a connection with an idea which already belongs to the preconscious, by *transferrring its intensity to it and by getting itself 'covered' by it"* (1900, page 562). In this passage, Freud states that transference refers to the transfer of an unconscious idea to a preconscious one. I think Dr. Lansky clearly demonstrates that these disturbed veterans did have representations in their dreams of battlefield tortures that appeared to also stand in for earlier childhood trauma of which they were not conscious.

Secondly, I liked Dr. Lansky's comments and assessments that these veterans volunteered for combat in Vietnam and that somehow they felt their disturbed feelings of narcissistic rage, anxiety and pain were better explained on a battlefield than at home where they seemed much more abnormal having these feelings. That, to me, made a lot of sense.

Next, Dr. Lansky, at the beginning and throughout, did warn us that it is difficult to generalize from this severely disturbed population and yet I take issue that he himself generalized in the title of his paper, "The Screening Function of Post-Traumatic Nightmares." This does imply he is stating that a general principle for dream process inferred from a study of one sample of severely disturbed people.

Dr. Lansky did not emphasize enough the repetitive process or the repetitive compulsion aspect of patients' suffering nightmares, which both seem to repeat their childhood traumas and are yet new additions. Dr. Lansky's comments that these were not exact repetitions from childhood was clarified by Dr. Robert Pynoos' comments in the discussion that no recollections of trauma, whether in dreams or immediate recall of real traumatic events, are exact repetitions, but are new additions, with various changes going on, partly adaptive attempts to defend against the severity of the pain.

From my perspective, the repetitive nature was not surprising in this population. This was a group of men who had had severe childhood traumas, terrifying events in childhood that must have been very influential in organizing their personalities. The fact that they repeated these traumas in their adult life, whether it was getting into a battlefield situation, or getting themselves into other situations where they experienced horrifying events and then horrifying nightmares, was not surprising. The repetition of unconscious process in present is transference phenomena, the meaning of which we don't always understand.

My principle criticism of Dr. Lansky's paper was that, unfortunately, he appeared to try to squeeze his data into an old theoretical framework. Specifically, Dr. Lansky took pains to show the secondary revision and the dream work, fitting it into Freud's theory of the 1900s on dreams. I felt this detracted from the marvelous data that he had. It is not scientific to try to fit current data into a theory that 90 years later may have many outdated concepts that no longer fit. Specifically, with the title "The Screening Function of Post-Traumatic Nightmares," I take issue with the word screening. Both Lansky and Leo Rangel in their discussions supported this concept of screening and both supported Freud's theoretical position on dreaming. Dr. Rangel especially attempted to refute the modern biologically based ideas about dream theory. It appears that both attempted to maintain and support the belief that Dr. Lansky's data today best fits within Freud's theory of dreams in the 1900s.

I, for one, am not convinced that screening is a function of dreams or nightmares. The repetitive and associative process that occurs in dreams is much more likely to have explanatory power without inferring a motive based on theory. Specifically, the screening assumed that the nightmare and the current events were attempts to defend against conscious awareness of

childhood trauma. They believed that the current nightmare or event was a less powerful and less painful emotion than the early feelings. I disagree and feel that the current trauma and the nightmare may be just as severe if not more so. I think a title such as "The Repetitive or Associative Phenomena in Post-Traumatic Nightmares" might more accurately describe the level of our knowledge today. I would refer readers to the book by Stanley Palombo, M.D., *Dreaming and Memory,* 1982. Dr. Palombo's research involved using analytic patients in a sleep laboratory to collect dreams after sessions. In his work, there was a much clearer understanding of dreams as information processing, most likely related to memory processing — that the dreams likely were similar to a day residue event creating an emotion such as terror. At night time, the brain attempts to put the current day's event into the proper order in the file on terror, while at the same time, incorporating or experiencing many other terror-like qualities. That's my characterization of Dr. Palombo's information processing model.

In summary, I think Dr. Lansky's research is a marvelous step forward in trying to get more objective data on the meaning of the dreaming process. I do, however, feel it was held back by his attempts to fit it into Freud's original dream theory.

BOOK REVIEW

The Anatomy of Psychotherapy
by Lawrence Friedman, M.D.

Reviewed by Joel Kotin, M.D.

This remarkable book is aptly titled. The author attempts to describe psychotherapy — what it is and how it works. Because the book is thick, with some highly theoretical sections, some readers may be put off initially. They shouldn't be. Much of the discussion is experience near for the clinician. I advise everyone in the field of psychotherapy and psychoanalysis to read and study this book. In the next few pages I will try to describe Dr. Friedman's arguments that support this bold assertion.

Dr. Friedman divides his book into six sections. *Part I, "Theory and Practice: The Trouble with Psychotherapy,"* begins with the chapter, "Whatever Happened to the Therapist's Discomfort?" Here and throughout his book, Dr. Friedman emphasizes that doing therapy is not only stressful, but that trouble — uncertainty and agony — is a normal, and perhaps *essential* experience for the working therapist. Why is this so? And why is it so hard to describe what psychotherapy is? The rest of the book is devoted to answering these questions.

Dr. Friedman looks to theory for help. He points out that since Freud introduced the ideas, three major curative factors have been generally discussed. These are *understanding* (including insight and some sort of deeper, emotional increase in awareness), *attachment* (meaning some sort of binding emotional reaction to the therapist), and *integration* (meaning increased unity and structure within the mind). He traces a controversy about the role of attachment (introjection) versus understanding (interpretation) in the curative process through the last fifty years, concluding that the debate continues in the works of modern authors such as Kohut and Kernberg.

Leaving theory temporarily, Dr. Friedman begins *Part II, "Practice Observed,"* by looking at the motivation of the therapist. "A therapist can comfortably treat people who do not get well. What he cannot gracefully do is feel like he is not a therapist." Profundities of this sort take some time to sink in.

In addition to acting like a therapist, a second motive is to satisfy *curiosity*. Like so much of this book, the discussion abounds with intriguing observations. For example, in discussing *curious about what?* the author mentions the adage that the psychotherapist asks, "What is the hidden affect?" while the psychoanalyst asks, "What is the hidden fantasy?" He then concludes that the questions are not so different, since affects and fantasies are linked with one another. At bottom, he concludes, the therapist is curious about the state of the patient's mind.

A third motive of the therapist is to elicit something desirable, "... the need to elicit personal interaction must be at the heart of psychotherapy." The author focuses on the inevitability (and legitimacy) of the therapist's wishes, "... therapy is a scene of two people's wishes tangling." Part of his discussion includes the following: "The only two dangers in psychotherapy are that no seduction occurs or that only one sort of seduction happens." These original and sometimes startling aphorisms abound throughout the book.

Later in this section Dr. Friedman discusses how the therapist makes sense of the patient and vice versa. He points out how theory interferes with communication between the patient and therapist. The patient cannot use the therapist's responses to guide the dialogue because the therapist's natural responses are encumbered by his theory. This leads to the idea of focusing on the difficulty the patient has in presenting himself to the analyst.

Friedman concludes that the therapist tries to respond to "natural points of change" in the patient, which requires treating the patient "as though he is what he would almost be." The therapist may be wrong in his ideas, yet the patient genuinely moves because,

> An interpretation is but the tip of an iceberg; underneath the words an attitude spreads out and sets the tone ... Because the therapist governs his speech, he thinks that he governs his message.

In pondering the patient's viewpoint, Friedman points out that what is unique to psychoanalysis is that it attempts to speak to the patient in his own voice. This leads to a problem:

> If the analyst's attitudes shape meaning, how can we say that the patient discovers his own voice? On the other hand, if the analyst does not plant attitudes, how does he keep his words from being twisted by the patient's attitudes?

"The thesis of this book is that theory is not a pasttime but a practical instrument." In part III and IV, Friedman expands this thesis.

> It [theory] colors the therapist's attitudes, and his attitudes determine what happens ... One must expect that the style and excellence of a therapist's theory of the mind will determine what kind of potential freedom he can find in his patient.

In *Part III,* Friedman takes Freud's theory as a paradigm of a theory of the mind. After a scholarly survey of the historical background of psychoanalytic theory, he proposes that "The Freudian revolution was the discovery of psychological entities that could be seen in multiple guises." Friedman points out that there can be no description of conflict within the mind without the danger of anthropomorphism. He notes that currently mental entities are in disfavor and that there is among therapists "a noticeable comfort and feeling of virtue when dealing with process."

Freud's theory requires conflict within a unity. It is both a structural theory of conflict and a process theory. It rests upon the instinct representative — "Neither a formed idea, nor a biological drive, it is that which represents the biological drive to the mind." Friedman concludes that rather than being an embarrassment, this concept teaches us about the mind. "Freud's theory is comprehensive just because it is a mixed theory . . . It is not coherent on a single plane."

In this section, Friedman discusses Ricoeur, Ryle, and Kuhn, among others. He concludes that psychoanalysis regards the mind as an object, with conscious phenomena as its properties, and that, clinically, the patient is helped to adopt this attitude toward his own mind. Psychotherapy is something like a paradigm clash as described by Kuhn. The process of helping the patient shift his paradigm begins with mutual agreement on a problem, even though patient and therapist may describe it differently.

Part IV is entitled, *"Debate About Theory of the Mind: Revisions."* This lengthy section (as well as much of Part III) might be skipped by some readers who have less of an interest in theory, without losing the main thread of Dr. Friedman's argument. There are chapters on Peterfreund, Sandler and Rosenblatt, Schafer, Gendlin, George Klein, Kohut, and two on Piaget. Friedman finds Piaget a useful addition to classical theory, both theoretically and practically (Friedman might not like this distinction).

Friedman concludes Part IV with a discussion of what he feels the revisionists have in common: holism, and an absence of descriptions of "specific potentialities, which is what theory of the mind consists of." He regards a focus on empathy as inducing in the therapist a reassuring feeling of inevitability. He feels the revisionists' writings are, in a strict sense, theoretically deficient, but useful to the field for their aesthetic and inspirational qualities.

In *Part V,* Friedman returns to a ground's eye view of clinical work. " . . . two people alone with nothing to do will exploit each other." Psychotherapy is a struggle. The patient struggles for acceptance by the therapist and change within himself. The therapist cannot help but be misleading to the patient, and must constantly balance ordinary social responsiveness and non-ordinary theoretical awareness.

Friedman believes that this ambiguity is at the heart of the therapist's position. Because therapy is both similar to, and different from, an expectable social relationship, constant uneasiness is produced in both the patient and the therapist. "Because contradictory duties are required of him, the therapist cannot help but err. He has only two choices: how much trouble to invite and from what direction."

Friedman describes three roles that have emerged from the therapist's search for an acceptable position. These are the roles of *reader* (making sense), *historian* (tracing origins), and *operator* (exerting influence). He fruitfully devotes a chapter to each.

In his chapter on the therapist as operator, Friedman focuses first on the reality that (of course) therapists *do something to* patients. The majority of the chapter is devoted to a discussion of what two therapists, Gill and Schafer *do,* with regard to interpreting the transference. His insightful discussion of their disagreements highlights the challenge therapists face in operating (choosing what to focus upon). In my opinion, this discussion alone is worth the price of the book.

In a chapter which serves as a denouement, Friedman states,

> I suggest that, within an ambiguous relationship, reading, understanding and manipulating create a living model or a performed metaphor (or a new map or a novel theory) of the patient as he would be if he were already what he will become through treatment.

He likens the therapist's constructing this model to other creative scientific and cultural endeavors. "Words are used in this process, but the metaphor or model that is built is a prolonged, infinitely detailed experience, as untranscribable as life." The interaction between patient and therapist *is* the metaphor, whose message hopefully will be internalized by the patient as a process.

The first chapter of the final section of the book, *"Implications,"* is titled, "Conclusion: No Resting Place." Here Dr. Friedman emphasizes the discomfort on both sides of the couch. Regarding the patient, "there is no way to stretch someone without stressing him." Regarding the therapist, he

> has to have wishes, and he has to have a view that precludes wishes . . . The therapist has to be manipulative, but not intend to manipulate. He has to try for something and not care about it. He has to engage in mutual seduction and yet forswear it. He has to exploit a patient and be selfless. The therapist is always in a false position . . . If the therapist is not fooling himself, he is not doing his job. And if he continues to fool himself always in the same way, he is not doing his job. There is just nothing a therapist can legitimately do about this problem except work on it through theory and practice, recognizing what he owes to which of his beliefs and where those beliefs fail him.

I cannot imagine an experienced therapist reading this passage without an appreciative, knowing sigh. And for students, who in my opinion must also read this book, it is just as well that they know what they are getting into.

Dr. Friedman presents a strong and original point of view about training.

> Therapy remains a puzzling business, so it is appropriately taught as a research project inquiring into its own nature . . . The bane of training is the unspoken myth that the therapeutic situation is normal . . . The presenting therapist should feel himself talking to a supervisor who takes it for granted that dilemma is the only normal feature of therapy.

Dr. Friedman wants the student to think not only about his patient, but also about the problems that he has with his work. In this way the usefulness of theory will grow naturally out of discussions about the work.

This review does not do justice to the elegance of Dr. Friedman's arguments, nor to his enormous erudition. Many other important authors, such as Hartmann, Gray, Lacan, and Loewald are creatively dealt with. I hope that my liberal use of quotes will pique the reader's interest to see how these have been arrived at and where they lead. On page after page, Dr. Friedman explores important and fascinating pathways through the enchanted forest of good clinical work.

It is rare in our field, with its exponentially increasing number of books and journals, for one new book to be a truly valuable experience for all readers. In my opinion, this is such a book.

Published by The Analytic Press, Hillside, NJ, 1988, 563 pages.

AN OPEN LETTER TO *NEWSWEEK*

by David James Fisher, Ph.D. and Rudolf Ekstein, Ph.D.

The following letter to Newsweek *was written in response to an article published in their "lifestyle" section of September 10, 1990. The Letters Editor ran a truncated version of our letter in the issue of October 8, 1990. In the interests of fairness, we are publishing the full text here.*

We were concerned about the distorted impression left by Nina Darnton's piece "'Beno Brutalheim'?" (Lifestyle, Sept. 10, 1990, pp. 59-60). With Bettelheim dead and unable to respond, it unleashes Bettelheim bashing in a most irresponsible fashion. The article presents a sensationalized and nasty portrait of him as the son of a bitch/genius who violated his clinical ethics by intimidating, devaluing, and physically injuring his hospitalized patients. Darnton alleges that he was sadistic and out of control. All of her documentation is suspect and flagrantly decontextualized; we learn nothing about the individuals being interviewed; more pertinently, we never learn about their reliability. Are isolated memories being blown out of proportion? Do we get fantasies of the doctor by former patients being reported as self-evident facts? Do the critics of Bettelheim have their own agendas? Why didn't they speak out while he was still alive? We question Darnton's professionalism and honesty as a journalist. Her research methods are shabby and unthorough. She did little or no fact checking. For example, she states two completely inaccurate facts about Dr. Rudolf Ekstein. ("Bettelheim's old friend Rudolf Ekstein, a retired California psychoanalyst now in his 70's who knew Bettelheim in Vienna before the war . . ."). Dr. Ekstein is not retired. In point of fact, Dr. Ekstein told Darnton he had to cut short her interview with him in order to see a patient. It is also false that he knew Bettelheim in pre-World War II Vienna; they met in America in the 1950's. This misinformation makes us suspect other inaccuracies in her article.

Severely regressed and disturbed patients in psychiatric settings require firm boundaries and structures, as well as a staff treating them with kindness, tolerance, empathy, patience, and knowledge. These therapists are subjected to an ensemble of anxieties, frustrations, disappointments, and regressive pulls on them in their everyday encounters with such patients. No therapist is a saint. None have attained the perfect self-control and self-discipline to react

without some semblance of emotional turmoil and even an occasional outburst. No clinician can practice his caring and internally consistent clinical philosophy in an absolutely impeccable fashion. At best they are "good enough" — exactly the ideal Bettelheim described in his book on parenting. As an administrator, Bettelheim was working with an extremely taxing patient population, a population of incurables, of individuals who had been given up by other therapists; he also had to contend with a spectrum of emotional responses to these patients on the part of his care-taking staff, who may have felt driven crazy by their patients at certain moments. Bettelheim, in short, had massive responsibilities for both his patients and his staff. That he expressed anger, impatience, frustration, and an authoritarian tone at times is not surprising or out of character. To insinuate that he was a cruel or insensitive bully — a patient abuser — seriously misrepresents the record.

Bettelheim remains the empathic advocate of the helpless child and of the most inaccessible of patients. What strikes us as "abusive" and "brutal" is this form of scandalous and debunking journalism. It could potentially damage the hopes of recovery for the severly disturbed patients currently under treatment in psychiatric hospitals, eroding their trust in their care-takers; and it also shows no grasp of the psychological difficulties and therapeutic aspirations of mental health professionals, many of whom were educated by Bettelheim's sparkling writings and inspired by his tough-minded humanity.

WORK, LOVE, PLAY — SELF REPAIR IN THE PSYCHOANALYTIC DIALOGUE

by Joel Shor, Ph.D.

Review by Rudolf Ekstein, Ph.D.

I am glad that Joel Shor asked me to review his book and to respond to it, not just in terms of improving the marketing, but to live myself into it, as well as recognizing its use and its limits. What did the book do to me? While I love the provocative phrase, it seems to be a dichotomy; the title speaks of self repair in the psychoanalytic dialogue, a therapeutic process between two people. Is the patient repaired by the analyst, or, does he repair himself? Does the analyst merely use the dialogue in order to avoid the task of curing the patient, thus giving him a chance to repair himself? Or, does the patient, during the transference that develops, utilize the relationship to his therapist and thus cure himself?

Freud once spoke about normalcy as the capacity to love and to work. If the patient, a human being, loves the work, he can therefore think of it as play; if he can only work, only love or only play, he is stuck. If he can work the love, play with it, it may be the foreplay, the play or the afterplay, thus making allusions to the erotic undertone of the eternal struggle between patient and analyst, the transference and countertransference battle.

The emphasis that Shor puts to all that gets him to select his wife, Jean Sanville, to write the foreword for his volume. And thus it is really a work of love. It is a work of love in terms of his impatience with himself and to help himself then in this process of self liberation. But it is also one that constantly comes back to the contributions of his teachers, the mentors that he has incorporated into his work, while at the same time he freed himself from them in order to make a contribution of his own.

Thus, as I read his book, I identify with the learning process. Yes, he describes himself as an *analyst becoming*. We speak about a Prometheus becoming, the process of growing, of developing. We also go through the pain of self doubt, of trying to overcome obstacles, of becoming one's self but at the same time being unsure of whether that is possible. Each of us who has seriously gone through the learning process of becoming an analyst knows that struggle, the

self doubt in achieving a professional identity, the constant doubt whether this identity is ever a truly stable one and we ask ourselves for constant clarification of the painful educational process.

I recall a remark of Siegfried Bernfeld who spoke of the analyst as one who never finishes the learning, of always being in a seminar, as a student or as a teacher. And if he is a teacher, he will only be a good teacher if he keeps learning and has no final view.

When Joel Shor prepared his book he must have been thinking of the audience. Who will be his readers? And of course, he hoped, as all of us do who communicate through the printed word, that it will have a large audience. Those who listen to us must be people who understand us. Do we understand them? Can we speak their language, their different psychotherapeutic languages? I speak here about the different theories that have developed since the days of Freud: I think Shor is all of that. After all, he listened to many teachers and he explored diverse ways of thinking and speaking, and of addressing the audience.

When I read his book I see that he has me a little bit in mind too, and wonders what kind of language do I speak. As he discusses, for example, Balint or Reik or Kris, he has to build a bridge for himself and for us between different schools of psychotherapy and psychoanalysis and thus prepares himself for a better and improved psychoanalytic dialogue, both with patients, with colleagues, with students and the educated reader. While he appears to overcome the insistence on mere diagnostic attitudes, he would admit, I'm sure, that he diagnoses the language capacity of the patients, their means of communication, so that not only can he understand them but can also be understood by them.

I might ask then: does the patient repair himself during the psychoanalytic dialogue, or, does the analyst repair his professional self in order to understand his patient, and to build a bridge to repair? Perhaps I would have liked him to add the idea of mutual repair. This repair will never be complete because I think he believes, as do I, that repairing never stops, that the growing never stops, and this book has, therefore, the purpose of not being the final version, the final point of view, but will induce us to move on. It is meant to be an everlasting self repair, an everlasting process, interminable, and thus will remain forever unfinished, to be read again and again. Shor says at the end of this volume:

> Since we are each the ultimate experts for our private experience, with the stimulus of ongoing self analysis, we can wish to share our fresh understandings and discoveries. The dialogues will go on amongst us.

And thus we wait for his next book.

(Double Helix Press, Los Angeles, 1990, 1300 Tigertail Road, Los Angeles, CA 90049).

RESPONSE BY JOEL SHOR, Ph.D.

Dr. Ekstein and I share those dimensions of psychoanalysis which are humanistic, reaching for richer meanings as pathways toward individual and social fulfillment. Yet he does expose a seeming paradox in my emphasis on *self repair.* The solution is facilitated, I believe, by recent infant observations on the subtle, non-verbal stages of self-developing in the context of good enough sensitive and abundant caretakers. The prerepresentational self evolves self representations in dialogue with primary others. Those discoveries, as by Spitz, Winnicott, Brazelton, Stern, Emde, Trevarthen, et al., offer models for refining the analyst-patient interplay. As we improve our negotiations and empathy with the person, we learn to play with equal, mutual respect, and a fuller sense of self emerges, to our individual and conjoint satisfaction. Both parents and therapists harbor anticipations and hopes for a somebody with whom to experience more meaningful dialogues. At my best, this is my prime motivation for practicing psychoanalysis.

Our field is rife with contending schools of theory in these realms, each emphasizing another dimension or potentiality, and each of us finds evidence to support our predilections. Ekstein's longstanding contributions to learning processes, whether in disturbed children, troubled youth, analysts in training, or in supervision, all make for principles of positive growth and creativity. His optative perspective encompasses much from all those diverse schools. He has expanded the idea of open ended evolution and development (from Darwin and Freud) so that the varieties of object relations and self psychology theorists can join their often equivalent terms and complementary discoveries. The adversarial spirit is fun only up to a point. A dialectic spiral or double helix is needed.

When Ferenczi advanced Freud's instinctual dualisms, especially "introjection" and "projection" (1913) to an "oscillation" which permits the dialectic of development (1913, 1926), he freed us to see the inherent dialogue processes within all human relating. His bold experiments with analytic method naturally ran into complications, which made Freud uneasy. Balint rescued psychoanalysis from that painful controversy by renewing our respect for the private self-measuring and deciding by the patient (1932). Such renewal and refinement have also fostered the recent revival of fruitful infant observations.

Balint prompts us to advance our therapeutic relating by a modest, careful oscillating between recognizing wishes for autonomy and for intimacy. This dialectic sensitivity is valuable for both transferences and counter-transferences. His view is an "ethical" position, I feel, and it supports his even bolder ideas about *Thrills and Regressions* (1959). Here he finds a constructive role for illusions of fusion and for benign regressions — which are still generally avoided or disapproved in our profession, except for some few of the British Independents, such as Winnicott and Milner and Bollas.

Yet all of these new theorists have been shy to spell out in systematic detail the concrete clinical revisions of our classical analytic method which may follow the fresh principles of flexible therapeutic dialogue. I have attempted to do this in my book. The search continues, as Ekstein agrees, "Truth is never final." Although each of us will experiment in selected ways, our mutual dialogues with patients and with colleagues permit us to amend our theories as we continue to learn from one another.

YESTERDAY AND TOMORROW: A MODEST PROPOSAL REVISITED

by Martin E. Widzer, M.D.

Yesterday I invented the "round." I have previously used wheels, but I relinquished and then renounced them after I discovered that the relationship between the wheel and the ground is as important for smooth rolling as the roundness of the wheel. Those who insist that roundness is preeminent do not welcome my observations. In fact, they persecute me. In frustration and anger, I swore that I would never use a wheel again — and I haven't!

Since that time, I have meticulously documented the relationship between various shapes of ground and sleds. However, my back hurts from dragging heavy loads and my followers have begun to question whether an alternative method might ease their burden as well. Therefore, I have invented the round, which facilitates the passage of my sleds. A round may look and act like a wheel, but — I assure you — it is not. As we all know, the primary rotation of a wheel at rest is from left to right. A round, however, rotates from right to left.

Sadly, this tale of mine approximates the predicament of various contemporary writers who have issued forth a spate of new terminology after finding themselves constrained to rediscover the tenets of the theory they abandoned. Many have expanded the theory and practice of psychoanalysis and have contributed exciting concepts and new terms to our lexicon. Others, whose ambition leaves them tone-deaf to the lyrical implications of classical theory, have rediscovered and/or renamed the wheel and have further confused and confounded an already cumbersome vocabulary.

Although "nothing new under the sun" is a path to darkness, let us also have the courage to recognize that "plus ca change, plus ca reste la meme chose" is not always axiomatic. As a matter of fact, tomorrow I plan to establish a haven for the concretization of subjective participatory democracy, where my followers will have an unprecedented opportunity for completely unrestricted freedom of association. I think I'll call it an asylum.