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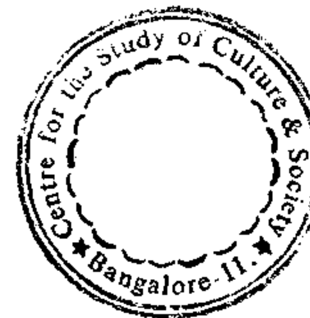

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DEVELOPMENT OF GROUP PSYCHOTHERAPY IN AMERICA, EUROPE AND ASIA

HAROLD KENNETH FINK

As everyone knows, there was a shortage of psychologists and psychiatrists in Armed Forces hospitals during World War II in America and elsewhere. The technic of group psychotherapy was introduced as a method of covering more patients in a shorter time, with a single doctor. The same belief was assumed in England, on the Continent, and in Asia : that group therapy made it possible to help more patients more economically within a given time.

Advantages of Group Therapy

As group therapy technics were expanded and broadened in the 1940s and 1950s, it was soon discovered that group therapy had certain advantages over individual therapy, without necessarily making individual therapy obsolete. Some of these advantages follow :

1. Patients in a group discover they are "not alone" in having serious depression, unrelenting anxiety and fear, embarassing symptoms such as tics, sexual dysfunction, etc. Most homosexuals in the 1940s had not yet dared to "come out of the closet," and some, therefore, misbelieved that there were few others with their problems of relationships.

2. The dynamics of group transference and countertransference are fascinating to the well-trained psychoanalyst or psychotherapist. The doctor is not the sole leader of the group ! *Every patient normally takes some part in "leading"* the group from time to time,

and "working on" other patients who show obvious defenses such as rationalization, obfuscation, etc. It is often easier for patients to take criticism or suggestions *from other patients,* than from the authority figure of the psychotherapist. Thus *patients learn from each other* and are more apt to accept such concepts with less defensiveness and fewer arguments.

3. I use a group psychoanalytic approach, interpreting dreams, transference, Freudian slips, and other unconscious manifestations of the patients. Of course, many group therapists prefer to avoid dealing with such material.

4. *Group sessions are longer than individual sessions.* In America (and in most places elsewhere; e.g., in England), groups are traditionally 90 minutes long. If one's individual sessions are 45 minutes long, this amounts to two combined sessions in length. One-and-a half hours is an advantage for the patients, giving them more time to work through problems and interpersonal dynamics.

5. *Group sessions decrease* the opportunity for patients becoming overly dependent on the therapist. In individual sessions, the patient has exclusive right to the therapist ("Big Daddy," or "Big Momma" in current slang), which he does not have in the group. In the group, the patient has to *share the parental figure* with the other patients, work harder to keep "afloat," to express himself, to defend his often distorted ideas, etc. than in the more tolerant embrace of the individual session.

6. In time, loyalties toward the group develop, and a patient will express the feeling that he hates to miss a session for any reason (e.g., physical sickness), for the group becomes integrated, with each patient loyal to the others, as in a "family." Some patients who meet in a group even start to date each other on the outside, since *loneliness* often is one of their primary problems. Some doctors feel this is inadvisable, since patients may be too neurotic or psychotic to choose partners intelligently in the early phases of the group's development toward health. Actually, very few marriages (in my experience) ever develop from these temporary alliances, but they serve to give the patients experience in dating and relating, and temporary friendship that they so dearly need!

Group Therapy Technics

1. I prefer *heterogeneous groups,* which are the most prevalent type in America and elsewhere. In a hospital setting, one could have a group composed of all schizophrenics, or some other diagnostic category. But I doubt that such homogeneous groups progress as well as heterogeneous groups where patients can learn more from others who are *different* from them. In private practice, where the number of patients in a particular category is more limited, it would be difficult to develop homogeneous groups, even if they were more desirable.

In one of my groups that happened to be composed of heterosexuals, a homosexual was introduced. It took courage for the homosexual male to enter my group, but he had been in individual therapy with me for some time and felt secure enough to dare the risk. As the other patients learned about his lifestyle, they became less afraid of him, and grew in tolerance, till he blended into the group just like the others.

Both sexes in the same group seems more natural and normal to me, and encourages interaction between the sexes, particularly helpful with shy patients, problems such as sexist stereotypic beliefs, equality of opportunity and pay for husbands and wives, marital decisions, budgeting, etc.

2. My groups have always been continuous, open-ended groups, i.e., patients who are satisfied and leave the group are replaced by new members, so that the groups never end, but the patient population keeps changing.

3. As for the question of age of patients, having young people and retired senior citizens in the same group may help bridge the "generation gap," but one needs to be careful in the selection of appropriate patients. Teen age and geriatric patients often prefer their own separate groups, where they can feel more comfortable in discussing their feelings toward the age group at the other end of the scale!

3. Ninety minutes seem to most of us psychotherapists to be an ideal length of time for each group session. Longer than an hour-and-a-half may tire the patients. Shorter than this will leave many unresolved situations and problems. From remarks of the patients themselves, 1.5 hours seems to be ideal for most patients. If reques-

ted by a particular group, there can be a ten-minute break at the midpoint of the sessions for refreshments if served, and for "calls of nature."

4. Most of my groups have met in the evening. The doctor has to sacrifice some evening time so as not to exclude those who work in the day and would otherwise be unable to come regularly each week. One might have a group of housewives in the afternoon, but again the homogeneity limits the amount of learning by the patients of other lifestyles and concerns.

One can have one's groups, of course, meet on a nonworking day such as Saturday or on holidays, but patients need to have some free time to spend with their families in recreational activities, just relaxing in preparation for the next work week, so I try to avoid such times when possible. (Also I too need a rest !)

5. In 1946, the author introduced a new concept into group therapy technics. In the 1940s, most psychotherapists were men so that groups had a male authority figure as "leader," in essence a *father-figure* against whom their transference reactions could be directed and reflected. Why not also a *"mother-figure"* to give a broader scope to the group members' transference reactions ? A woman, working for her doctorate in psychology, served as co-leader of my groups, and became the *"group mother"* (Fink, 1956, 1958). This arrangement worked very well because the father-figure could defend a patient against the mother-figure when it seemed necessary and vice-versa. If the group mother was too critical of a patient's dependency needs, irrational behavior, or defense patterns, the group father could reassure the patient without cutting off insight. By the same token, if the group father seemed too critical of a patient, the group mother could defend him against the leader's authority.

Such an arrangement only works where the man and woman are comfortable working together with roles, and where neither therapist tries to compete with the other. We were both happily surprised at the improvement noticeable in the rate of progress after this technic was begun. Insight and behavioral and personality changes were facilitated by the presence of both "parents" in the group "family." It was easier for the patients to work sometimes with the "mother" and sometimes with the "father." For example, a man who had a bitter relationship with his father in childhood, might prefer to

address the group mother, whereas a girl who could not stand her domineering, hostile mother might naturally prefer to work with the father-figure. This method opened up infinite posibilities in the groups for much deeper dynamics and healthy progress.

Husband and wife cotherapy teams exist today (Hoffman and Hoffman, 1981) as well as teams of clinical psychologist or psychiatrist with a female assistant.

A dictionary of defense mechanisms : Addendum

After the above article was written, it suddenly dawned on me that I had omitted an important unconscious defense, *AMNESIA* ! What better way to avoid facing a serious conflict or threat, an impossible marriage, a serious loss of a lifelong job or of one's material goods than unconscious forgetting !

We'll omit Organic Amnesias, the result of toxic chemicals, a blow on the head or other trauma, or neural degeneration, since the mind, in this type of amnesia, is not trying to protect itself from unnerving facts. *Psychogenic Amnesia,* on the other hand, is a defense, through forgetting, of anxiety-producing, painful experiences. The person, by losing the memory of the incidents, avoids also their consequences. (At least *he* is not aware of the responsibilities involved.) A common example is forgetting a dental appointment or a job interview when the individual finds such confrontations frightening.

In *Anterograde Amnesia,* the forgetting extends forward during the time *after* the initial amnesia attack. In *Retrograde Amnesia,* the memory loss extends *backward* in the time *prior* to the initial attack, as (for instance) after ECT. In recovery, memories *closest* to the onset of amnesia are the *last* to return !

Unbearable anxiety may be neutralized by *Paramnesia* (Confabulation), the memory distortions arranged by the mind to protect the victim from the truth he needs to face. In *Retrospective Falsification,* we unconsciously choose appropriate memories (or falsehoods) to satisfy the needs of the ego, ignoring details inconsistent with one's mental set and determined beliefs. Such defensive distortions protect us from fear and anxiety, where the truth is hard to take.

Thus amnesia, in its various ramifications, is a quick and sudden method of escaping superego pressures, responsibilities and duties

(e.g., a boring job !), and people one does not want to have to associate with.

Like anything else, *amnesia can be faked* when this serves an ulterior motive for the person. In a Florida city, the Police Dept. asked me to hypnotize a man who claimed to have hitched a ride into town, been hit on the head by the driver or someone, and his suitcase stolen. He entered a bar along the road where he found himself walking, called the police, and told them this story, claiming he had amnesia for the details of the assault. Under hypnosis that night, the man revealed a good deal about himself, including the motive for his pretended amnesia : He was a WW2 veteran with a 15% disability, and wanted to raise the disability percentage in order to get a larger monthly check from the government ! (Incidentally, when he came into my office, he chuckled, saying : "If you're going to hypnotize me, you'll fail !" He fought it, but after a half hour during which my verbal suggestions almost put *me* to sleep after a tiring day, he finally went under trance, and we were able to get the information we needed to prove he was a fake, thus saving the government a lot of money from this con artist.)

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(Note : the Hoffman paper above contains a bibliography of other recent co-therapy teams utilized in group therapy.)

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THE PSYCHIATRY OF ADOLESCENCE*

SUNIPA SINHA (ROY)

Adolescence is the period of growth from puberty to maturity and independence. The beginning of adolescence is marked by the appearance of secondary sexual characteristics, usually at about the age of 12 years, and termination is marked by the achievement of sexual maturity at about the age of 20. Since the definitions of economic, political, social and psychological independence differ somewhat, it becomes a matter of choice as to which is preferred when deciding where adolescence stops and adulthood begins. A better way of conceptualising adolescence, is to think of it simply as a stage of life, during which the major experience is one of transition and change. It is during this period that the individual experiences the greatest change in every area of life. It is this dramatic change, that gives adolescent psychiatry its particular characteristics and problems.

It is during this period that the biological, psychological and social changes are experienced. There is a close interrelationship between the various biological changes associated with puberty, particularly, growth spurt and maturation. The hormones from the endocrine glands are responsible for it. The onset of growth spurt, i.e. the accelerated rate of growth begins at 13 years in boys and 10—11 years in girls, and the peak is reached in the 14th year in boys and 11—12 years in girls. There is an increase in the size and weight of the heart and increased ra e of growth of the lungs and

* This paper was presented at the seminar 'On Adolescence', under the auspices of the Indian Psycho-Analytical Society, held on on 15th December, 1984.

sudden decline in the basal metabolic rate, associated with the growth spurt. Sexual maturation and secondary sexual characteristics accompany the growth spurt. Menarche occurs later in the developmental sequence, immediately after the peak velocity of the growth spurt. The adolescent feels different and actually becomes very different, in a very short space of time. The adults rarely appreciate the psychological efforts needed to cope with this process.

Psychological changes experienced are associated with intellectual growth and emotional needs. Intellectual change in the growth of reasoning or formal operation, involves a shift of emphasis in the adolescent's thought from real to possible. The adolescent under goes a lot of stress and strain in order to achieve independence and break off childish ties with the parents. Often he gives up the childish modes of behaviour before he is ready to accept fully the adult world. This sometimes creates a sense of emptiness and loss, which leads to moodiness and depression. Transient feelings of depression and isolated neurotic symptoms occur in about half the normal adolescents. (Henderson et al. 1974 ; Rutter et al 1976). With such emotional changes, the individual is forced to face up to the fundamental questions . For this reason, Erikson (1960) has talked of adolescence as a time of 'identity crisis'.

Social pressures also play a significant part. The expectations of adults, concerning adolescent behaviour is often a powerful force in directing and determining the changes in social behaviour. The individual is often caught between two different standards, i.e. those adopted by his peers and parents. Friends may expect the adolescent to stay out late and wear certain dress, while parents expect something very different. Consequently, the youngster is frequently faced with gross discrepancies between the internal world and external world's attitude towards him, which again exacerbates his identity confusion.

Incidence of Psychiatric disorder in Adolescents

In attempting to estimate the incidence of psychiatric disorder in adolescent population—there is difficulty in differentiating healthy from unhealthy disturbances. No full scale epidemological survey of the adolescent population has yet been reported, so reported

figures are marked underestimates. Masterson (1967) compared a large group of psychiatrically referred adolescents with a matched control group. His findings suggest that psychiatric referrals appeared to be a reasonably reliable index of adolescent morbidity and adolescent turmoil merely exacerbates and gives a characteristic flavour to pre-existing and continuing psychiatric disorder.

Henderson et al (1967) investigated all adolescents who were referred to for psychiatric opinion in Edinburgh 1964—65 (excluding mental retardation), and found the annual referred rate to be 5.6 per 1000 at risk and 6 of the sample of 230 teenagers were referred from courts. Half the examples were referred by general practitioners ; the 30% who were referred following attempts at self-poisoning, came from the lower social class. Kidd & Dixon (1968), conducted a similar study in Aberdeen in the same year and found the annual referred rate to be 6.6/1000. Their results suggest that the period of adolescence was much less emotionally turmultous than what was previously thought. Only a small minority of youngsters demonstrated definite psychiatric symptoms. Majority showed symptoms of internal unrest and anxiety.

Factors predisposing to breakdown at adolescence

1. *Previous adjustment*—The adequancy or otherwise of previous adjustment. 30% of the consecutive sample of disturbed adolescents seen by Evans (1965) had previous referrals to child guidance.

2. *Separation experience*—Adolescents who have been separated from parents in the early years are vulnerable and the children are likely to display later character traits of over-dependency and complain of depression or antisocial aggression.

3. *Chronic illness, physical disability or abnormality*—A child who is in any way disabled or abnormal is at risk of psychiatric complications at adolescence. Chronic illness in other family members, produces its own problems in the family's adaptation to adolescence e.g.. the wife of a disabled man may resist the developing independence of her son or daughter on whom she had depended financially.

4. *Minimal cerebral dysfunction*—Some adoloscents, who whatever reason (head injury, encephalitis, prenatal factors etc) have some impairment of cerebral functioning, these young people have

special difficulties in mastering adolescence. Graham & Rutter (1968) attempted a controlled study with behaviour disordered school children and found a history suggestive of organic brain dysfunction to be 5 times as common as in general school child population.

5. *Parental age*—Older parents have more difficulty in adapting to their child's adolescence than younger ones.

6. *Family disharmony or deviance*—Adolescents from families with deviated cultural norms are more vulnerable than the general population. Gregory (1965) has shown that adolescent children of one-parent families are specially vulnerable to delinquency and academic failure in absence of parents of the same sex. The families of disturbed adolescents almost invariably exhibit evidence of disturbances themselves.

7. *Maternal attitude to pregnancy*—Unwanted children show significantly high incidence of delinquency, school failure and psychiatric ill health, than a group of wanted children. Forssman and Thuwe (1966).

8. *Social Class*—There is no known social class in incidence of adolescent disturbances, but social class appears to influence the route by which the adolescent reaches the psychiatrist.

Disturbances & alienation in adolescence

This can be viewed in 2 different ways :—

I. Transient symptoms II. Persisting symptoms.

I. *Transient Symptoms*—Many clinicians view adolescence as producing a disequilibrium for both the child & his family, and thus accompanied by several parent-child problems. Freud (1958) said that "there are few situations in life, which are more difficult to cope with than an adolescent son or daughter during the attempts to liberate themselves." Offer (1969) in Chicago and Rutter et al (1976) in a comprehensive study of 14 year olds on the Isle of Wight, fourd minor conflicts with parents common, whereas severe difficulties were absent.

The particular contribution of adolescence is the colouring it gives to any symptom and special problems it introduces in the treatment situation.

II. Persistent Symptoms—Such symptoms which produce definite psychiatric disorder with some social handicap are less common than transient symptoms. Henderson et al (1971) studied adolescents in both rural & urban community in Victoria, Australia & found approximately 15% showed psychiatric disorders. In Isle of Wight 14 year olds, 21% showed psychiatriac disorder.

Classification of specific syndromes

The American Psychiatric Association (1968) describes, "Adjustment Reaction of Adolescence as a transient situational disorder, & includes severe adolescence turmoil, that is involved in the emotional vicissitudes of dealing with tensions of adolescence. This is characterised by irritability, depression, temper & consequent school failures which may reach psychotic proportions, hypomania, drug abuse & stealing.

Although adolescence clearly affects the manifestation and content of the symptoms of any disorder, there is no justification for using any specific adolescence diagnosis.

A modified version of the system suggested by the group for the Advadcement of Psychiatry 1966—lists the following diagnostic categories.

Healthy Reactions

Transient reactions of adolescents to stress which are either intra-psychic & developmental or exogenous. In making this diagnosis, the psychiatrist should make a careful evaluation of the precise maturational stresses with which the adolescent is struggling and relate this to his evaluation of the mental state. The most significant indicator of serious adolescent disturbance is his level of day to day functioning, his relationship with the family & peer group and attitude towards his developing a degree of interest in opposite sex, his school or work performance. If he is functioning reasonably satisfactorily in most of the areas—essentially healthy maturational reaction can be diagnosed with confidence.

Developmental deviation

A deviation in time of maturational pattern i.e. precocity, delay or fixation at an early stage or in specific areas of development, i.e.

motor, sensory, speech, cognitive, social, sexual or integrative. Mental subnormality may be seen in specific maturational delay. Both an enuretic adolescent and a late adolescent with no drive to become independent may be classified at this group – exhibiting maturational delay in social and sexual areas of development.

Conduct disorder

The concept of conduct disorder depends on a persisting picture of antisocial symptoms occuring in many spheres of the child's life, usually accompanied by abnormal interpersonal relationships. This is commonly seen in boys, particularly in families characterised by disruption and parental disharmony. In girls, high rate of extra-marital pregnancy associated with difficulties are in late adolescence. It seen is not just an adolescent rebellion against authority.

Neurotic disorder

Generalised anxiety, phobia, and depression may be found. In older group, the picture is similar to that seen in adults. The individual ruminates on the difficulties with his parents and teachers and lack of understanding shown to him. Sexual and bodily pre-occupations occur. He fails to see any role in adult life for himself and becomes filled with despair about the future. A presenting symptom may be school refusal, which may become particularly intractable and treatment should be started early.

Suicide

Increase in depressive conditions is paralleled by a rise in the rate of suicide. Approximately 7–10% of the referrals to child psychiatrists were for threatened or attempted suicide.

Bereavement

It may be important for the suicide in the age group 10–19 years, and is significantly associated with parental death.

Anorexia Nervosa

Although far more frequently found in females, in 5–10% cases the condition is seen in males.

Psychotic disorders

The incidence of schizophrenia seems to rise but the peak rates are not reached till 20 years. Manic-depressive psychosis may occasionally be seen in older adolecents.

Psychosomatic disorder

Obesity can be a major concern in this age group, for both male and female. 20–30% have been described as overweight, but there is little difference in treatment from adults.

Drug abuse and Alcoholism

Experimentation with various drugs is widely practised among adolescents. The experimentation may be serious, when it indicates that the individual's involvement in education or work is deteriorating, or he begins to withdraw from former social contacts and mixes only with other experimenters. Clinical assessments showed that most of these adolescents have personality disorders or had started taking drugs during identity crises but could not get out of it because of physical addiction. Treatment is very difficult, because the majority do not wish for help.

Sexual difficulties

Sexual difficulties concerning masturbation, heterosexual and homosexual relationships are frequent in neurotic adolescents.

Adolescent disturbances can only be assessed within the total context of the life situation, no single symptom or syndrome should be regarded in isolation as indicative of serious disturbances.

The psychiatrist is faced with difficulty in diagnosing and treating the adolescents, because of the intra-psychic fluidity and impulsive tendency of the adolescent to act on his feelings, and in honestly reporting his problems to an adult.

Most of the adolescents are referred to treatment by their parents or other adults, against their conscious desire.

Drug treatment in adolescents is similar to that for adults. In considering the use of antidepresant drugs, it should be remembered that adolescents are struggling to become independent and to make them dependent on drugs is age–inappropriate.

They cannot be relied upon to take their medication regularly

because of an antipathy towards authority figures. Also they are emotionally labile and so it is difficult to assess appropriate medication.

Summary

Although adolescence is a period of marked change together with considerable stress—most adolescents and their families are able to cope with this. The psychiatric symptoms shown by adolescents should be regarded and treated in the same way as adults or children. It is erroneous to assume that the illness or disorder will terminate with the end of adolescence. There is no need for specific diagnostic system for adolescent psychiatry. The rate of disorder is higher than in adults, but very few adolescents go for treatment.

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ANALYSIS OF A FOLK VERSE

R. C. DAS

Background of the Verse

It is a long tradition of Bengal—nobody knows when this tradition began—that the children are told before they go to bed wonderful stories by their grandmas and aunties whose unwritten duty it is to lull the children of the family to sleep at fixed hours of the night. The stories, of course, are so fascinating – they are about ghosts and demons, kings and queens, princes and princesses, magicians and witches, strange animals like the winged horse and the thousand-headed monster, and about horrible fights and hair-breadth escapes—all brought to life in the dark of the night by the unparalleled narration of the story-teller that they get into the life-blood of the young listeners and thereby enrich their imagination, enkindle their creativity, and embolden them to face and conquer the adversity of reality as they grow up.

It is true that modernisation of the families with the spread of education, industry, and recreational technology has some freezing effect on the stories being told and listened to in the above fashion, but the extent of such effect is still very limited and confined to only a small number of families mainly in urban Bengal. This trend, however, may gradually gather momentum and a day, which appears to be far off though, may come when these stories will be lost from the popular memory for ever.

Virtually, there is no limit to the number of such stories or folk tales in Bengal. Only a few have so far been recorded in books like Folk Tales of Bengal by Day (1931) and Thakumar Jhuli, i.e. Granny's

Sac by Mitra Mazumder (1967). Many more are yet to be collected and recorded. As a safeguard of these invaluable literary treasures it is necessary to preserve them in print. However, one encouraging point is that the human mind has a natural craze for stories. Still another is that the process of weaving out folk tales, though very slow, is a continuous one, giving rise to newer and still newer stories having their main sping in the group mind of the community. Thus it seems folk tales will ever continue to grow and develop in spite of modernisation of our social life.

The Verse

A striking feature of the folk tales of Bengal, as pointed out by Day (1931), is that all of them end with a common verse which runs as follows :

"Thus my story endeth,
The Natiya-thorn withereth.
"Why, O Natiya-thorn, dost wither ?"
"Why does thy cow on me browse ?"
"Why, O cow, dost thou browse ?"
"Why does thy neat-herd not tend me ?"
"Why, O neat-herd, dost not tend the cow ?"
"Why does thy daughter-in-law not give me rice ?"
"Why, O daughter-in-law, dost not give rice ?"
"Why does my child cry ?"
"Why, O child, dost thou cry ?"
"Why does the ant bite me ?"
"Why, O ant, dost thou bite ?"

Koot ! Koot ! Koot !"

ANALYSIS OF THE VERSE

Day (1931) observes, "What these lines mean, why they are repeated at the end of every story, and what the connection is of the several parts to one another, I do not know. Perhaps the whole is a string of nonsense purposely put together to amuse little children." But is it really so ?

(a) **Agricultural Implications**

Folk tales seem to have their origin, at least in their elaborate forms, when agriculture relieved the wandering man of his anxiety for food and gave him a sedentary life. Therefore, everything—art, literature, festivals, and all else—centered round agriculture in those days. This is clearly true of Bengal (now divided into West Bengal of India, and Bangladesh) where majority of the peoples are still engaged in and dependent on agriculture. Viewed from this perspective, the verse in question, which has apparently no meaning, at once turns into a meaningful counsel of obvious agricultural significance.

The counsel is : If none else takes care of the child it will be bitten by insects and begin to cry. In that case, its mother, the housewife, will have no other alternative than to attend the child neglecting the work of cooking rice and serving it to the neat-herd of the family. As a result, the hungry neat-herd will not tend the family cow (cattle). The cow (cattle), thus unrestrained, will enter the corn field (Natiya-thorn, which is used as an item of food in Bengal, symbolises the corn in the field) in the neighbourhood and destroy the crop to utter misery of the cultivator.

The verse indicates that agriculture is a social and collective enterprise. If one in the chain is negligent of one's share of responsibility that will enormously affect the harvest and bring disaster to the farmer's family. Cooperation was considered at one time so important in agriculture that even the children had to be repeatedly told about it with the expectation that this would dissuade them from disturbing their mothers in cooking rice for the neat-herd of the family by taking to crying or such other devices. This seems to be the purpose behind the origin of the verse and its repetition at the end of each folk tale narrated to children. The practice persists although the context has changed, as is the case also with many of the mores and rituals of different parts of the world. In the words of Rivers (Allchin, 1963) : "...the ritual has persisted while the beliefs at the bottom of the ritual have largely disappeared."

(b) **Psychoanalytical Implications**

Where repression is strong, the repressed desires often manifest themselves through symbols. As Freud (1933) observes, " . . . . these

symbolic relations are not peculiar to the dreamer or to the dream-work by which they are expressed ; for we have discovered that the same symbolism is employed in myths and fairy tales, in popular sayings and songs, in colloquial speech and poetic phantasy."

It seems a psychoanalytical interpretation of the present verse in terms of symbols—universal and local symbols of different orders which it contains—will unearth some universal repressed wishes of the child and of mankind in general.

The symbols used in the verse are : *Ant* (an insect or a little animal) symbolises siblings ; *Cow* symbolises grandmother (Hindus —men and women, young and old, children and parents all treat the cow as the Great Mother or Mother Bhagawati, because she provides everyone with milk which is considered to be the best form of food) ; *Neat-herd* symbolises the father whose duty it is to take care of his old mother who not only lives in the family but also enjoys supreme power in the household affairs. It is likely that the Bengalee society was matriarchal in those days, but even in the present patriarchal Bengalee society the grandmother has a ruling role in many cases ; *Serving rice (food) to the neat-herd by the daughter-in-law* stands for satisfying the *sex hunger* of the father by the mother ; *Browsing on Natiya-thorn*, i.e., pulling off the tips of this bushy shrub (having a clear reference to genitalia) symbolises onanism or coitus interruptus which prevents the possibility of conception of the mother, besides separation between the two parents. Prevention of birth of siblings symbolises death of the existing sibs. Sexual death of the father symbolises his actual death.

Interpreted in terms of the above symbols the verse means that the child, constantly suffering from *sibling jealousy* and *Oedipus complex* (koot : koot : koot :, i.e. constant ant bite indicates continuous suffering of the child), goes on crying to snatch away his mother from his father and siblings by *forcing her to pay all her attention to* him and wishes that his grandmother, the real tough mistress of the house, will not tolerate the indifference of his father (irritated on account of sex deprivation caused by the child's constant interruption) towards her and, as a punishment, she will permanently separate him from his wife and thus bring about his death (*it may be noted here* that denial of food (rice) for a number of days will surely cause death to the neat-herd, the father symbol). The child wishes that his

brothers and sisters will also die and, in that case, he will have absolute possession of his mother which he desires so intensely.

The child in the present verse represents the child in all men. Thus the verse indicates that Oedipus complex and sibling jealousy are age-old psychological problems which haunt the human mind for indirect satisfaction of the underlying unconscious wishes.

Concluding Remarks

In the present verse we see libidinal wishes have expressed themselves in the guise of agricultural symbols. The land which produces crops is naturally imagined as a woman. In West Bengal the farmer, as reported by the present author (Das, 1975), would not till his land on the last day of the first week of the rainy season which he thinks to be the day of menstruation of Mother Earth. Das (1966), who based his observations on materials he gathered from Golden Bough, Themis, Encyclopaedia of Religion and Ethics, and Rik Veda, reports that the primitive man, to whom the earth was a woman, believed that performance of sexual acts and utterance of slang words in the field would warm up the earth and increase her fertility. He also reports that the Greek words *Garia* and *Demeter* were names of the Mother Earth whom the Romans called *Terra Mater*. In the Rik Veda the earth has been addressed as Mother. The things and activities of agriculture seem to be apt symbols of sexual reproduction and libidinal wishes.

Summary

Rev. L. B. Day thought the lines in the verse to be nothing but a string of nonsense purposely put together to amuse little children, but our analysis reveals that it is a meaningful coherent composition with two-level significance. On the surface, it turns out to be an agricultural verse stressing on comprehensive cooperation of all concerned, including the children of the family. At depth, it transpires to be a manifestation of sibling jealousy and Oedipus complex through agricultural symbols. Agriculture being a reproductive process readily serves as a vehicle for expression of libidinal wishes. In this verse cow stands for grandmother, neat-herd for father, serving rice to the neat-herd by the daughter-in-law for satisfying father's sex hunger by mother, and browsing for sexual separation

between the parents as also the consequent prevention of conception by the mother, thereby implying death of both father and sibs. The child wishes that his grandmother permanently separates his parents whom he only temporarily disunites by constant crying. He wishes both his father and siblings will die as a result and, in that case, his mother will bestow all her love, attention, and company on him, and him alone. The child of the verse, in fact, represents the child in every man.

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