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PSYCHOANALYSIS AND RELIGION : BEDMATES OR ALIENS ?

HAROLD KENNETH FINK

Freud, himself, felt that religion was the "opiate of the people, "but later in life began to admit its importance in the treatment of neurosis ··· as did his rebel student, Jung, who made religion a seminal part of his analytic approach. Many analysts in the early half of this century felt that religion had no business in traditional psychoanalysis, and carefully avoided any mention of their own beliefs to their patients. I have always held the belief that no analyst can be completely neutral on any subject, and he will reveal himself through body language (facial expressions, etc.) if not by words, in terms of his reactions to his patients' views on religion, politics, or any other topic. I further believe that a doctor *should* develop some philosophy of life and a belief in ethical and moral values, so that he can be a model for his patients. If the doctor is having an affair and cheating on his wife, how can the same behavior in himself or herself is wrong? If the doctor does not have exemplary character, at least he should try to keep his personal life out of discussions, though some of you will consider this hypocritical ··· which it certainly is !

There has been much infighting between the analysts who consider that they should not reveal any of their own opinions on anything and those that consider it more honest and constructive for the patient to share some ideas about everyday topics important in the doctor's life that might help the patient develop his own viewpoints and philosophy in a healtheir vein.

Because the analyst is a deist, however, does not mean he should criticise the patient's atheistic or agnostic orientation. The patient has a right to his own beliefs, and the analyst should not foist his own upon the patient. On the other hand, to pretend to be agnostic when he isn't, in order to present a "neutral" stance, only confuses the patient who finds it hard to identify with the analyst in the positive transference if the doctor seems to be a whimp about his own beliefs ! (Fink, 1986).

Whether the patient is a Buddhist, Christian, Moslem, Hindu, or other religious persuasion, this affiliation should be respected. Again, the analyst does not of course try to change his patient's religious identification, or criticise it in any way. That would be outside the proper boundaries of good therapeutic techiquc.

"It is not the role of the therapist to evengelize or proselytize for his own particular religion. It is his job to help the patient to become his own particular religion. It is his job to help the patient to become his own true self, to overcome the obstacles which prevent him from growing naturally to his full emotional and spiritual stature. The specifics of religious belief and practice ··· will be dealt with (in treatment), not as doctrines but as positive or negative factors in this particular patient's emotional makeup. On the basis of (his) insights ··· the patient will reaffirm, revise, or discard his previous religious belief(s) on the basis of his new understanding and conviction, not on the basis of the therapist's say-so" (Fink, 1957, p. 95).

There are some doctors who claim that their patients *never* know the doctors' true feelings about anything since they hide them so well. This is questionable since the patient, intelligent enough to seek help, is probably intelligent enough to ascertain the doctor's outlook on many of the subjects they discuss.

The therapist's religious faith "plays an important role in psychotherapy, even if it is never defined as such. The total moral attitude of the therapist forms a basis for the close relationship between himself and the patient. It helps to determine his feelings about the worth and the potential of the (patient) ··· It is a factor in determining the analyst's goals for the patient" (Fink, 1957, p. 95).

The analyst's ability depends on *training, experience, and character.* In psychoanalysis and psychotherapy, "direct discussion of

the moral and religious is still infrequently emphasized, and it certainly does not occur in a routine or ritualistic way that can be easily taught to a beginning psychotherapist ··· In other cultures, such as India..., it is openly acknowledged that the *Pir* or *Baba* heals with the use of 'soul force' (Grusky, 1987, p. 4). "(O)ne of the patients of the *Baba* (Kakar, 1982, p. 39, in Grusky, 1987, p. 4), an Indian man who trained as a psychoanalyst and consulted healers from both cultures ... (stated :) 'It is the Vishwas (soul force) a healer inspires that is crucial.' Yet in much of the Western world there is almost a contempt for any effort to explain healing outside the language of empiricism ··· On the other end of the continuum, the freakish esoteric religious cults that have flourished in recent decades are an equally disturbing indication of this dichotomy."

Also helpful in developing spritual insight (besides, of course, church and temple attendance) is Grusky points out, the *training analysis.* Theodore Reik (1948, in Grusky, 1987, p. 5) felt that "every analyst who had been deeply analyzed realized that there was no basic psychological difference between analyst and patients. "*Both have to work out their life problems* ! Only by having gone through the same experience (i.e., a didactic analysis) can the doctor truly empathize with, and understand, his patients !

Development of Religious Relief

Religious faith is normally developed in childhood, depending on several influences : Do the parents encourage the child to attend Sabbath School ? Do the parents themselves have a strong religious faith and attend church at least periodically ? A child who grows up in an atheistic or agnostic home has a difficult time getting interested in what the church or synagogue have to offer.

Conversion can be healthy or sick, depending on the motivation. If belief is sought just to get rid of rational) guilt, the conversion is only a crutch to show off to the world, that the individual can brag about, but is fairly empty and meaningless to the individual !

If a woman's experiences with her own father have been negative, particularly if there has been physical or sexual abuse in childhood, it is all the more difficult to develop a positive transference on her husband (Fink, 1986). Her husband becomes "the enemy." He does what he wants (including even adultery at times), despite his

wife's suffering, like a Florida churchman who resigned from his church "because of ill health." but actually at the request of the church deacons because he refused to stop an affair with his nubile blond secretary while his wife was dying of cancer ! Such a selfish husband may lord it over his wife, claiming the fundamentalist doctrine of the husband being the absolute ruler of the family. no matter how exploitive his behavior. He does not listen to her ideas, opinions, or suggestions, because she is "only a woman," outside the charch hierarchy !

Analysts' attitudes toward patients' religious beliefs

It is tempting for the analyst to question the rationale of certain religious beliefs of his patients'. The doctor has a right to express an opinion about some belief, but never to put down the patient for believing it ! Some Christians (even some priests), for example, question the truth of the Virgin Birth of Jesus. Nonfundamentalist Christians do not take every word of the Bible literally, recalling that it was written by many different people at many different times, often decades after a particular event, always subject to error and copied by monks who often added concepts not in the original wording. Nor do all Buddhists, Shintoists, Taoists, etc' take their written word completely literally. Sometimes myth or allegory can teach an important lesson. Jesus taught in parables that were not supposed to be true accounts but stories to clarify a point. In sum, the therapist has to be careful not to step on the toes of his patients in relation to their deeply-held beliefs.

On the other hand, there are times when the analyst can help a patient, too committed to fear of the Devil and Hellfire, where his underlying, exaggerated guilt about some past error in behavior is both unrealistic and unhealthy (Fink, 1963). I don't approve of organized religions mis-using fear as a means of getting people to conform to certain life styles or behavior. AIDS is NOT a "punishment" from God for the lifestyle of homosexuals, although some religious leaders have promoted this idea recently in the United States. How do they explain the fact that hetero-sexuals also can get AIDS from blood transfusions, etc. ? One could rationalize—as they actually did centuries ago—that syphilis and gonorrhea are God's penalty for the "sin of intercourse," although, till the advent

of artificial insemination and surrogate mothers, there has been no other method for a couple to bear children.

God does not sit in judgement, deciding which individuals will die in plane or car crashes, or from other causes, because of their "sins. Sometimes it seems as if the most decent and honorable people we know die prematurely through circumstances out of their control. Let's not blame God for this—but circumstances. (There is no room here to deal adequately with another view, the Buddhist belief in Karma that every action has a reaction, appropriate to its nature. According to the Karma concept, every good deed of man or woman is rewarded by good fortune of some kind, if not in this lifetime, in the next. By the same token, every evil action we suffer or cause to happen will be neutralized by something that happened earlier in life or in a previous lifetime or will happen in the future.)

The main point is to *distinguish for our patients between rational and irrational guilt.* The drunk who insists on driving home from a party and runs over a child on the highway *should* feel guilty because he has done something teribly irresponsible, and he should feel *guilt.* For him to say : "I couldn't help it because I was drunk" is plain stupid. His error was driving at all in such a state when others at the party probably offered to take him home. But, on the other hand, a man I knew in California drove home one night in a "Pea soup" fog, carefully creeping along at less than ten miles an hour, and suddenly hit and killed a dog in the middle of the road, mesmerized by the car lights. He had no justifiable reason for punishing himself since the accident could not be avoided - unless he had not driven home at all that night. This type of guilt I call *irrational gilt* - something the analyst needs to work with, to protect his patients from obsessive self-recrimination (Fink, 1963).

Status of Women in the Church

A New York City rabbi informed me that the men in his synagogue sat in front on rich, red-leather seats, while their wives and children had to sit in isolation in back on hard wooden benches. He saw nothing unjust in this - It was the (religious) law !

Some women, trained as pastors, priests, or rabbis, cannot get jobs because of their sex, even though "at least 60% of most Christian and Jewish congregations are female" (Research Unit of the

Support Agency, United Presbyterian Charch, USA, 1982, in Rayburn, 1985, p. 803). Religious women have often sensed a coldness from analysts. Religious students need supportive therapy because they are more anxious than other students and "see themselves as less adequate and—(with) lower self-esteem—and more dependent and defensive (particularly among the females-HKF) ; complaining more often of tension ; less self-actualizing ; and less self-accepting" (Dittes, 1969 ; Lea, 1982 ; Dreger, 1952 ; Dreger. 1952 ; Rokeach, 1960 ; Graff & Ladd, 1971 ; Hyelle, 1975 ; Maslow, 1962 ! as quoted by Rayburn, 1985, p. 804)-

According to the fundamentalist teachings of the Baptists and Mormons, women are told they are inferior to men. Baptist and other church women are more apt to go to their ministers than to professional counselors outside the church, whom they may distrust. They tend to be defensive and perfectionistic. Many therapists have difficulty dealing with biblical and other religious concepts, partly through ignorance and partly from fear of seeming overcritical. The fundamentalist view puts women on an unsteady pedestal ; "(W)omen are to be passive, obedient, submissive, and meek" (Rayburn, 1985, p. 804). The Virgin Mary model for Catholic women is presented as weak, dependent, passive, and playing a secondary role to men. There is understandably much irrational suffering still prevalent, despite some progress with these attitude problems, in religious women (Fink, 1964).

Pastoral Wives

Ideally, marriage should be an egalitarian' creative partnership, with each member of the "corporation" having equal voting rights (Fink, 1962). Religious women, such as nuns, the wives of rabbis and ministers, etc. 'may think they are betraying God, their religious leaders—by seeking psychological help. They label having difficulties as punishment for some sin and they may thus experience guilt in dealing with their problems (Rayburn, 1985, p. 803). The analyst has to help such persons get over their irrational guilt and face the reality of their frustration experiences.

Women hesitate to challenge the values of organized religions. Black churchwomen particularly are self-depreciating. Wives of pastors and rabbis feel that they are always being observed at parties

or other social functions—and ineeed they are ! Do they drink, and if so how much ? If too friendly, they are labeled 'flirtatioas." They work hard, perhaps leading the choir or playing the organ for it, or teaching Sunday School, but with little recognition for these "free" services. Understandably, divorce is slowly increasing among the clergy. Of the ministers' wives I've counselled, all presented a feeling of *hopelessness* (one of the main signs of depression), of being *downtrodden, exploit d. unappreciated, and unloved.*

However, the rejection of religious faith that some church women develop is "usually not the (end) result of thinking through, but an emotional reaction against the parents. By maintaining that religious faith is unimportant, such persons forestall the necessity of facing the reality of their own inner (spiritual) poverty" (Fink, 1956, p, 236).

If the husband is judgmental. he only increases his wife's guilt. Most individuals "who come for counselling already have a deep sense of guilt which may become unbearable if the minister (or husband !) moralizes and condemns" (Fink, 1956, Ibid).

What is reprehensible is when TV or church evangelists try to make *irrational* guilt into *rational guilt* ! The religious woman, of course, being around the church so much, perhaps even married to a church leader, is more apt to experience irrational guilt and label it rational. *Helping her make the distinction between these two types of guilt, can free her from a torturing mental load* !

Religious wives are like other wives, only more so. Living in a "fish bowl" environment with so many church members watching her every move and listening to her every spoken word creates more tension than the average wife endures. It's no wonder that such wives may sometimes prefer to go to a psychologist than to a minister for help, for the latter may defend the husband's role and spout moralistic phrases about her having to act as the "good, obedient wife," no matter what happens to her.

Minister's wives may not even be invited to church functions. It is difficult for the analyst to train these ignored and forgotten women to express their angry feelings, and become more assertive concerning their rights. They may have been brought up to be so pollyannish that they believe such emotional expression is "not nice for a woman" or even "sinful."

Analysts heed to help these women to express and assert themselves. Nuns fare no better than ministers' or rabbis' wives. Nuns are usually not permitted to help in making church decisions, although they recently (in America) are defying the rigidity and obsolescence of the present pope in connection with his stand on such subjects as birth control and abortion.

Religious women need to be "encouraged to take control of their lives and to name and define their own traditions, structures, and reality. (They)—benefit from therapy with an egalitarian therapist who is willing to listen, to aid selfhood, and who is comfortable assuming a non-authoritarian role. Too often — *such women have remained in a suffocating child relationship with the critical parent' of the patriarchal religious establishment* (Italics added) (Rayburn, 1985, pp. 810-811).

One minister's wife told me, a little apologetically, that she watched soap operas on TV in day while her husband was away. This occupation served as an escape and a substitute for the excitement missing in her own life. I asked her if her husband felt guilty when he held hands with female parishioners, as he listened to their problems. She doubted that it had occurred to him. When the minister's daily encounters afford temptation that leads to impulsive affairs adultery breaks down the fiber and trust of the marriage and usually eventually becomes known to the congregation. But watching love affairs on TV soaps does not result in adultery unless the wife is already primed and desperate, and planning for it ! Most men and women indulge in *vicarious* pleasures and daydreams, such as through watching exciting movies or football games, or reading adventure books. We may not get enough stimulation from real life, so it's natural to enjoy vicarious stimulation to enrich our often boring existence, and serve as a safety value to prevent us from going out and getting into trouble.

The analyst's compassion and understanding can do much to reassure and comfort the pastoral wife. This may not improve her marriage, but helps her to endure it. Sometimes she is able to lure her husband to come with her to the doctor for at least one session. Since husbands feel threatened by being asked to see a therapist, I always suggest the following : "Tell your husband I need him to come in and explain *your* problems and give me ideas on *how to deal with you.*" In other words, he is asked to come in to advise the analyst about his wife's condition. In this way he saves face and his pride is preserved, for he is coming to help *her*, not *himself* ! But once in session, questions can be asked to get him to talk about *his* role in his wife's unhappy state. If he is not too resistant, he may even gain some insight into his own responsibility for her welfare and happiness.

In another case, the minister's wife would come alone at night, while her husband made housecalls to the ladies of his congretion who would unburden their problems to him. But when his wife would ask for personal help with some promblem such as the discipline of their child, he would become enraged, rebuff and ignore her, not wanting to be bothered with such time-consuming counselling with someone who did not contribute to the church (his pockets) as much as the lonely church ladies.

Another minister's wife broke down in her first session in my office and sobbed uncontrollably for several minutes, the first time she had allowed the release of her feelings. (If she had done this with her husband, he surely would have ridiculed her, telling her how weak and babyish she was !) Incidently, the minister in the previous paragraph used for divorce and married his young blond secretary who in session had sworn to me that there was "absolutely nothing between them !" What is ironic is that his first wife is a bright, college-trained woman who lifted him up from a mediocre manual job into the ministry. While he attended the seminar, she worked to support him, a story often heard by analysts. Adultery was the thanks she got for her sacrifices for him, since he did not appreciate her but preferred the dazzle of a beautiful, younger high school graduate.

Admittedly, it is a vocational hazard that the minister's wife has to face : She *will* be alone a lot, but she can get involved in church activities so that she does not feel left out of the church doings. In the case just reported, when the minister was home, he rejected his wife, not giving her the TLC she needed and then deserted her. If he had shown her a modicum of attention and affection, she might have willingly put up with the lonely mights. The minister was a hypocrite. One example will suffice : I had discussed with him

in one of our sessions the *importance of communication in keeping a marriage alive.* He took our discussion and fashioned a sermon around it. After discussing the importance of communication, when the sermon was over, his wife ran up to him : "Let's communicate !" He insisted that he had no time to do so ! He was a minister *unable to practice what he preached* !

The Superego and Scrupulosity

The relation of man to God can be a difficult and confusing one. *God can be pictured as a loving, understanding father,* or as a tyrannical Superego figure, where the minister's wife develops irrational guilt when she questions her husband's behavior and fights him about his chosen lifestyle. One male patient stated : "The church is like father. I'm too dependent on it, so I want to break away. I don't want to lean on God to solve my problems . . . . I'm tired of taking orders and I don't want anyone over my head. I don't want God's guidance, because it represents dictatorial authority" (Fink, 1954 ; Fink, 1957, p. 91 ; Fink, 1961). Substitute for the word "God" the word "husband" and you have the feelings of many church women !

Freud's Superego is the "higher, moral, spritual side of human nature," fighting to keep the instinctual drives (Id) in check. Freud believed that "Religion, morality, and a social sense were originally one and the same thing" (Gibson, 1984, p. 8).

The Catholics have an appropriate word for a person who is *overreligious* in a sick way : *scrupulosity*. I had a patient with this problem, a young Catholic man who was so disturbed that he felt guilty holding his penis while going to the bathroom, because it reminded him of masturbation of which he also felt guilty. His visits to his church were only to attend confessional when, with a donation, his homosexual affairs for the past week were forgiven by the priest and the man would return to his homosexual lifestyle without any change.

Defense mechanisms against guilt

One of the most frequent problems analysts must deal with in their patients is irrational guilt (Fink, 1963). Freud discussed ten of

the defense mechanisms (introjection, isolation, projection, reaction formation, regression, repression, reversal, sublimation, turning against the self, and undoing), to which his daughter, Anna, added : altruism, denial, identification with the aggressor, and retriction of the ego. These and the many other defenses (Fink, 1985) help Combat rational and irrational guilt and defend the ego against the instinctual drives. For example, the harassed wife of a minister can complain : "It's not my fault that he's so mean to me ! it's because he doesn't love me any more and would rather be with the young ladies of the church," an example of projection or blaming others for one's own problems or misery. Of course, there are times when the projected concept has *truth* in it !

References

Fink, H. K. (1954), *Long Journey, A Verbatim Report of a Case of Severe Psychosexual Infantilism.* New York : Julian Press. Press.

Fink, H. K. (1956). The context of effective counseling. *Journal of Pastoral Care, 10(4),* 234-256.

Fink, H. K. (1957). When trouble runs deep. *Journal of Pastoral Care, 1p(2),* 91-97.

Fink, H. K. (1961) Psychosexual infantilism. *Real Life Guide* (June), 49-69.

Fink, H. K. (1962). Marriage as a creative partnership. *Real Life Guide* (May), 10-19 ; (July), 20-30.

Fink, H. K. (1963). Guilt and the obsessive-compulsive personality. *Samiksa, 17(2),* 82-96.

Fink. H. K. (1964). Irrational suffering. (Oct.).

Fink, H. K. (1935). A dictionary of defense mechanisms used in psychoanalysis and life. *Samiksa. 39(5),* 91-115. Also : Addendum, *Samiksa, 39(3),* 71-72/

Fink, H. K. (1986). The function in the doctor-patient relationship of transference and countertransference in psychoanalysis. *Samiksa, 40f2),* 46-74.

Gibson, M. B. (1984), M. B. (1984). Psychoanalysis, *Encyclopedia of Psychology* (R. J. Corsini, Ed.), *3*, 89. New York: Wiley & Son.

Grusky, Z. (1987). The practice of psychotherapy : A search for principles in an ambiguous art. *Psychotherapy, 24(1)*, 1-6.

Rayburn, C. A. (1985). Some ethical considerations in psychotherapy with religious women, *Psychotherapy, 22(4)*, 803-812.

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THE PATIENT ANALYST INTERACTION —AN AFTER EDUCATION

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Any discussion regarding "The patient-analyst Interaction" is bound to be concerned with one or the other aspect of "Transference-counter-transference" paradigm. Literature on these topics is so vast that any attempt to cover it is out of question. My intention, in this paper, is to focus attention on one particular aspect which is the need of the patient. The patients that are described as "borderline", "narcissistic" and "psychotic".

A detailed description and review of literature on transference is given by Joseph Sandler (5). From it I will quote what Freud has said : "If the patient puts the analyst in the place of his father (or mother), he is also giving him the power which his super-ego exercises over his ego, since his parents were, as we know, the origin of his super-ego. The new super-ego now has an opportunity for a sort of "after education" of the neurotic". Further on sandler, referring to Hampstead Index Project, writes : "Another role of the analyst is his function, in certain cases, of being what has been referred to as "auxiliary ego" — something which we see particularly in "borderline" and psychotic cases....." Now these two functions form the essence of my paper.

These two functions are such that they can be easily confused with counter-transference tendencies and acting out. Really speking, the analyst remains a "participant observer" in. what D. N. Winnicott (8) calls, "The use of an object".

The patient is, in transference using the analyst as an object, and for the first time as it were learns, what a healthy child learns through using mother, all the emotional experiences and awareness of subjectivity and objectivity.

I will try to illustrate these points through presentation of two short vignettes of two cases.

Case No. 1 ; Mr. J. J. a twenty year old young man, who looked and behaved like a small child, was brought by his father. According to father, J's problem was 'complete withdrawal'. J would sit silent in the house, not talking with any body or would walk tirelessly for hours without any aim. When I interview J alone I could observe that he was tense and anxious to speak but could not. I expressed this feeling for him and he gave his assent nodding his head and felt more shy. There was no use probing the boy and I started interviewing mother as well as his father. It was his mother who pointed out that J was many a times repeating the."
that is : a bad son sometimes be, but a bad mother never." This spoke volumes for diagnosis and treatment. In the subsequent meetings' a with the boy and parents it came out that when J was a month or two he had a terrible crying spell. He was under constant pain but it could not be located and hence treated. It was almost accepted that he would die. Fortunately an ear infection was found and treated successfully. This early traumatic experience and frail hold on objects had been the cause of his very low frustration tolerance. Hence his first failure in exam. at school he left studies. Equally he left his first job, for fear of failure. Our working at this level helped him to build his consects, a new.

Case No. 2 : M. B. aged 40 was a patient at Govt. Mental Hygein Clinic. He was restless, hyper-irritable and touch, stubborn; having brief rage attack, particularly with his mother and elder brother's wife, hypochondriac with loguacity, constantly and repeatedly talking about his physical and mental pains etc.

From his case history important points to be noted are : his high narcissism is rooted back in his father, who was a hundred years back, was more wealthy then the Thakor Saheb of his native village. His father had built the palaces of Giakwar of Baroda and Nizam of Hyderabad. Still all this wealth his father lost in speculation. Due to his father's magical thinking, the father used to ask M, then aged

about 5 years to draw a lucky number. A child being nearest to God. On the other side what was happening was : an adult woman was using him to masturbate her. The place they were staying was called "Chand-mary" street or chowk. Leaving aside the conotanion of the word "Chand-mary" and other associations with it. I will focus attention on the three phasic concept of trauma. The first phase is when an adult seduced him. The second is when he gets stimulated and the third is when he actively approaches the adult partner, the partner rejects him for whatever reasons he or she has. The amount of confusion and guilt that was generated by this has been the core of his repetitive behaviour.

Upto high school studies he was brilliant student, but unfortunately he was shifted from the home environment and was put in a college at Bombay. He began to decline in studies, was almost always quarreling with neighbours for "eve teasing" or for prostitution, actual or supposed. By this time his father had died, leaving huge debt which his elder brother was trying to square up to keep up their narcissistic image. To solve the problem of M. elders thought marriage to be the best remedy. This brought about a shift in the area of quarrels. Now it was between him and his wife. Again the elders thought that instead of staying with the joint family, if they are given a separate house, adjustment will be easy. So such an arrangement was made, and on the day they were to move to their new house, they had gone there for some preliminary arrangement. According to the patient, his wife invited him to come in the bedroom. Probably with an intension for a sex intercourse. He refused and she became more firm and he became more obsessed in his refusal. A fight ensued. M says he did not know but his wife had already poured kerosene on her clothes, and when he was adamant in his refusal, she set fire to herself. M in a panic tried all he could to put out fire and got himself very badly burnt. They were hospitalised, where the wife died, and M was swinging between life and death for six to eight months, and had to undergo several operations for skin grafts etc. This memory of the experience and torture he used to go on repeatedly talking out, partly to avoid thinking what might have made his wife to commit suicide. I posed this question to him. He of course tried his 'don't know' response but on further probing came out his doubt about an illicit conception and her love letters

and affair before marriage etc. This of course opened up the doubt about responsibility and guilt. I was further able to show the connection between his first traumatic experience which we had nicknamed "Chand-mary" experience and the question of guilt. All this brought about a marked reduction in his pathological behaviour but he disrupted therapy to avoid getting out of his dependency on his brother and particularly mother, most probably.

These two cases illustrate "Traumatic Neuroses" but what we are considering now is the study of structural consequences of drama. J. Cohan (2) in his article on this topic writes : "In the light of these considerations trauma can be viewed as a developmental event or pattern that interfers with Id-maturation and Id-ego differentiation at whatever stage, by interfering with the formation of adequate micro-structure (wishes and memory traces, based on experience of satisfaction) necessary for the operation of the pleasure-principle". Further Cohen and Kinston(3) elaborate the same concepts and say : "We accept Freud's view that meeting a need leads to mental representation in the form of a wish and argued that a failure in need mediation would result in a persistent absence of associated wish (internal self/object relation) and thus a gap in the emotional understanding (psychic structure). Such a failure was held to be the essence of trauma and the basis of mental illness....."

Cohen, further quotes Winnicot (6) who a-rgues that in the area of "ego-needs, in contrast to "id-wishes", the analyst must adopt to the analysand rather than frustate him. So the delicate task that the analyst has to perform, is to distinguish between Id-wishes and ego-needs. The ego-needs can better be described as failure of the environment to meet needs. This task which was performed by the parents, successfully or not has to be taken over now by the analyst, in the here and now situation. It is in this way a 'Primary object' and a 'primary relatedness' with the analyst comes into being.

The specific concept of 'Primary object' was introduced by Balint (1). The person who is relating to the Primary object "has no sense of power or control over the primary object, but if harmony with the object is disturbed there is a profound threat to life and violent aggression ensues. Balint Compared this primary object concept with, Anna Freud's" need-Satisfying object, "Hartman's average

expectable environment", Bion's 'container', Winnicott's holding function or facilitating environment.

The central task of the analyst, as I understand is to judge when to be supportive and when to be giving interpretations. In essence he has to find ways to exist with the patient so as to enable the patient to enter into a genuine relation. Interpretive capacity is essential but as Cohen notes ".....much controversy exists about the nature of mediation. Different approaches are evident in the work of various workers, for example, klein and those influenced by her, use of a complex conceptual system centered on splitting and projective identification, Kohut emphasizes the analyst's accepting of mirroring and idealising transference etc.

Freud (4) contended that : "the first aim of the treatment (is) to Attach (the patient) to it and to the person of the doctor". Further he explains : "to ensure this nothing need be done but to give him time. If one exhibits serious interest in him, carefully clears away the resistance, that crop up at the beginning and avoid making certain mistakes, he will himself form an attachment. For Freud, this attachment and the associated rapport with the patient was part of the mysterious phenomenon he labelled 'Transference' and he specifically assigned the analyst responsibility for activating it.

When a situation of 'primary object' and 'primary relatedness' have been achieved, which occurs during a long and successful analysis, the therapeutic action of psycho-analysis, as Cohen says, "Can best be understood as the exposure ..... and the transformation of trauma into paychic structure in a context of primary relatedness".

Recent psycho-analytic research supports the notion that "wishes consist of linked self—and object-representation and should be considered the basic units of psychic structure. In adult life psychic structure mediates between needs and effective wits—based activity as the parents mediated between the child's needs and the world. The analysts' task, in this respect, is not unlike that of parents, though the method is very different. Finally all these mean that the analyst is there to be "used as an object" as described by winnicott in his classical paper. A detailed discussion on it may be very important, but to me it appears to be beyond the scope of this paper.

References

1. Balint, M. (1950) Thrills and Regression, London, Hogarth.
2. Cohen, J : "structural Consequences of psychic-trauma : a new look"—Int. Jo. Psycho-anal. (1980) Vol. 61 pp. 421.
3. Cohen, J and W. Kinston : "Primary Repression : Clinical and theoritical aspects" Int. Jo. Psych. anal (1953) Vol. 67 - pp 337.
4. Freud S : "On begining the treatment (1913) S. E. 12.
5. Sandler J. Holder, A. Kawenoka, M. Kennedy, H. E. and Neurath, L. "Notes on some theoretical and clinical aspects of transference". Int. Jo. Psych. and (1969) Vol. 50 pp 633.
6. D. W. Winnicott : "Meta psychological and clinical aspects of regression within the psycho-analytic set up "In collected papers : Through padeiatric in psychoanalysis (1954) London Tavistoc (1958).
7. D. W. Winnicott — Ego Distortion in terms of true and false self in : the maturational processes and facilitating Environment. London Hogarth Press (1965).
8. ".....: The use of an object" Int. Jo. Psycho-anal (1969) 50 pp. 711.

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