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# Clinical Manifestations of Superego Pathology

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The discovery of the technique of unlocking the unconscious and direct view of core neurotic structure by the author offers an unrivalled opportunity for checking aspects of psychoanalytic theory against empirical evidence. In the present article clinical material from five cases is presented, each of which illustrates the following four phenomena: (1) self-destructive behavior, (2) violent and murderous underlying impulses, (3) intense guilt and grief, (4) impoverished personality; the higher the intensity of repressed murderous impulses; the intensity of guilt and grief, the higher the level of resistance. Detailed examination of the evidence points overwhelmingly to the operation of a self-punitive mechanism identical with Freud's concept of the superego; and this emphasizes the crucial part played by the superego in creating and maintaining the human core neurosis. Although this material confirms Freud's over-all formulation, it is also clear that the superego can arise from non-Oedipal conflicts at least as early as the beginning of the second year of life, so that Freud's view that the superego is exclusively "heir to the Oedipus complex" is not confirmed.

### Part I: Introduction

#### The Threefold Division of the Psyche

If anyone thinks clearly about the forces operating in human beings, it seems almost inevitable that he will end up classifying them into three broad categories. (1) First, there are the basic drives or instinctual reactions, and their accompanying feelings or emotions, which supply the energy leading toward action; (2) second, there must be some function which mediates between the drive and reality, and decides whether the action is possible, or wise, and if so, how it is to be carried out; and finally (3) there must be a third function, which is concerned with "approval" or "disapproval" by the self or others, and modifies action accordingly, or reinforces it, or holds it in check. Because we tend to think in terms of concrete analogies, we begin to speak of these functions as belonging to three different parts of a structure. For the overall structure we can use the term "psyche," and for the three parts we can use terms such as (1) "instinct," (2) "ego," and (3) "conscience." Thus this threefold division of the psyche is a natural consequence of using purely armchair or introspective reasoning on aspects of mental functioning that are entirely conscious.

#### The Triangle of Conflict

However, if, like Freud, we study human beings with the help of the psychoanalytic method, we discover much greater complexity than this. Of

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all psychoanalytic observations the most fundamental consists of another triad, the triangle of conflict, which turns out to be closely related to the one above, namely, (a) that feelings and impulses associated with certain drives may be *kept out of consciousness*; (b) that the way in which this is achieved is by the use of various *defense mechanisms* which themselves may be unconscious; and (c) that the *reason* why this occurs is that the feelings or impulses are loaded with *pain, anxiety, or guilt*, which also may be unconscious.

#### The Relation between the Two Triads

The relations between the three elements of the triangle of conflict and the three divisions of the psyche can be expressed as follows:

(a) The *feelings and impulses* that are kept out of consciousness, at any rate mostly, belong to the "instinctual" part of the psyche, i.e., (a) is related to (1).

(b) According to the threefold division of the psyche, it is the "ego" that mediates between the drive and reality, and thus we may reasonably say, as Freud did, that it is this part of the psyche that mediates between the drive and *consciousness*, i.e., that the ego is responsible for the defenses, so that (b) is related to (2).

(c) It is difficult to decide which part of the psyche is responsible for *pain* and *anxiety*, though we know that Freud attributed them to the ego. However, it is obvious that *guilt* comes from that part of the psyche which we have called "conscience," and therefore where guilt is involved (c) is related to (3).

Since, as stated above, feelings and impulses, defense mechanisms, and guilt may all be unconscious, we have arrived at the position that all three divisions of the psyche can have unconscious components.

A quotation from Freud's *The ego and the id*, published in 1923 describes the empirical evidence on which one aspect of this theoretical position is based, namely the existence of an unconscious component in the "ego":

Now we find during analysis that, when we put certain tasks before the patient, he gets into difficulties; his associations fail when they should be coming near the repressed. We then tell him that he is dominated by a resistance; but he is quite unaware of the fact, and even if he guesses from his unpleasant feelings that a resistance is now at work in him, he does not know what it is or how to describe it. Since, however, there can be no question but that this resistance emanates from his ego and belongs to it, we find ourselves in an unforeseen situation. We have come upon something in the ego itself which is also unconscious . . . (Freud, 1923; p. 17)

#### Complexities in the Concept of "Conscience"

In the present article we are mainly concerned with the third division of the psyche, namely the "conscience." It is here that we meet the greatest

complexity of all, part—though only part—of which may be formulated as follows:

(1) The operation of conscience cannot only involve the *avoidance* of pain—in the sense of preventing a person from doing something that he will later regret—but it can also involve a *sense of guilt* leading to the *need* for pain, in the form of a need for punishment.

(2) Observation makes clear that if the punishment does not come from the outside, then this need may express itself as *self-punishment*.

(3) This need for punishment or self-punishment can itself be either conscious or unconscious.

(4) Since punishing someone is an aggressive act, self-punishment by definition consists of turning aggression against the self.

(5) And finally, the ultimate in complexity, self-punishment may therefore become not only a way of *dealing with* guilt-laden aggression, but also a devious way of *expressing* it, and thus a fusion of aggression and guilt.

#### Freud's Concept of the Superego

It was complexities such as these that made Freud feel the need to coin new terms for the basic drives, on the one hand, and conscience on the other, dividing the psyche into "id," "ego," and "superego," in German, *das Es, das Ich, und das Über-ich*. Condensed quotations relevant to the concept of "superego," with which this article is concerned, and the observations on which this concept is based, are given below. Freud introduced the term in 1923 in *The ego and the id*, but the first quotation shows that his thinking was leading in that direction many years before:

We may say that a sufferer from compulsions and prohibitions behaves as if he were dominated by a sense of guilt, of which, however, he knows nothing—so that we must call it an unconscious sense of guilt, in spite of the apparent contradiction in terms. (Freud, 1907, p. 123)

In our analyses we discover that there are people in whom the faculties of self-criticism and conscience are unconscious, and unconsciously produce effects of the greatest importance. This new discovery compels us to speak of an 'unconscious sense of guilt,' especially when we gradually come to see that in a great number of neuroses this unconscious sense of guilt plays a decisive economic part and puts the most powerful obstacles in the way of recovery. (Freud, 1923, pp. 26-27)

Patients do not easily believe us when we tell them about the unconscious sense of guilt. We may, I think, to some extent meet their objection if we give up the term, and speak instead of a 'need for punishment,' which covers the observed state of affairs just as aptly. (Freud, 1924, p. 166)

There are certain people who behave in a quite peculiar fashion during the work of analysis. When one speaks hopefully to them or expresses satisfaction with the progress of the treatment, they show signs of discontent and their condition invariably becomes worse. They exhibit what is known as a 'negative therapeutic reaction.' This reveals itself as the most powerful of all obstacles to recovery. In the end we come to see that we are dealing with what may be called a 'moral' factor, a sense of guilt, which is finding its satisfaction

in the illness and refuses to give up the punishment of suffering. (Freud, 1923, p. 49)

If we turn to melancholia, we find that the excessively strong super-ego which has obtained a hold upon consciousness rages against the ego with merciless violence, as if it had taken possession of the whole of the sadism available in the person concerned. Following our view of sadism, we should say that the destructive component had entrenched itself in the super-ego and turned against the ego. (Freud, 1923, p. 53) (Here, to lessen confusion, it may be right to say that Freud seems to be using the term "ego" in a different sense, namely as synonymous with "self.")

From the point of view of instinctual control, of morality, it may be said of the id that it is totally non-moral, of the ego that it strives to be moral, and of the super-ego that it can be super-moral and then becomes as cruel as only the id can be. It is remarkable that the more a man checks his aggressiveness towards the exterior the more severe—that is aggressive—he becomes in his ego ideal. It is like a displacement, a turning round upon his own ego. (Freud, 1923, p. 54) (Here Freud is again using the term 'ego' to mean 'self,' and he also seems to be using the term 'ego-ideal' as almost interchangeable with 'super-ego'.)

A large part of (an individual's) conscience may have vanished into his masochism. In order to provoke punishment the masochist must do what is inexpedient, must act against his own interests, must ruin the prospects which open out to him in the real world, and must, perhaps, destroy his own real existence. The sadism of the super-ego and the masochism of the ego supplement each other and unite to produce the same effects. (Freud, 1924, pp. 169-170)

All these quotations are concerned with the theme of the present article, namely the aggressive, punitive, self-destructive aspects of the superego; but it is important to note that there are many other complexities, controversial issues, and unanswered questions, of which the following are examples:

(1) To what extent is the superego something intrinsic in human beings, which comes into existence quite independently of the environment, and to what extent does it arise from *identification* with prohibitions arising from parents, parent substitutes, or society in general?

(2) To what extent does the operation of the superego express *love* of parents (or others), and the *wish to protect them and not to hurt them*, in addition to guilt, fear of punishment, or fear of disapproval?

(3) Does the superego arise only from the *Oedipus complex*, as Freud believed, i.e., from guilt about erotic feelings toward the parent of the opposite sex and jealous or hostile feelings toward the parent of the same sex, within a three-person situation, or are there other sources of guilt as well?

As it is well known, inferences about the early development of human beings made from studies of both adults and children, especially those of Melanie Klein (e.g., 1932, 1933) and Winnicott (1933), suggest clear answers to all these questions, which may be presented very briefly as follows:

It is thought that aggressive impulses of a very primitive kind can arise very early in life and be directed against the mother. Here I shall entirely leave aside the extremely obscure and controversial question of the degree to which these are intrinsic, or constitute a response to inadequate mothering. In the first few months of life it seems that the child expects impulses of an equally primitive and ruthless kind to be directed back at him either from the outside world or from inside himself, which gives rise to what Melanie Klein calls "persecutory anxiety." These impulses thus form a kind of primitive superego. At about the age of six months, however, there is a major change, which accompanies the dawning awareness of the mother as *another person*. Then *persecutory anxiety* gives way to "depressive anxiety," *fear* is replaced by *guilt* and *concern*. Thus Winnicott suggested the term "stage of concern" for this point in development, which he regarded as more satisfactory than Melanie Klein's term "depressive position." The superego now becomes less primitive, and in normal development will mature into what we mean by "conscience." Winnicott wrote: "The healthy child has a personal source of sense of guilt, and need not be taught to feel guilty or concerned."

Thus the tentative answers to the above questions are as follows:

- (1) Part of the superego is intrinsic and independent of the environment.
- (2) Part of the force of the superego arises from love and not just from fear.
- (3) Part of the guilt arises very early, before the child could possibly be aware of the three-person, Oedipal situation.

#### Problems in the Concepts of Id, Ego, and Superego

One of the problems inherent in the concept of "structure" in the psyche is that it is in fact only an analogy, and it is very easy to get led away into regarding it as an actual physical entity and then to meet all sorts of theoretical difficulties and contradictions. If we return to the first quotation given above from *The Ego and the Id*, and continue it, we can see Freud struggling with one of these difficulties, which arises from the question of whether something can be *unconscious* without being *repressed*—since the ego is regarded as being responsible for repression, it seems difficult to regard the unconscious part of the ego as repressed:

We have come upon something (i.e. resistance) in the ego itself which is also unconscious, which behaves exactly like the repressed—that is, which produces powerful effects without itself being conscious and which requires special work before it can be made conscious . . . We recognize that the *Ucs.* (i.e. Unconscious) does not coincide with the repressed; it is still true that all that is repressed is *Ucs.*, but not all that is *Ucs.* is repressed. When we find ourselves thus confronted by the necessity of postulating (an) *Ucs.* which is not repressed, we must admit that the characteristic of being unconscious begins to lose significance for us. (Freud, 1924, pp. 17-18)

Here it is worth saying that this seems to express Freud's despair at making his threefold division of the psyche into a self-consistent system, since if anything is central to psychoanalytic theory it is surely the characteristic of being unconscious.

There is another important difficulty which Freud also struggled with in *The Ego and the Id*. As touched on above, Freud clearly ascribed both grief and psychic pain to the ego, and yet he recognized that pain "behaves like a repressed impulse" (Freud, 1923, p. 22). Certainly in Intensive Short-Term Dynamic Psychotherapy it is necessary for the therapist to handle grief and pain in exactly the same way as he handles anger, i.e., to challenge the defenses against them in order to bring them to the surface, so that they can be experienced and their power can be neutralized. This will play a major part in the clinical examples that follow.

All these considerations suggest that Freud's threefold division of the psyche is *not* really a self-consistent system, and therefore that the use of Freud's terms in the present article is only a convenient piece of shorthand, and does not necessarily imply a slavish adherence to psychoanalytic theory. Perhaps surprisingly, on the other hand, the *superego*, in spite of being the most complex of the three concepts, is probably also the most self-consistent.

#### The Status of Evidence in Psychoanalytic Theory

The final point in this long introduction is as follows: Freud presented many of his concepts and theoretical ideas as overall impressions or conclusions, without a detailed examination of evidence from clinical material, and without the usual scientific discipline of a careful consideration of alternative hypotheses. One of our most urgent tasks is to try and sort out the wheat from the chaff, to answer the questions: which of his ideas are inescapable scientific facts, which are half-truths with a mistaken emphasis, and which need to be discarded altogether and assigned to a historical museum? But how are we to find the evidence on which any answers are to be based?

The almost insuperable difficulty of trying to base answers on psychoanalysis or long-term psychotherapy lies in the fact that the process is so gradual, and the material becomes so voluminous, that direct evidence is almost impossible to obtain. For instance, if therapeutic effects occur, how can one know what factors were responsible for them? Another consequence is that so few analyses can be conducted by any single therapist during a lifetime that he is in no position to present cumulative or statistical evidence based on a number of similar cases. As a result, single cases tend to be used as a basis for generalizations of highly questionable validity.

If only it were possible to unlock the unconscious and achieve a direct view of its contents in a single session! Then, we would be in a position to provide real evidence which would enable us to answer the questions posed above, and to put psychoanalysis—or rather psychodynamics—on a proper scientific basis.

And this is exactly what I have discovered, namely the triggering mecha-

nism for the unlocking of the unconscious with the direct view of the core neurotic structure in a single interview which is now the basis of the trial therapy for Intensive Short-Term Dynamic Psychotherapy. The present article is a preliminary communication in which an important psychoanalytic concept, that of the punitive superego, is examined in the light of evidence obtained in this way.

#### The Mechanism of the Unlocking of the Unconscious

Perhaps it never dawned on Freud and later generations of analysts that it is possible to achieve a major unlocking of the unconscious, making possible a direct view of the dynamic unconscious and the core neurotic structure responsible for the patients neurotic suffering. I have systematically demonstrated that this is not an event that happens with a few dozen patients, but it can be achieved with the whole spectrum of patients suffering from structural neurosis with the sole exception of those with very severe, fragile ego structure. In summary, my standard technique for handling resistance and unlocking the unconscious is as follows:

- Rapid identification and clarification of the patients defenses in the transference.
- Pressure toward the experience of impulse/feelings, which leads to the intensification of resistance.
- Systematic pressure and challenge to the resistance, which leads to a rapid rise in the patient's complex transference feelings and further intensification of resistance.
- Systematic pressure and challenge to the transference-resistance leading to a further intensification of resistance.
- Head-on collision with the transference-resistance. Creation of intrapsychic crisis with turning of the ego against its own defenses.
- Direct experience of the complex transference feelings—the "triggering" mechanism.
- Mobilization of the unconscious therapeutic alliance and the first unlocking of the unconscious.
- Systematic analysis of the transference to remove the residual resistance and widen the entry into the unconscious.
- Major de-repression of current or recent past (C) and distant past (P) conflicts, leading to a direct view of the dynamic unconscious and multifocal core neurotic structure.

As we can see the transference is activated and intensified by immediate and repeated challenge to each of the defenses which make up the resistance and eventually these become exhausted and the transference feelings break through and can be both experienced and acknowledged. This has the effect of loosening the patients whole psychic system.

With this technique the therapist has an unrivalled opportunity not to make inferences about the unconscious, but to observe what lies there directly, and thus to test the validity of many concepts that form part of

psychoanalytic theory. The operation of this powerful research tool will be illustrated by presenting the following clinical material.

## Part II: Clinical Material

### The Case of the German Architect

I shall start with a case (already described in this journal; see Davanloo, 1986) which shows the operation of the superego particularly clearly.

The patient was an unmarried man in his early thirties. The therapist opened with the standard question, "Could you tell me what seems to be the problem"? In response, the patient manifested immediate resistance, using the defenses of vagueness and intellectualization: "I only have some hazy idea . . . I'm not sure whether these difficulties are the normal part of being a human being," and so on. The therapist responded with repeated challenge, and the patient's resistance rapidly crystallized in the transference—he became evasive, stubborn, sarcastic, provocative, and at times openly insolent, maintaining emotional distance by avoiding the therapist's eyes. Thus what he was doing was to *express aggressiveness* toward the therapist without himself becoming *emotionally involved* in it.

In an everyday human relation this provocativeness would inevitably bring some form of retaliation and set up a vicious circle, and that the similar behavior occurred outside the therapeutic situation. This was therefore the first indication of one of the patient's self-destructive patterns.

Here the therapist employed the *head-on collision with the resistance*, forcefully pointing out the self-destructiveness inherent in the position that the patient was maintaining:

*TH: If you stay like this, vague, nonspecific and withholding, then we will depart from each other without getting to the core of the problem. Then I would be totally useless to you. So obviously what immediately is coming to focus is that you have a self-defeating pattern. My question is why an intelligent person like you wants to do that?*

In this intervention the therapist is speaking directly to the patient's therapeutic alliance in order to shift the balance between it and the resistance. (To anticipate terminology to be used later, the therapist is speaking to the ego in order to shift the balance between it and the superego.) The result was some immediate evidence that this shift was beginning to occur, and after further repeated challenge the patient's defense of noninvolvement in his own aggressiveness was finally penetrated. He became overtly angry, raising his voice to the therapist for the first time:

*TH: Again you leave it in the state of limbo. 'I think so.'*

*PT: Well I do think so! Goddamn it, I'm not a psychiatrist.*

*TH: How do you feel right now?*

*PT: I feel fine. I'm getting belligerent.*

Although there was nothing dramatic in the breakthrough of the patient's anger, in fact it represented a major change in his psychic system, and it illustrates the profound unlocking effort which this kind of direct experience of transference feelings invariably has. Now, in response to the therapist's request that could he describe a situation in which he had become angry, a crucial communication emerged. This took the form of a "cover memory": an incident which summed up a large part of his core neurosis.

The incident occurred in a bistro. The patient witnessed a drunken man repeatedly insulting and needling a woman. He got into a rage and attacked the man, but only hit him on the shoulders, with the result that the man was unhurt and was merely provoked into beating him up. The patient ended up with a bleeding nose and a black eye.

He became very deeply involved and, perhaps surprisingly, very sad and tearful as he described this incident. He was quite unaware of its significance or the reason for his sadness.

Under pressure he admitted that he wanted to do much more than hit the man on the shoulders, and that he could have done so: "I could easily have hurt him"; and when he was asked if he had really wanted to "beat him up to the level that he would not move," he responded with words that clearly expressed his impulses, "You mean, 'I want to kill, I want to kill'."

Shortly after this he spontaneously mentioned his parents, which reactivated his transference-resistance. He put his feet up on the table, thus expressing insolence, while at the same time he tilted back his chair, putting himself in danger of falling over backwards. He spontaneously linked his defiance of the therapist with the relation with his father, and the therapist linked the mixture of aggression, on the one hand, and putting himself in danger, on the other, with the incident in the bistro:

*TH: . . . you took the defeated, beaten position as a mechanism to deal with the impulse which had a **murderous quality**—that you could have knocked him down with the first strike, but defensively you managed to be the beaten man with the bleeding nose, and to be humiliated in front of the woman.*

To this interpretation there was a major response:

*PT: Okay, the closest I have come to **murder** is when my father went for a lung operation . . . and I expressed the wish out loud that he would die.*

Not only this, but shortly afterwards he brought up a fresh memory of having used a table knife to try and slash the wrists of one of his brothers, Gustave, who was the favorite of their father. "I am very relieved that it wasn't sharp" (later he said, "Thank God I didn't cut his artery"). Mention of his brother introduced an entirely new theme, because his jealousy implied the grief-laden wish that he had had a warm and close relation with his father.

By now the patient was in a far more responsive state, with his unconscious therapeutic alliance strongly in operation, and it was possible to explore the family situation that had led to his neurosis:

With sadness, frequent sighs, much anxiety, and sometimes tears, the patient described how his father, a Calvinist minister, had been authoritarian, brutal, and sadistic. He frequently beat the patient on his bare behind with a brass-studded ruler; at table he would hit him over the knuckles with the blunt edge of a table knife; and after punishing him he would often lock him in a dark cellar. This continued till the patient was about 11. The mother was always busy, physically undemonstrative, and utterly subservient to the father. The patient was the eldest of four surviving children, and neither his brothers nor his sister were punished in the same way as he was. He became the black sheep of the system.

During the course of this account the patient began to show signs of both wanting, and trying to avoid, a closer relation with the therapist, and when this was brought into the open he spontaneously revealed the disappointed love lying behind his anger. He spoke of his paternal grandfather, who had become a father-substitute for him, and with whom he had developed the close and warm relation that he had never had with his father. It also emerged that he had found mother-substitutes in his two grandmothers and an aunt. He said that each time the family moved, "I would always find some kind of substitute for parents, a mother and father, whom I could call aunt and uncle."

When his adult life was explored, it became clear that he suffered from major problems in relation to people of both sexes. With men, particularly those in authority, he adopted the same kind of detached or belligerent attitude as he had to the therapist, provoking retaliation and spoiling the relationship. With women he had a serious problem over commitment, and though his feelings might start positive, sooner or later they changed and he broke the relationship off. His last relationship had been totally disastrous, since the woman had moved in with him, had had a psychotic breakdown, and he had had to look after her for three years because she had nowhere else to go. As far as his professional life was concerned, he made clear that he was quite unable to fulfill his potential. The final result of all this was that his life was empty.

As the patient spoke of his mother, he began to express resentment against her for never standing up for him or protecting him from his father. The therapist gave a summing up interpretation—the helpless mother and brutal father (like the couple in the bistro)—and the patient's search for refuge and parent substitutes.

At this point the patient became extremely sad and tearful, though still trying to avoid both the impact of his feelings on himself and the emotional closeness that would result from sharing them with the therapist. After these two forms of resistance had been challenged, he de-repressed what was an important central issue in his pathology, very sad, tearful, with waves of painful feelings and with the intensely felt words, "I don't want to punish them any more," which was followed later by: "I don't want to tell them that they have been terrible parents, which they have been."

Here the therapist pointed out that he was punishing himself as much as punishing them.

Finally, it is worth mentioning that during his subsequent session the patient recalled the following incident: that he went alone into the woods to cut down a tree, and positioned himself in such a way that the tree fell on him. This happened not once but twice. On the first occasion he was not discovered for many hours.

#### The Case of the German Architect, Discussion

The clinical material on this patient can be summarized under four main headings.

##### (1) Self-Destructiveness

The evidence for this is as follows:

(a) The first manifestation in the interview of self-destructiveness occurred in the patient's initial state of resistance, in which he used the defenses of detachment and provocativeness. Obviously, if this resistance could not be penetrated, the whole therapeutic process would be defeated.

(b) In an everyday situation this kind of provocative behavior would inevitably bring retaliation, which would set up a vicious circle and would probably result in the destruction of the relationship. Enquiry revealed that this was what actually happened in the patient's life outside, and that it was a recurring pattern, particularly with men in authority.

(c) With women he also showed a recurrent pattern, namely losing his feelings and terminating the relationship.

(d) In the incident in the bistro he behaved in such a way as to get himself beaten up.

(e) It soon became clear in the interview that in his defiance of the therapist the patient was repeating a pattern which he had expressed with his father over a period of many years, and which had clearly led to a vicious circle of provocativeness and punishment and a disastrous relationship between father and son.

(f) Finally there was the patient's serious accident caused by felling a tree, which happened not once but twice.

##### (2) Sadistic and Murderous Impulses

(a) The patient more or less admitted that his rage against the man in the bistro was murderous in quality.

(b) The parallel between the situation in the bistro and that in the patient's family, an aggressive man attacking a helpless woman was very striking. Moreover, the man in the bistro was described as very energetic in his movements, which represented another parallel with the patient's father. In other words the potentially murderous attack on the man in the bistro was a symbolic attack on the patient's father.

(c) At the age of 11 the patient had openly expressed the wish that his father would die.

(d) In his childhood the patient had made an attack on his brother Gustave, which was at least a *symbolic* if not an *actual* attempt at murder. He demonstrates a high level of resistance which correlates significantly with the intensity of murderous impulses as well as repressed guilt and grief.

### *(3) Intense Guilt, Remorse, and Grief*

Once the breakthrough had been made, these feelings permeated the whole interview, often expressed all at the same time. One example occurred in the words, "Thank God I didn't cut his artery"; and the climax came with the words, spoken with deep and intense feeling, "I don't want to punish them any more. I don't want to tell them they have been terrible parents, which they have been. I just want to let sleeping dogs lie as far as they are concerned."

Here we may ask the highly relevant question, in what way was he punishing his parents? Since they were in Europe and he was in Canada, he had little means of punishing them *directly*. Therefore the answer can only be that he was punishing them *through his own suffering and the messing up of his own life*. In this way he could become a living reproach to them, and could fuse anger and guilt in a single pattern of self-destructive behavior. Thus the evidence becomes strong for a mechanism of *turning the punishment on himself*.

### *(4) Impoverishment of the Personality, Sterile Relationships*

(a) It was clear that the patient's distancing and inability to allow emotional closeness with the therapist also occurred in his relationships outside.

(b) As mentioned above, he had never had a satisfactory relation with a woman.

(c) His neurosis considerably stunted his ability to fulfill his potential in work.

(d) His major ego functions are impoverished in varying degrees.

The four elements of (1) self-destructive or self-punitive behavior, (2) violent underlying impulses, (3) guilt and grief, and (4) impoverished personality are observed in all the cases about to be presented.

### *The Case of the Man from Southampton*

The two initial interviews with this divorced man by the present author were described in a two-part article by Malan in this journal, entitled "Beyond Interpretation" (Malan, 1986a, b). The following is a summary of the relevant features in the order in which they emerged. Many of them show a striking parallel with the Case of the German Architect.

### *Initial Massive Resistance*

At the time of the initial interview he was 47-years-old and divorced and had had 20 years of previous psychotherapy which had done little more than reinforce his defenses. His resistance, which was present from the beginning, took the form of vagueness and distancing. He was unable either to describe the nature of his difficulties or to give specific examples of situations in which his difficulties arose. He mentioned "anxiety" and "guilt," but when pressed for his inner experience of these feelings he would only say that these were the labels applied to them by his previous therapists.

### *Impoverishment of Personality, Sterile Relationships*

There was already evidence of this in his state of vagueness and distancing, since these transference phenomena were almost certainly typical patterns in his relationships outside. He confirmed this by saying that in his personal relations he had never really felt close to anyone, in particular neither to his wife nor his children. He also said that he was unable to fulfil his potential in work.

### *Challenging the Self-Destructiveness in the Transference-Resistance*

An essential part of technique with these patients suffering from severe character disorders is the intervention of head-on collision that I have described in detail in other publications in which the self-destructiveness in the transference-resistance is pointed out and strongly challenged. Here the therapist's aim is to mobilize the therapeutic alliance against the resistance, or—to anticipate terminology that will be used later—to mobilize the ego against that part of the resistance which is maintained by the superego. The following is part of the relevant passage:

*TH: Now let me ask you this. If you remain vague and if you remain evasive and continue to generalize and not be specific, then what would be the end result of this session with you? You said you have had 20 years of treatment, and it hasn't got you anywhere obviously. So then the end result of this session would be of no use to you, wouldn't it?*

*PT: Not very much use.*

*TH: So if you continue to be vague and evasive and generalize and keep things in a state of limbo then we would not get to understand the core of your problem, and the end result would be that I would be useless to you like the 20 years of your past therapy, okay? Now my question is this. Why do you want to do that? . . .*

When correctly timed, this assault on the superego begins the process of breakthrough, as in this patient, whose feelings were mobilized in the form of intense sadness about his wasted opportunities.

### *Evidence for Self-Destructive and Self-Punitive Behavior*

(a) The patient said, "I always sell myself cheap and let myself be exploited."

(b) After his therapeutic alliance had been partially mobilized as described above, followed by some degree of experience of transference feelings, he spontaneously began to give deep interpretations of his own behavior. He described himself as accident-prone, saying that this was a suicidal equivalent. (We may compare this with the German Architect's tree-felling accidents.) On one occasion he had overturned his car under conditions which, though icy, were not dangerous to a careful driver. On another, when in a state of rage with his wife, he had driven through a stop sign, and the car had been hit by a truck on the passenger's side where his wife was sitting.

(c) The following piece of dialogue, in which he spontaneously gave another deep interpretation, illustrates the degree to which he was aware of his need to perpetuate his own suffering:

*TH: So there is a sort of self-sabotaging and self-punishing pattern in you.*

*PT: Yes there is, constantly.*

*TH: That in a sense you carry this suffering with yourself in life.*

*PT: Yes. I think that's what led to my wife and I staying together for so many years, when we should have realized many years ago that things were not right, and we should do something about it.*

### *Guilt-Laden Violent Impulses in the Patient's Recent Life*

The patient suffered from violent outbursts which broke through his attempts at control. On one occasion he had been angered by a shop assistant and had smashed his umbrella down on the counter. His wife used to have outbursts of violence such as trying to hit him over the head with a chair or smashing the television down on the floor, and at times he had said to himself that he would kill her.

### *Activation of Transference and Breakthrough of Transference Feelings*

Under repeated challenge his transference resistance was eventually fully penetrated, and he became able to acknowledge and experience both his anger against the therapist and, with tears and sadness, his warm appreciation of the therapist's concern for his welfare. He clearly revealed that the origin of the grief lay in disappointed love when he contrasted the therapist with his father, who used to ridicule him if he spoke of his feelings and became upset. This experience of both positive and negative transference feelings led to a breakthrough into his unconscious and the possibility of exploring the roots of his neurosis in the past.

### *Family Relationships*

There were a number of striking parallels between this patient's situation and that of the German Architect:

(a) The father was dominant in the home and—though not so obviously sadistic as the father of the German Architect—would frequently administer physical punishment with a belt. The patient did remember an early close relationship with him, which represents a contrast from the German Architect.

(b) When the patient was in his early teens, there was an incident involving himself and his parents directly—in contrast to the *symbolic* incident with the German Architect in the bistro. The father had become angry with the mother and called her a pig, and the patient had raised his fist in defense of his mother, wanting to attack his father, who said he would disown him. The relation between father and son steadily deteriorated, and the situation eventually became so bad that a cousin took the patient into her home.

(c) As with the German Architect, the other siblings were much more favored than the patient, who became the black sheep of the system. In particular there was a brother, younger by one year, of whom the patient was extremely jealous. There were many fights between them, and the father bought them boxing gloves and told them to fight it out properly. In spite of the fact that the patient was a year older, he eventually got knocked backwards into a china cabinet, after which the mother forbade further fights. There was also evidence of other ways in which he allowed his brother to gain the upper hand, thus "taking the role of loser."

(d) The following piece of dialogue reveals yet another striking parallel with the German Architect who, it may be remembered, had tried to slash his brother's wrists with a table knife:

*TH: How did you feel when your brother knocked you down? Did you feel that you wanted to get at him?*

*PT: I don't know how I felt.*

*TH: We know that when you get into a fight and your wife humiliates you, there is the feeling that you wish that you could kill her. So the question is this: Was there any time the wish that you could do that to your brother?*

*PT: I'm sure there was. Yes, because on one occasion I remember fighting with him in the field . . . and I did a terrible thing when he walked away. I took a stone from the ground and threw it at him and hit him on the back of the head.*

*TH: If you didn't have a brother what would have happened?*

*PT: Well, I would not have had a rival in the family, would I?*

*TH: And the rival is the one that knocked you down and beat you and humiliated you.*

*PT: Yes.*

*TH: Now the question is, what does that mean? If you didn't have a brother?*

*PT: I don't know. Only that there would have been no one between my father and myself, I imagine.*

As with the German Architect, this passage reveals both guilt-laden murderous feelings toward the more favored brother, and a longing for a closer relation with the father.

In summary, we see the following:

- (1) Self-destructive and self-punitive behavior. Taking the role of loser.
- (2) Violent and murderous impulses toward people close to him.
- (3) Guilt about the above murderous feelings. Grief about the warm relationships that he did not have.
- (4) Impoverishment of his personality and his inability to form a meaningful relationship; high level of resistance and a harsh punitive superego.

#### The Case of the Woman with the Machine Gun

The first part of the initial interview with this 30-year old single woman was described in an article in this journal (Davanloo, 1987), the purpose of which was to illustrate the special restructuring technique that needs to be used with patients suffering from chronic depression. Many of these patients, when asked to describe their experience of anger, are quite unable to do so and describe *defense* or *anxiety* instead. It is necessary to use a technique of *graduated* rather than *unremitting* pressure and challenge in order to bring them eventually to the experience of anger in the transference, and then to drive home insight into the distinction between the true impulse of anger and the defense or anxiety which they have been mistaking for anger hitherto. Once this has been done it is safe to use unremitting pressure and challenge in order to achieve the final breakthrough into the unconscious.

The following are the features in this patient relevant to the theme of the present article.

#### Masochistic Relation with a Man

The early part of the first interview quickly crystallized around two incidents in which the patient had been severely humiliated by a man called Tony. It is highly significant that she described Tony as a man with a cruel streak, who liked to put people down, and although she knew this she had "set her cap" at him with the aim of eventually enticing him into bed with her. In the first incident he had led her on and then deliberately rejected her, and two weeks later he had had sex with her sister in the bedroom next to hers.

These two incidents would be expected to arouse extreme anger, and indeed the patient said she had been angry, but when pressed all she could describe consisted of anxiety or defenses:

*PT: The second episode was even more humiliating. I did not sleep all night. That is the worse I've ever experienced. Then I experienced*

*the anger. I don't know if it was anxiety, but I didn't sleep. I was ruminating, thinking about what was happening.*

*TH: What was your reaction?*

*PT: Aside from the lack of sleep I was . . . I gotta think back because I . . . I haven't blanked it out because otherwise I wouldn't remember any of it, but I . . .*

and so on.

#### *Self-Directed Aggression*

It emerged that after the second incident the patient had ended up by banging her two hands against the wall, which had resulted in their being so badly bruised that she was unable to use them for some days. She then became depressed. Moreover, when much later the therapist asked her if there had been any other incident involving her hands, she described how in her adolescence she had been humiliated by her brother and had severely bruised her hands by banging them against a tree.

#### *Three Major Depressions*

She had one in her early adolescence and the second one in her late adolescence which was of many months duration.

#### *Anger in the Transference*

The therapist finally succeeded in bringing her to the point of really experiencing her anger with him, which she expressed in a fantasy of taking him by the lapels (with her *hands*) and throwing him on the floor. After a second experience of anger in the transference she was able to say that now she understood the difference between this and what she had previously mistaken for anger. Moreover these experiences resulted in the disappearance in the interview itself of both the physical and psychic manifestations of anxiety, namely sweating and mental confusion, respectively.

#### *Defense against Emotional Closeness in the Transference, Showing the Parallel with Lack of Fulfillment in Other Relationships*

As with almost all patients suffering from chronic character disorders, the defense against anger is not the only problem leading to resistance in the transference. Their disappointment in previous relationships also leads them to defend themselves against emotional closeness with any other human being, which of course includes the therapist. This patient became uneasy whenever the subject of positive transference feelings was mentioned, and the therapist therefore asked her if she put the same kind of "wall" or barrier between herself and other people. In response she spoke as follows:

*PT: Yes, definitely, I can't recall a single satisfying relationship with anyone, with a man either emotionally, or . . .*

*TH: So in a sense all men are on the other side of the wall?*

*PT: Yeah, it's as if half the population doesn't really exist.*

#### *Lack of Fulfillment in Her Life in General*

The patient was well aware of the degree to which her life was marked by lack of fulfillment, as is shown by the following passages of dialogue:

*TH: . . . We are here to get you out of this crippled life. Of course you are the one to decide is it a crippled life or isn't it?*

*PT: Yes, it is.*

*TH: And it is sad that a woman of your age is running a life which is so paralyzed. On one hand you have your potentiality and on the other hand you have paralyzing forces within you . . . And you have tears in your eyes, and you avoid my eyes . . .*

*PT: I don't like to cry.*

*TH: Do you function at the level of your potential in life?*

*PT: No.*

*TH: Or do you function much below your potential?*

*PT: Considerably below.*

#### *Major Unlocking of the Unconscious: Violent and Murderous Impulses Directed against Everyone Close to Her*

The second occasion on which she reached the direct experience of the impulse in the transference resulted in a dramatic breakthrough into her unconscious. She became intensely involved in her fantasy world, and de-repressed hitherto entirely unconscious fantasies of murdering first her mother, then her father and sister, and then almost everyone to whom she had ever been close, with a machine gun.

#### *Evidence for the Love Lying Behind the Hatred*

It is very important to note that her murderous fantasies were accompanied by the most intense grief and waves of intense painful feelings. For much of the time she was in tears, and the therapist described her as "choked up and trembling." She also expressed positive feelings behind the negative in relation to the therapist, saying that although she wanted to attack him she didn't want to damage him. In the later part of the interview she compared her feelings toward the members of her family with those toward the therapist, saying that she didn't want to do more than throw him to the floor. The dialogue continued as follows:

*TH: Why do you think that is?*

*PT: It is because the caring is not there. I mean there is no way I can care for you as much as I care for my family. If they hurt me it hurts more than if you hurt me.*

This gives a very important indication of some of the forces at work in the patient leading to her self-punitive behavior.

#### *Response to Interpretation about Lifelong Guilt*

After her fantasy of murdering her mother the therapist asked her what happened next, to which she said, "I don't get caught." The therapist reiterated that she had "massive, murderous impulses" toward her mother, and she said, "Anger, anger." The therapist then said that if she could face all these painful feelings she had a chance of freedom. He then gave an interpretation of her lifelong guilt, which the patient made clear that she understood at a deep level:

*TH: . . . because your life is like the life of a murderer if you look at it.*

*PT: I'm in hiding.*

*TH: You are running and running and running, hmm?*

*PT: I've been hiding for all these years.*

#### *Summary*

The relevant features found in this patient can now be summarized as follows:

(1) Self-destructiveness and self-punitive behavior: A sexual attraction for a man whom she knew to be cruel, resulting in severe humiliation. Anger expressed in the form of injuring her own hands, a self-directed aggression.

(2) Extremely violent and overtly murderous impulses directed against her mother and almost everyone close to her.

(3) These impulses accompanied by the most intense grief and pain. We see a high level of resistance: Intense repressed murderous impulses as well as intense guilt and grief with harsh punitive superego.

(4) A self-defeating and self-sabotaging pattern which has permeated all aspects of her life, a marked vulnerability to clinical depression and she has already had three major depressions.

Finally, it is important to emphasize that in her fantasy she attacked the therapist with her *hands*, and murdered everyone close to her with a machine gun and it was her hands that she damaged by her self-punitive behavior. Hands are not the only part of the body used in such fantasized attacks. This issue will be discussed more fully later, after the presentation of other case material.

#### *The Case of the Woman Who Bruised Her Thigh*

This was a patient who was interviewed by the author and was the subject of an article by Said in this journal, the purpose of which was to illustrate the application of Intensive Short-Term Dynamic Psychotherapy in treatment of patients suffering from characterological depression (Said, 1986).

At the time of the initial interview she was in her forties and suffered from the following disturbances.

- (a) Lifelong depression, with episodes of major clinical depression marked by motor retardation and ideas of committing suicide by drowning.
- (b) Chronic anxiety.
- (c) Characterological problems—compliance and passivity alternating with stubbornness and defiance.
- (d) Major problems in human relationships, which included an inability to allow herself intimacy and closeness, and a pattern of seeking relations with people by whom she was used and abused.
- (e) A lifelong pattern of self-defeat and self-sabotage.

Thus she showed features clearly indicating the operation of a self-destructive tendency in her life. However, there was an additional striking feature, namely the close correspondence between one detail of her self-punitive behavior and the violent impulses that were revealed when her unconscious was unlocked.

As in the case of the Woman with the Machine Gun, the interview crystallized around a recent incident in which the patient had been unable to experience her anger. She had got into conflict with a woman supervisor called Catherine and had walked out of Catherine's office. The therapist pressed her to describe how she experienced her anger, which produced marked resistance:

*TH: We are focusing on how you experienced your rage towards Catherine and you want to talk about how incompetent she was.*

*PT: Well it is clear that I am not able . . .*

*TH: Simply declaring that you are incapable, you are helpless and crippled to tell me how you experience your rage, is not going to help us.*

*PT: (Sigh) I walk out . . .*

*TH: Walking out is a mechanism, it is not experiencing it. You have said that you get depressed, but that is a mechanism of dealing with rage. It is not the experience of rage.*

*PT: Well I was banging into things, bruising myself . . . I mean like my balance was off . . . I remember I got a big bruise on my leg because I walked into something with a sharp corner.*

*TH: You mean when you left Catherine's office?*

*PT: No, during that period of conflict with Catherine before I left my job.*

The patient went on to say that in situations like this she moved "very fast and very jerkily," and that on this occasion she had got "an enormous bruise" on her thigh. It later emerged that it was her *right* thigh that she injured, and that this had happened on a number of previous occasions when she was faced with a situation that should have made her angry.

We now move on to a passage that occurred some time later, when the

therapist was able to challenge the resistance against declaring her feeling in the transference.

*TH: . . . first we want to know here how you feel towards me.*

*PT: I feel angry with you.*

*TH: Angry towards me. How do you experience this anger physically?*

*PT: I feel like kicking.*

*TH: . . . how would the kicking be like?*

*PT: Kicking your shins so that you would get out of my way.*

*TH: Left leg or right leg?*

*PT: With my right leg to knock you down, to get your feet out from under you so that you would fall.*

*TH: How then would I fall?*

*PT: You would fall to your right side, would be lying down straight and I would step on you and walk out.*

In the following passage it is important to note the "positive" feelings of love and concern, which are accompanied by intense sadness:

*TH: Then what happens to me? And what do you do further?*

(The patient is highly emotionally charged, with a rise in her voice.)

*PT: Pick you up, help you up.*

*TH: So on the one side of the massive rage there is also positive feelings?*

*PT: Yes.*

*TH: In what way am I damaged?*

*PT: You are not too damaged.*

*TH: Why don't you want to damage me? You see you want to protect me against your anger.*

*PT: I could really hurt you but I don't want to kill you . . . I am capable of killing.*

*TH: From where does it come that you are capable to kill?*

*PT: Rage. I could have sat on you . . . when I had you on the ground I could have stamped all over you but I didn't want to do that.*

*TH: You mean you could have murdered me?*

*PT: Yeah. I could have really hurt you.*

*TH: Now if you go further in terms of thoughts and fantasies?*

*PT: That is what I'm doing.*

*TH: Okay, with the thoughts. If you had gone to the level that you wanted to murder me how would you murder me in terms of thoughts? We can see your fist.*

*PT: I would step all over you with my shoes on.*

*TH: But not your fists, which are like that?*

(The patient sighs deeply, there is a high rise in complex transference feelings)

*PT: Okay, yeah.*

*TH: What would happen? Where would be the target of your rage?*

*PT: Your stomach.*

*TH: Am I bleeding to death or am I what way? I mean is there blood or what?*

*PT: It is not to . . . you're not . . . I am not going to kill you but I could really hurt you.*

*TH: Damage me?*

*PT: Yeah . . . your stomach.*

*TH: Mm hmm. And then after you have done it what would be the extent of the damage to my stomach?*

*PT: The thought that came into my mind was, whatever is in your stomach would . . . come out.*

*TH: Oh, open up, you mean that way, you mean . . .*

*PT: No, not open up, I think . . . I mean . . . I mean . . . that is, it is a baby.*

*TH: Baby?*

*PT: In there. It is not you, it's my mother.*

*TH: Mm hmm. Again you move to your mother.*

*PT: Well that is who I was really imagining, not you.*

*TH: So a sort of baby would come?*

*PT: Or whatever it is, I don't know what is in there.*

*TH: And what do you do with my damaged body?*

*PT: Help you up.*

*TH: Are you saying, in a sense, again in this massive rage toward me there is also positive feeling for me? Or which you are equally terrified.*

*PT: I need you.*

(The patient has become very sad, tearful, and highly charged emotionally.)

*TH: How do you feel, because I feel that in a sense your eyes . . .*

*PT: I feel sad.*

*TH: I feel there are some tears in your eyes.*

*PT: Yes, I feel sad. I am thinking of my mother.*

*TH: Right now?*

*PT: Yeah.*

We now meet the source of the anger which, as so often, lies in disappointed love:

*TH: What are your thoughts about your mother?*

*PT: Very sad (crying).*

*TH: Any thoughts that come to your mind? You must have a lot of mixed feelings there.*

*PT: Well, she did have a baby.*

*TH: She did have a baby?*

*PT: In her tummy, yes.*

*TH: Mm hmm. What happened?*

*PT: She had another baby when I was a year old.*

*TH: Mm hmm.*

*PT: And the baby was sick and she had to take her to the hospital and she left me.*

*TH: How old were you?*

*PT: One year old, 13 months. She left me with my Grandfather and my great aunt.*

Thus the Woman with the Machine Gun had the impulse to attack the therapist with her hands, and it was her hands she damaged in her self-punitive behavior; while the present patient had the impulse to attack the therapist with her right leg, and it was this leg that she damaged as a result of her inability to control her balance.

In summary, we see in this patient the same four features:

(1) Various forms of self-punitive and self-destructive behavior.

(2) Violent impulses toward her mother and murderous impulses toward the unborn baby.

(3) Intense guilt and grief.

(4) An impoverished personality. The ego has lost its autonomy in relation to punitive superego.

#### Brief Summary of other Relevant Cases

##### *Other Patients with Bruising of the Right Leg*

The patient just described was one of a series of 24 highly resistant and poorly motivated patients suffering from major characterological problems and episodes of severe depression. In this series there were two others who suffered from frequent attacks of staggering with bruising of the right leg. It so happens that both were female, and in both the traumatic experience was the mother's pregnancy when the patient was very small—one-year-old in one case and two-years-old in the other. In these two cases also the unlocking of the unconscious revealed an impulse to attack the mother with the right leg, in one case on the abdomen and in the other on the head.

##### *The Case of the Unwilling Moose Hunter*

This patient was one of a series which included patients suffering from obsessional and phobic disorders who had a hostile relationship with either their father or their mother. The striking feature of his recent history was that when seen he was in his third marriage, and that all three had been to women who were highly explosive and violent. Every day he was in a state of inner rage with his current wife, with a whole set of characterological defenses against his own violent impulses.

The history of his background revealed a sadistic father who frequently used to beat his son, laying him down on an ironing board. In the parents' marriage the mother was completely subservient and the patient formed an alliance with her against his father. When the patient was in his

twenties the father mellowed and showed a great interest in his son before he died.

After the unlocking of the unconscious the patient became highly emotionally charged and recounted the following incident: When he was a boy his father had forced him to come on a moose-hunting expedition. He had been unwilling to go but had complied. Some time during that day his father asked him to climb a tree and search the area with binoculars. He had refused and his father had become very angry and in a temper had climbed the tree himself, leaving his rifle on the ground. The boy had had the impulse to pick up the rifle and shoot his father, but as a defense he had developed weakness in his limbs. He told of this incident in a state of intense guilt and grief, at times unable to speak because of a tremor in his face.

Once more we see certain features common to all these cases: a repeated pattern of self-punishment, here taking the form of marrying violent women; and, lying behind this, violent murderous impulses in the patient's childhood, which were laden with intense grief and guilt. Another striking feature not yet mentioned is the resemblance between the marriage partner and the family member against whom the murderous feelings were directed. This has an important bearing on the origin of the phenomenon named by Freud the "compulsion to repeat," which will be discussed below.

### Part III: Discussion

#### The Relation between Suffering and Self-Punishment

Of course a life of suffering is intrinsic to chronic neurosis, but we need to ask whether there is evidence that these patients show behavior in which they actively seek suffering. Such behavior can be: (1) direct, in the sense of inflicting suffering on themselves, or (2) indirect, in the sense of causing others to do it for them.

As examples of (1) we may cite: (a) the self-inflicted damage to her hands in the case of the Woman with the Machine Gun, which occurred at least twice and was a quite conscious act; and (b) in other patients, a number of unconsciously based and apparently accidental occurrences, all of them also repeated, such as the bruising of the right leg in three women patients, the German Architect's two tree-felling accidents, and at least two avoidable and serious motor accidents in the case of the Man from Southampton.

Examples of (2), in which the patient causes other people to inflict the suffering, are found in: (a) the German Architect, whose pattern in relation to his father in his upbringing, and to all authority-figures since then, was to provoke them into retaliation; (b) two male patients, the Man from Southampton and the Moose Hunter, who married violent women, one three times; and (c) the Woman with the Machine Gun, who tried to seduce a man whom she knew to be cruel, with the result that she was exposed to severe humiliation.

Now it is possible to find alternative explanations for every one of these phenomena, if each is considered in isolation. For instance, the accidents could be described as the result of "carelessness" or chance; provocative be-

havior could be interpreted simply as a way of expressing aggression, which of course it is, with the induced retaliation no more than an inevitable by-product; the seeking of relations with violent or cruel partners could be dismissed as the result of poor judgment; and so on. But anyone who puts forward such alternatives is ignoring the true power of the argument in favor of the active seeking of suffering, which comes from the following sources:

(1) Patients like the Woman with the Machine Gun, who express anger in a way that injures themselves.

(2) Cumulative evidence from individual patients. Thus it becomes difficult to dismiss *two* tree-felling accidents as due to simple carelessness; or *three* marriages to violent women as simply due to poor judgment, or—to use an example not mentioned above—*repeated* self-injury to the same part of the body, as simply due to lack of coordination when under the influence of suppressed anger; and so on.

(3) Cumulative evidence from the sample as a whole, in which there is an *overall pattern* of behavior that can only be described as self-injuring or self-destructive, the details of which vary from one case to another.

(4) Finally, there is the correlation between the part of the body that certain patients injured, and the part of the body used for fantasized attacks. Again, each individual case can be ascribed to coincidence—after all, the parts of the body that can be used in physical attack, or are likely to get repeatedly injured, are fairly limited—but *three* patients who both injured their right leg, and used the same leg in fantasized attacks on their pregnant mother, carry the argument in terms of coincidence toward the edge of credibility. Moreover, this evidence suggests something more specific than simply the seeking of *suffering*, namely the seeking of *punishment*.

#### The Underlying Reasons for Self-Punishment

In all these patients we find the same set of phenomena, namely *violent and murderous impulses toward close members of the family*, which are laden with intense guilt, remorse, and grief. The inference that it is these impulses that lead toward the need for self-punishment then becomes almost inescapable.

#### Impoverished Personality, Sterile, Destroyed Relationships

The evidence for (a) impoverished personality, and (b) sterile or destroyed relationships in all these patients is overwhelming. Obviously, they condemn the patient to a life of suffering, and impoverishment of the major ego functions. There can be little doubt that part of the explanation lies in the operation of *defenses*: (a) the repression of sadistic impulses, intense guilt, and grief, which means the loss of immense and essential areas of the personality; and (b) the avoidance of emotional closeness for fear of a repetition of earlier disappointments, which makes fulfilling relationships impossible. On the other hand the evidence for feelings of guilt and self-punishing

tendencies in these patients is so great that it seems difficult to believe that these defenses are not reinforced by the need for suffering. This will be discussed in length in a later article, "Ego and Superego and the Problem of Resistance."

#### The Ego and Superego

If we assume that one of the main functions of a "normal ego" is to enable an individual to achieve satisfaction and fulfillment and to avoid pain, then these patients behave as if their ego has lost much of its autonomy and functions and has been taken over by some alien, all-pervading, self-destructive force. We can add that beneath this, in all these patients, we have found violent and murderous impulses against close members of the family, and profound guilt, remorse, grief, and pain.

Thus we reach evidence not only for Freud's concept of the punitive superego, but also for the mechanism underlying its formation. This latter consists of *self-punishment for murderous impulses*, which are laden with intense guilt and grief.

#### Grief and Love

It is important to emphasize that guilt is not the only emotion accompanying these impulses. In all our cases there is also a mass of related, much more "positive" feelings, consisting of grief, remorse, love, and (Winnicott's term) concern, and there is also strong evidence for *disappointed love*. Some of these feelings are epitomized by the German Architect's deeply felt statement, "I don't want to punish them any more"; or the statement made by the Woman with the Machine Gun, "There is no way I can care for you as much as I care for my family. If they hurt me it hurts more than if you hurt me"; or that made by the Woman who Bruised her Thigh, "I need you"; and many other examples.

It is clear that these positive feelings, which themselves are unconscious, supply much additional power to the repressing forces. This also raises the possibility that part of the function of the self-punishment is to express love—"I would rather hurt myself than hurt you"—and, by directing the aggression inwards instead of outwards, to protect the people against whom it was directed originally.

#### The Superego and the "Compulsion to Repeat"

The discussion of this subject may be approached through the Case of the Moose Hunter. This patient had married a succession of violent women, against whom he was in a constant state of suppressed rage; and in his background it emerged that his father was violent and sadistic, and that the patient had entertained highly guilt-laden murderous impulses toward him. Thus in his recent life the patient was exposed daily to the same kind of conflict as he had experienced in his upbringing. Could it be that there was some force at work driving him to choose partners who resembled his father?

This is not an isolated observation. In the case of the Man from Southampton we saw that the father was punitive and frightening, and the patient married a woman who smashed the television and attacked him with a chair. This observation is a universal phenomena in all our patients suffering from character neurosis.

Moreover, there is a corresponding observation in both sexes in relation to the mother. In a series of severely neurotic, highly resistant, and poorly motivated patients, we have found the following:

That when the mother was demanding, critical, and punitive, there was a resemblance between the *wife* and the mother in the case of men, and between the *husband* and the mother in the case of women.

These patterns are still more striking when there has been actual physical abuse, in which case there is an even greater need for masochistic suffering. In spite of their best intelligence these patients tend to choose partners who use and abuse them, and each time they escape they quickly find someone else to do the same, thus going "from the frying pan into the fire."

These are all examples of what Freud, in *Beyond the Pleasure Principle* (Freud, 1920), named the "repetition-compulsion" (the literal translation of the German compound word *Wiederholungzwang*) which was later retranslated by James Strachey into the less unwieldy term "compulsion to repeat." His view of this extremely obscure phenomenon was that it represented the ego's attempt to master the traumatic situation, and although this explanation does not seem to be entirely satisfactory, so far no one has since come up with a better one. The evidence from our extensive clinical data indicates that at least part of the compulsion to repeat involves the superego, and represents the need to suffer as a punishment for the violent and murderous impulses found so frequently in patients suffering from severe character neuroses. This whole subject will be discussed at length in a later article, "Clinical Manifestation of Superego Pathology, Repetition-Compulsion."

#### The Question of Self-Directed Aggression

As was mentioned in the introduction, punishment is an aggressive act, and therefore self-punishment must by definition involve self-directed aggression. The clinical material presented here certainly confirms Freud's view that the superego is as sadistic as the patient's id. On the other hand, in these cases at any rate, there was little or no detailed evidence that it was the *same* underlying impulses that were expressed by the patient both against the outside world and against himself. We can illustrate this with the Woman who Bruised her Thigh: This patient's fantasized attack was on the mother's abdomen with her leg and if she was going to direct these impulses against herself we would expect that she would find some way of bruising her own abdomen. In fact, of course, it was her leg that she bruised, which obviously represents *self-punishment* but does not seem to represent the *turning of her own impulses against herself*. Equally, the German Architect did not slash his own wrists, and the Moose Hunter did not have the impulse of shooting himself. This means that, in these patients, whereas the description of *self-punishment* for *aggressive impulses* is obviously correct, the description

of turning the aggressive impulses against the self does not quite seem to fit the evidence.

#### The Time of Origin of Neurotic Conflict

All our clinical material confirms one of my most fundamental general findings, namely that the vast majority of neurosis stems from the patient's conflicting feelings within family relationships, and is laid down at the time when the child is already aware of the existence of members of the family in addition to his mother, including, of course, a sibling not yet born.

#### The Role of the Oedipus Complex in the Formation of the Superego

It seems that Freud believed the superego to develop relatively late, and to be invariably bound up in both sexes with the Oedipus complex. In his last major work, *An Outline of Psycho-Analysis* (Freud, 1940) he wrote: "The super-ego is in fact the heir to the Oedipus complex and is only established after that complex has been disposed of" (Freud, 1940, p. 205). The implication of this statement is that the only source of guilt in human beings consists of incestuous feelings for the parent of the opposite sex and hostile rivalry for the parent of the same sex. Our systematic research data using the technique of the unlocking of the unconscious surely demonstrates that this view is quite erroneous. Of course Oedipal conflicts are a major source of guilt, and in the clinical material presented here there is no doubt that murderous impulses toward the father in male patients, and toward the mother in female patients, play a prominent part. But where the father has been punitive and the mother passive and distant, as in the case of the German Architect, the murderous impulses would seem to be more obviously explained as a retaliation for the father's sadism rather than an expression of rivalry for the mother. Moreover, in cases such as the Woman who Bruised her Thigh, the murderous impulses indeed had their origin in a situation of jealousy and rivalry, but one that had nothing whatever to do with the Oedipus situation, namely the threat of being displaced in the mother's affection by the birth of a sibling; and, since this event actually occurred when the patient was 13 months old, it long pre-dated what Freud, though not Melanie Klein, would regard as the Oedipal period. Freud's narrow view of the origin of the superego is surely one of those that should be assigned to the historical museum.

#### Conclusion: The Role of the Superego in Neurosis

Our extensive clinical data emphasizes the immense importance of the punitive superego in the causation and maintenance of neurosis. The technique of unlocking of the unconscious and the direct view of the core neurotic structure indicates that all patients suffering from character neurosis who are highly resistant and poorly motivated have a punitive superego which have eroded their ego function and have impoverished their character structure. In cases of severe character neurosis, patients with highest

level of resistance, what we see is the invasion of ego functions by a harsh punitive superego with much more impoverishment of patient's personality. Our work in Intensive Short-Term Dynamic Psychotherapy highlights the importance of directing attention to the weakening of the punitive superego, and particularly its major contribution to resistance, as an essential part of a therapy. This is something that has been lost sight of by psychoanalysts and dynamic psychotherapists.

On the other hand, careful reading suggests that Freud did not underestimate the importance of the superego in his later writings, as is shown by two further condensed quotations from *An Outline of Psychoanalysis* (Freud, 1940, pp. 172-173):

The severest demand on the ego is probably the keeping down of the instinctual claims of the id. But the demands made by the super-ego too may become so powerful and so relentless that the ego may be paralysed, as it were, in the fact of its other tasks. We may suspect that the id and the super-ego often make common cause against the hard-pressed ego which tries to cling to reality in order to retain its normal state. If the other two become too strong, they succeed in loosening and altering the ego's organization, so that its proper relation to reality is disturbed or even brought to an end.

Our plan of cure is based on these views. The analytical physician and the weakened ego of the patient, basing themselves upon the real external world, are to combine against the enemies, the instinctual demands of the id and the moral demands of the super-ego. (Strachey's 1949 translation)

These ideas of Freud's have been entirely confirmed by my work. Indeed the whole concept of the superego, as expressing a need for punishment for aggression and yet itself being partly derived from aggression, appears to be one of the most essential both in the theory of neurosis and the practice of Intensive Short-Term Dynamic Psychotherapy.

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