CHAPTER 11

A NEW THEORY OF THE GENESIS OF SYMPTOMS

Most have the seeds of judgement in their mind:
Nature affords at least a glimmering light;
The lines, though touched but faintly, are drawn right.
But as the slightest sketch, if justly traced,
is by ill colouring but the more disgraced,
so, by false learning is good sense defaced
Some are bewildered in the maze of schools,
And some made coxcombs Nature meant but fools.

Alexander Pope, 1711,
An Essay on Criticism, Part I

In the beginning, the parents created the children,
and their psyches were without content,

and the parents said,
"Let us put there what they need."
But they had had difficult families, and
the problems were never resolved, and
the parents had needs of their own, and
they "put" them "there" instead.

Though wishing to offer light,
they could not provide it.

So darkness from their objects' depths
stripped the children of conceptual norms,
and their world was so till about the seventeenth year
when the parents ended their work.

Anderson, 2001,
Reflections on Creation

INTRODUCTION

This chapter will describe how real parental objects and infant/child selves feature in particular types of interactions that produce symptoms in the children. Some of the ideas that I will present are quite new, while others will be familiar. However, those that are operationally accepted by some analytic

workers are usually not declared official theoretical beliefs. They sit in shadows and are dominated by other conceptions that contradict them. The problem is one of *"faintly touched lines, justly traced right, then bias-coloured, and lost from sight"*, and it is one that this chapter aims to correct.

Multiple Theories and Theoretical Muddles

The roles of the "real objects" in the genesis of symptoms have not been readily accepted by many psychoanalysts whose clinical presentations indicate that they adhere to the infant/child "self-produced-conflict" theories of Freud and other analytic pioneers. References to the symptom-generating effects of actual caretaker objects can be found in their works but they are commonly paired with the original Freudian (or so-called Classical) theories of "innately unfolding developmental conflicts", and the latter ideas are awarded the greatest causal weighting.

The impression created is one that is common in several general areas of analytic theorizing. It is as if two very different explanations for the initiation of a single beginning can and should coexist in illogical bliss forever. It is not a matter of sequencing, that is, first one factor, then another. It is neither the child's "anal-sadistic faecal retention" followed by an angry parent, nor "the impatient parent" followed by an opposing child, protective of his(her) autonomy. It is both, and it is an unseparated muddle of aetiology.

Time, observation and good reasoning are pulling actual parents out of the tangle into the causal foreground, but they are being forced to tug inconspicuously and exercise reserve and diplomacy. It is as if a royal decree had granted the earliest theories decades to adapt to the fact that they were not the perfect constructions of a genius but only groping beginnings. It is as if the findings of a new science had been warned that they would only be accepted at the palace if they outwardly deferred to their incompatible cohabitants. Lip-service obeisance to the king's edict would suffice. A mere show of fealty would be what mattered most.

Science Replaced by Politics in Current Psychoanalytic Theorizing

In my opinion, this type of two-tiered explanation with one cause esteemed and the other treated as a poor-sister family secret, has been the product of analytic politics. At the formal, institutional level, the profession tolerates and even champions the idea that several theories for explaining the same phenomenon can be valid. The motive appears to be to keep the disparate "schools" of psychoanalysis together in an international organization. But why should such a scientifically-costly goal be desirable? To anyone

committed to the thrill of original discovery, political statements at international so-called "scientific" meetings are easy to recognize. They dull the ears of curiosity and interest. All promise of exciting search at the edge of knowledge turns to the numbing boredom of a clutching revivalism. Serious critiques fall back from expression because roles have been prescribed. And contradictions continue on their scientifically unmerry ways.

The "multiple theories" myths and the contradictions they permit are two unfortunate facts of analytic life, and only a few bold critics have taken their proponents to task. Yorke (1985, p.236-7) has pointed out that almost any issue of any analytic journal contains points of view that are completely at odds with each other. And Paniagua (1995) has criticized the popular but unexamined belief that all theories work equally well with the same material. The latter author even subjected a segment of his clinical work to examination by colleagues of different theoretical persuasions, and the results showed (p.361-365) that different metatheoretical positions produced different theories of technique. The experiment provided concrete evidence (p.359) that countered Wallerstein's (1988, p.13) notion that analysts of different theoretical leanings do comparable work and facilitate the same orders of clinical change.

Freud Shifted from Science to Politics, and Took His Science with Him

The scientific position was well put by Freud, himself, early in his career. Fenichel (1945) reported that, in a discussion of the aetiology of Hysteria, he (Freud) (p.32):

> "compared psychoanalysis to a jigsaw puzzle, in which the aim is to construct a complete picture out of its fragments. *There is but one correct solution.* So long as it is not discovered, one can perhaps recognize isolated bits, but there is no coherent whole." (my italices)

The same thing should be said of theories in general. When two theories purport to explain the same thing, either one of them is wrong or each applies to a different part of the as-yet unexplained whole. It would therefore make sense to test their hypothetical underpinnings and work at the problem until new data brings in a verdict.

Freud (1913) once spoke in this vein, too, saying (p.207):

> "psycho-analysis is not a child of speculation but the outcome of experience; and for that reason, like every new product of science, is unfinished. It is open to anyone to convince himself by his own investigations

> of the correctness of the theses embodied in it, and to help in the further development of the study."

However, seven years later one finds a weakened adherence to that credo, and a mind-set that has shifted from science to something else. In 1920, he started to assert that acceptance of the Oedipus Complex was the mark of a psychoanalyst, exclaiming (in a 1920 footnote appended to 1905 paper, "Three Essays on the Theory of Sexuality") that (p.226):

> "With the progress of psychoanalytic studies, the importance of the Oedipus complex has become more and more clearly evident; its recognition has become the shibboleth that distinguishes the adherents of psycho-analysis from its opponents."

The language Freud uses in this declaration gives the matter of "adherence" overtones of, *"Are they for us or against us?"*.[1] "Shibboleth" was a word used by the Gileadites to distinguish an Ephraimite enemy. The Ephraimites could not sound the "sh" in the word, and when they spoke they made themselves known as the foe. The word "opponents" also has connotations of *"enemies and combat"*.

Freud's championing of the Oedipus Complex shows a *general* shift in his thinking. It is also an example of how he took wide turns with his theories of *symptom genesis* and took the other early analysts with him[2]. Like the Merton Gill with the workshop participants of my last chapter, he illustrates how the unscientific bias of a powerful theoretician can shape a basic belief in other members of the analytic discipline. And in this case in particular, it reveals how a cherished speculation began to engulf and close on the scientific question of whether it is the objects or the infant-child selves that initiate and drive the formation of character and neurotic symptoms during early child development.

In the course of the theoretical progressions described, the prevailing position on symptom genesis became one in which the *child* started the conflicts that led to his(her) own internal troubles. However, that viewpoint was not the consequence of science-based discoveries. It emerged and established itself as a result of socio-political forces and the group pressures they carried with them. When Freud for reasons of his own developed an affinity for the "enterogenetic" idea, institutional psychoanalysis took on the belief that the parental objects that infants and children internalized were projectively-created self concoctions. The characters of the real objects and the interactional behaviours they issued, began to have little or nothing to do with the representations of those figures in the child's psychic structure.

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[1] Here, I must assume that his expression was retained in the translation. But in any case, what is written and publicized opens itself to critique whether it be accurate translation or not.

[2] They were not called his "followers" for nothing.

In the same footnote cited above, Freud more or less said as much when, speaking of "the sexual fantasies of the pubertal period", he claimed that they were:

> "distinguished by their very general occurrence and by being to a great extent independent of individual experience."

Cherished Beliefs Interfere with Assisted Self Research and Theory Development

Conceptions in the order of the Oedipus Complex have taken a long time to come under the scientist's methodological knife, and during the interval many analysands have had to accept such ideas from their analysts as:

1. There is such a thing as an Oedipus Complex.
2. You have one.
3. It is the "nuclear complex of your neurosis" (Freud, 1905, footnote added in 1920, p.226).
4. Your parents did not initiate the conflicts that gave rise to your symptoms.
5. You did.
6. And to get better you must give up your rivalrous strivings.

During my analytic training, I was taught that one developed an Oedipus Complex if one had the most benign, neurosis-free parents. It was also suggested as a source of my own symptoms during my training analysis. I accepted the latter idea, too, even though it had no ring or resonance of experiential truth for me at the time.

It was not until well into my subsequent self analysis that I was taken to the depths of what had really produced my lifelong torments, and no conventional analytic theories directed me there. To discover the childhood experiences that had moulded my character and a variety of "neurotic" symptoms, I had to identify and challenge unchecked traditional theoretical assumptions. And when I asked questions about the concepts I had been taught, untested beliefs emerged in abundance from the theoretical woodwork, the Oedipus idea among them.

Unfortunately, Freud's beloved notion still continues to determine analytic outcomes to this day. It re-routes journeys that lead to the depths of infant memories and prevents analysands from getting at the true sources of their symptoms. I have heard trained analysts say to me, when faced with current conflicts, *"I must watch my Oedipus Complex."*. It was obvious that

their analyses had ended with that idea accepted as the explanation of their woes

The Oedipus idea also stymies institutional growth. As a young analyst, my reasoning was taxed beyond its limits at one point in my local Societal experience. A non-training analyst majority had arranged a meeting in an attempt to recover powers that an earlier generation had given to an autonomously-operating Institute of training analysts. Before the event, I was invited to discuss the issue with a group of Institute members, and my proverbial "penny" began to hover over its slot. And as it became clear that I was being lobbied, it entered and began a slow descent. Then, at the meeting, as I listened to the complainants putting their case, a further experience caused it to hit bottom and open the door. An Institute member sitting beside me whispered that *"it was too bad they had not finished solving their problems with their fathers"*, and all obstruction to relieving insight into institution-style, non-reasoning, problem-solving methods was removed.

In Chapter 6, I spoke of the fact that the parents of analysands have often insinuated "Standards of Convenience" into their SEEI structures, and the above example indicates that organized psychoanalysis has matched the act with at least one "Theory of Convenience".

Critical Examinations of Theory Have Been a Long Time in Coming

It has only been a recent and seldom occurrence in psychoanalysis for theorists and practitioners to ask for proofs of established ideas. Simon, for example, in the preamble to his 1992 paper, *"The Oedipus Complex: A Reevaluation"*, referred (p.641) to obstacles standing in the way of settling the scientific status of the theory, among them being:

1. The political controversiality of the issue;
2. Problems with psychoanalytic criteria for establishing the validity of theories.

Freud's Non-Science: A Tradition that Lasts and Resists New Developments

While the first analysts apparently took note of actual parental behaviours, they did not adjust their fundamental theories accordingly. In their writings they refer to the parents and speak of symptoms as the result of problematic interactions with their children, but the real objects do not emerge from their pages as the main sources of neurotic conflicts in the offspring selves.

Fenichel (1945), for example, devotes pages of his section on the oral stage to (p.63) *"oral eroticism"* and its *"first aim"* of *"the pleasurable autoerotic stimulation of the erogenous zone and later the incorporation of objects."*

He also refers briefly to the factors that create fixations (p.65), namely, *"excessive satisfactions"* and *"excessive frustrations"* - both phenomena being obvious results of object activities. But not much is said about what the parents did to produce the phenomena, and nothing is said about what, in the objects themselves, led to their symptom-generating (i.e. fixating) behaviours.

Fenichel further refers to the role of reality in the development of some of the most (p.64) *"fantastic"* of the *"oral-sadistic fantasies"*, saying that *"they ... express ways in which an undeveloped archaic ego perceives (and misunderstands) a frustrating reality"*. But he does not go into the features of that "frustrating reality" or the questions of who or what creates it. Nor does he discuss what has caused the infant-child to misperceive it.

Of course all that I have described here could be considered "condition normal" for a program of scientific research. Scientists begin with a piece of a larger puzzle, and they are not required to speak to its other parts for a while, perhaps even for many years. However, one does not expect them to take as long as has been the case in psychoanalysis. Nor does one expect them to show the level of opposition to new observations that is characteristic of its tradition. Had analytic research followed the type of course taken by the other sciences, many of its old speculative theories would have given way to testable new certainties long ago. In the area of symptom genesis, for example, earlier attention to the observable facts of family life would have led researchers to scrutinize the roles of the actual parental objects. They would then have spotted their unchecked assumptions, abandoned the use of suggestive interpretations, and set about helping analysands recover material that threw direct light on the subject.

The Obvious Ignored, Freud's "Analyst as Detective" Ideal Propagated, Scientific Methods Rejected, Symptom Genesis Research Delayed

The discoveries of infant observation are vividly indicative of the very real and primary roles that parents have in the trouble-bound moulding of child selves. One simply has to watch a taped segment of a modestly-troubled family's interactions for a few moments before being thoroughly impressed by the concrete signs of a conflict being introduced by one or other (or both) of the caregiver(s).

But if one is an interested observer of everyday family life beyond the experimental situation, *formal* observations are not even necessary. Casual notations of parents in engagement with their offspring rapidly reveal the

symptom-generating behaviours of the adults. Twenty-five years ago, as I sat in a restaurant waiting to go to a committee meeting, I was startled to hear a father tell his four-year old son that if he did not stop fussing and fidgeting he would call the police to take him away. The boy - who was obviously tired and bored because of the time of evening and the long dinner - abruptly pulled himself together with a look of terror on his face. And on another occasion, while visiting a distant relative, I became much distressed as an infant daughter was repetitively frustrated by her parent while trying to soothe herself by sucking her thumb. When the thumb went in the mouth, the mother angrily pulled it out, while telling me proudly (and assuming that I shared her idea) that there would be *"none of <u>that</u> stuff"* with *her* children.

Analytic clinical reports in the literature also describe problem caretaker objects that infant-child selves have internalized by means other than the operations of undeveloped, *"archaic egos"*. For example, the parents that emerge to view during treatment can be unqualifiedly portrayed as *"cold and rejecting"* or *"absent and passive"*. However, in such reports, they are usually not designated to be the initiators of symptom processes in their progeny. The internalized self-and-object conflicts of analysands are still commonly thought to be rooted in developmental-phase processes in the children and phenomena that are only secondarily (if at all) influenced by the caregivers.

Freud-originated theories of symptom genesis (e.g. the “Classical” Theory and theories like Klein's that have been significantly influenced by it) continue to be applied in current formulations of symptomatic material. Many paper presentations indicate that Freud's antiquated beliefs are still held, and that interpretations based upon them are still suggested and even imposed. Too often it is the analysts and not their consultees who "discover" and "reconstruct" the origins of the conflicts that lie in the buried depths of symptom-producing childhood experiences. There is no primary focus on assisting them with the systematic identification and dismantling of defense systems in order to release what lies under them. They are too often *told* what went on at times that are not yet free to emerge to direct view, and they are not expected to be able to recover objective perceptions of their original objects from a time when their symptoms were first developing. And their perceptions of the parents that *do* spontaneously emerge in the course of free-associative efforts are still often treated as projections of self parts.

At this time of the analytic theoretical ethos, a researcher would become a psychoanalytic outcast if he(she) were to set about testing the idea that the phenomenological roots of symptom-producing object-self conflicts could remain in memories or "part-memories" that could be released to scrutiny. And an examination of the further idea, that a gradual devolution of object-representational details in the transference to genetic origins could release such memories, would not be popular. The common traditions of practice do not support such clinical investigations, thus clinicians and their analysands

never get a chance to even *suspect* that memories of the moments at which symptoms were laid down can be recovered.

Institutional habits that sanction the use of unassessed theories to create "reconstructions", determine that interest in their validity, and in the clinical research that could decide it, be dropped in favour of a Freud type of detective work. A dream "cigarette butt" in the associative "ashtray" is all the clinician needs to drag some derivatives from his own conflicted mind and set about conjecturing. And as his conjecturings become certainties and are internalized by the unwitting analysand, the latter becomes the murderer of his own soul. When his spontaneous material directs him to his real objects, he thinks he is avoiding recognition of forbidden impulses and attributing them to the innocent. It is no longer important that he was at the "scene of the crime". It does not matter that if he had continued his self exploration without such formulative interference, a closet might have opened to show troubled objects holding dripping knives.

Reasonable inference and even Classical theory itself is calling for a complete revision of the technique of reconstruction using untested data-distant theories, but institutional psychoanalysis has its fingers in its ears. I will use two examples from the literature in a particular area of symptom work to illustrate this point.

Examples in the Area of Dream Analysis

This part of the large book has been omitted to suit the limited purpose of the subject in the website's goal.]

A Repair of Misdirected Methods of Clinical Research

The M.I.-M.F. methods, when used to carry out clinical researches, offer skeptics of existing symptom-genesis beliefs a refreshing opportunity to exercise curiosity without the bindings of political correctness and symptomatically-attractive convention. Because interventions are of the minimalist, data-close and single-inference variety, they do not force premature closure on any theoretical questions. They allow analysand and analyst to systematically proceed to the facts of the symptom-bearing SiC's[3] internalized experience.

[3] The MF Methods' short form of the analysand's "Self-in-Contact", the self organization that engages the analyst in sessions (e.g. that has operative transferences to him/her).

As the analysand, Valerie C., said in her fifth year of analysis and after having moved through successively-appearing layers of serious and sometimes totally disabling symptoms:

> "This is truly amazing! We have rolled right into, through, and beyond, the things that one usually takes to be the roots. You remember when I thought for sure that you would see all the usual stuff about Oedipal fantasy in my associations? And then I was convinced, for a while, that I had been molested by my baby sitter? And after that, I thought we had reached bottom when ... ".

An experience of this order, after long periods of mutual toil, is exciting for the analysand, the analyst, and psychoanalytic theory-making. It precludes the possibility of premature (and false-memory type[4]) closure on the question of the roots of symptom genesis by taking the analytic duo to murky depths of remembered real experience where true beginnings are laid bare. When the hard facts of early genetic material are emerging before the eyes of the suitably-intrepid twosome, the less admirable elements of psychoanalytic theorizing lose their power to distract. The stale fares of personal bias, group constriction and political interest slink off the stage from which they are crowding science, and convention is overthrown by new and independent possibility.

THE NEW THEORY: IN FOUR BASIC CONCEPTUAL PARTS

PART #1

A: Real Parental Objects with Neurotic Symptoms

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[4] In certain respects, some of Freud's theories are analogous to the "premature explanation and closure" phenomena of the False-Memory Syndrome, and I would hypothesize that the reasons behind them are of the same order as those responsible for that condition. The premature ending of Freud's self analysis, the persistence of his severe character and neurotic symptoms, and the emergence of his emotional insistence on enterogenetic theories like the Oedipus, suggest a psyche that is seeking rationalizations for ending exploration into threatening depths.

This is not a criticism of Freud's level of courage. It is an effort to help a new breed of analytic thinkers challenge the institutional habit of treating the original discoverers as supermen and women, "geniuses" who can supply the unmet needs of later generations, ambivalently-held "masters" who can and will guide and protect them from the terrors of their depths. It is an attempt to have them treated as interesting, respected figures who launched wonderful new intellectual adventures by the "gropings" I referred to earlier in this chapter**. [Note, 2014: And the total overthrow of all such people and their theories by later movements from objective to subjective (e.g. "Freud is dead!" i.e. his theories are all wrong] is s similar problem at the opposite end of such irrational thinkings.]**

That the real objects and their real behaviours are the beginnings of symptom developments in the infant-child, is one conclusion to which the researcher is led when using the M.I. and M.F. methods. In the case of symptom genesis, the parent acts, and the child reacts[5].

But what determines the parental actions that lead to conflict and symptom development in the children? And how do they produce their effects?

The answers begin to take shape when systematic work with layered transferences takes the clinical explorers to the representations of the original object-self conflictual events from which they were derived. Then, the actual object activities and self responses that were internalized in the moments preceding the onset of symptoms become directly observable. And what is revealed is that at least one caretaker object[6] has frustrated a naturally-evolving need of the infant/child's developing self while at the same time requiring it (the self) to gratify an inappropriate (i.e. neurotically-determined) need of its (the object's) own.

But how does such a situation develop? And how does it produce symptoms?

The details come together when further analytic work enables the analysand to systematically explore his(her) symptoms at beginning bedrock level. Then they are noted to be the results of interactions initiated by a parent or other primary caregiver, and driven by a neurosis (and sometimes a psychosis) in him(her). Character neuroses are the chief culprits, and they are sometimes combined with a symptom neurosis. But in all cases an afflicted object self incorporates the infant-child's developing self into service in a pathological effort to achieve a measure of psychic homeostasis and relieve its own symptoms.

As details are accumulated, the behavioral manifestations of the parent's intrapsychic structure-processes at the times of symptom genesis also become clear. The child self's memories (including "part memories" of "part objects" by "part selves") of the actual parent are spontaneously released when the analysis of defense systems allows them to emerge. It is then further observed that the *parent's* symptoms were the product of similar object-initiated symptomatic interactions on the part of his *own* parents. That is, the parent of the analysand internalized *his* problem parents during development, then, years later, projected objects and self properties on his child at various stages

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[5]It should be understood that I accept without question that the "reaction" feeds back to, and influences, the "action". But here I am chiefly concerned with how conflicts leading to symptoms are initiated. It should also be taken for granted that no "blaming" of parents is involved in what I am discussing. Science is not interested in finding faults, and as one of its strong proponents neither am I.

[6]Sometimes (in my experience, more often than not and perhaps always), internalized moments of problematic interaction with a single object are accompanied by synchronous internalizations of other objects. This point is the nucleus of a new theory of transference layering that will be described in detail in chapter 14.

of his(her) growth and generated the conflicts that led to the analysand's symptoms.

When the analysand's infant-child self is released to direct view, it might be found imbedded in a parental acted-out defense system, an agent of protection of the neurotically-vulnerable adult's self. Or it might be the transference-determined gratifier of an unmet need. Or it could be the inheritor of multiple object transferences from the same internal parent - a victim of contradictory demands to inhibit and express at the same time. It might also be the target of a self projection (a "self transference") that requires it to inhibit what the parent is unable to contain in himself. Or it might be saddled with another version of that type of projection, and be busily giving expression to a parental drive that a problem object in the adult's SEEI has forbidden him to have.