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THE CORE OF ANALYTIC psychotherapy, both individual and group, consists of the working through of the transference relationships which arise and change form, shape, and intensity during the course of therapy. One of the most important advantages the group analytic setting has over that of individual psychotherapy is that it offers patients a multiplicity of transference objects, that these multiple relationships in the reality of the group impinge on the patient, and that in the group setting unusually high and low levels of anxiety do not necessarily prevent patients from experiencing transference relationships of great intensity. In individual psychotherapy and psychoanalysis the formation of strong transference relations is often interfered with by such character defenses as isolation of affect. Certain patients are very slow in seriously involving themselves in the psychotherapeutic process and may fail altogether to form a strong transference relationship to the therapist, thus making therapy of questionable value and sometimes only of temporary benefit. Similarly, unusually high levels of anxiety also often impede the formation of strong transference relationships, thus affecting the chances of success of psychotherapy.

The shifts in transference in individual psychoanalysis and psychotherapy are often slow, and the basic transference theme may last for months and sometimes longer without much basic change. In the analytic group, on the other hand, transferences are much more fluid, and their

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nature changes much more quickly. Although working through is easier in individual therapy, the group setting offers these transference shifts as a distinct advantage to the patient.

My experience of working with patients both in individual and group therapy has led me to the conviction that, contrary to general belief, many patients experience a great deal more difficulty in expressing their libidinal feelings toward the therapist and other patients than their aggressive wishes and impulses. Perhaps because of the generally acceptable levels of violence in our society, many patients are able eventually to express raw aggressive impulses toward both the therapist and other patients, including details of murderous wishes, with all degrees of cruelty. On the other hand, tenderness and love feelings are expressed only with great hesitation, are sometimes not verbalized at all, and occasionally may be denied altogether. It is indeed sad to note that this may well be not only a result of, but also an important causative factor in, the prevalent feelings of alienation in our society.

The following clinical case illustrates a situation unique to the group setting in which the working through of positive transference feelings was made possible only after the introduction of an additional transference object.

D. E., a woman in her early forties, was first seen because of marked depressive episodes occurring over a period of many years. She had gained more than one hundred pounds during the current such episode which had been going on for approximately three years. During those years she never answered the phone, never left the house, never answered the doorbell, and peered out of the house only through closed shutters. Inside the house she was moody but efficient in terms of carrying out the responsibilities of a mother to several growing children, and she was a not unwilling sex partner to her husband. Eventually, however, her relationship with her husband and children also deteriorated, and she sought psychiatric help at her husband's insistence. She had had a previous experience with psychoanalytic psychotherapy lasting for several months. No positive rapport was established, however, and the strength of the negative transference reactions caused her to leave therapy with much disappointment and pain.

In the course of individual therapy with the present author, which preceded her entry into a group by about a year, it became obvious that

the patient had serious unresolved problems concerning her female identification. The patient had grown up in a puritanical Southern family in which all expressions of sensuality were considered sinful. Not only were card playing and drinking taboo in the house but also the wearing of make-up and anything but the simplest and most modest and tasteless of clothes. There was very little communication between the patient and her siblings and parents, except in a most matter of fact way that was often tinged with much hostility.

The almost total lack of openness in interpersonal relationships and the many double-bind messages had caused rather severe emotional difficulties in some of the other siblings, one of whom had ended by committing suicide. The mother was seen as a good woman, quiet in the suffering she experienced at the hands of her husband. Abusive and loud, the father was remembered mainly for his cruel beatings of the patient which she was however completely at a loss to account for. She had no pleasant memories of the father, from whose abuse she had allegedly fled by running away from home at age fifteen.

It did not take long in therapy for the patient to see that it was her mother who had completely rejected her, although never openly, and who had envied and undercut any expression of femininity in her. The father's outbursts, although violent, were the closest form of relationship that she had had. Of all the children, she resembled him most physically and was considered by others to have been his favorite. Furthermore, she became aware in therapy that many of his outbursts must have been induced by his need to ward off his sexual attraction to the patient. Even more troubling to the patient was the fact that it became increasingly obvious that, in many ways and completely unconsciously, she had been seductive toward her father in an effort to get some of the affection that was in such short supply in the house. The more seductive she had become, the more had the father become brutal and the more had the mother become rejecting and hostile.

As these developments were worked through, the patient became more and more able to express freely and openly her anger toward the therapist, who represented both father and mother at various stages of therapy. When combined therapy was initiated, her outbursts at the therapist and at other patients in the group were violent in temper and obviously

reminiscent of her father's, although the patient's controls were good and she was able at all times to remain verbal. She became less depressed and lost over sixty pounds; her mode of dress became more colorful and womanly; she was no longer confined to the house and even acted as a chaperon at a high school dance for two of her sons. At this point, however, her therapy came to a standstill; she was completely unable to proceed for months, and, discouraged, she felt that perhaps she had received maximal benefits and was ready to quit. She was obviously unable to work through her oedipal wish for the father, only a few glimpses of which she was able to catch before it was repressed again.

After several months of combined therapy in which very little happened in terms of the patient's progress, a psychiatrist was invited by the author to visit this group for one session. The patient very strongly resented both his coming and his manner. She felt that he acted disrespectfully to the group, that he took advantage of his visiting privileges, and that he was cold, arrogant, and nonfeeling. By contrast, she and the group praised the regular therapist, remarking on the differences in personality and claiming that their own therapist was warm, empathic, and more understanding and giving than the visitor. This led to more open expression of libidinal feelings, and eventually this patient, as well as a few others, was able to produce dreams that expressed her oedipal conflicts much more directly than ever before.

The turning point came after a session in which the patient again expressed much unrestrained anger at the visiting therapist. That night she dreamed that she was taken by ambulance to a hospital, that her regular therapist was with her, and that she found herself tied in a bed with raised guard rails. She realized that the therapist was sitting at the head of her bed, keeping vigil and apparently very much concerned about her welfare. She softly called him, and as he untied one arm and then the other, she noticed a very soft, fatherly look on his face and a tear in the corner of his eye indicating that he was very much saddened over and concerned about her predicament. In the dream the therapist softly touched the patient's hair and kissed her lightly on the mouth. This was reported to have been the end of the dream, the patient adding that she knew it was an innocent, fatherly kind of kiss, the kind given to a child. She spontaneously associated that the bed guards made the bed

look like a crib and added that she felt as if she were three or four years old. After awhile, with much embarrassment and hesitation, she reported what she had forgotten before: that this fatherly kiss was returned by her but it became passionate and had obvious sexual meaning and intent. The therapist was reported to have been surprised and eventually sexually aroused. It was through this dream and its associations that the patient began to recognize and work through her forbidden impulses to possess the therapist-father.

This was a turning point in the patient's therapy. She continued to lose weight, her depression lifted, and she was generally able to function on a much higher level than ever before. Prior to the dream, her therapist had been seen as punitive, judgmental, and untrustworthy; she could not allow herself to experience any libidinal feelings and had to deny her seductive intentions. Only by the splitting of her father transference onto two therapists at the same time was the impasse broken. It is conceivable that even without such splitting the progress would eventually have occurred, but not, in all probability, before a great deal of time had elapsed, if, indeed, the patient had remained in therapy at all. Although many transference objects had been available in the group before the outsider's visit, it was apparently necessary to split the father transference between two father figures, a role no patient in the group had filled.

The unfolding of these developments was helpful to other members of the group also, for it afforded them an opportunity to work on similar problems themselves. Two complementary dreams were brought in by other members of the group, and their associations helped them and the original patient to intensify the working through of their oedipal conflicts. Only when the punitive and violent aspects of the father were physically separated from him and attached to a new transference object who was openly hated could the libidinal impulses toward the desired father be experienced and expressed.

This case illustrates the usefulness of the splitting of transference not only among members of a group but also between visiting therapists and co-therapists. Lessening of anxiety is facilitated when the transference object is split, and fewer difficulties in working through of highly cathected, forbidden conflicts are then encountered. It would seem rather

obvious that the more forbidden the wish, the greater the benefit of such a situation, for the greater is the anxiety surrounding it and the more helpful is any method for reducing it.

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