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Changing Clinical Orientation, Humor and the Transitional Space

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The relationship between therapist and patient has radically changed during the last several decades. Psychoanalysis was submerged in an aura of seriousness and the interaction between student and mentor was often formal and stilted. Around forty years ago, I noted when attending professional meetings, that the atmosphere was funereal. Bearded psychoanalysts smoking huge cigars would make profound judgments with such solemnity that it appeared that the future of civilization was at stake. Arguments could become acrimonious, and heaven help the heretic who threatened the supremacy of Freud's pronouncements.

Regarding our mentors and training, a subgroup of eminent psychoanalysts lacked a sense of humor, which may have been reflected in a lack of imagination and forceful dogmatic assertions, usually punctuated with a foreign accent. Somehow, many of my generation mistook some of these peculiarities for greatness, which, in many instances, concealed a sadistic orientation.

The psychoanalytic community was, in essence, a cult and the training program and hierarchy was ritualistic, competitive and mysterious. Often it was also confusing. One of my teachers had a reputation for being brilliant and intuitive, although he never presented or published a paper. He was known as a very serious person totally dedicated to his clinical work. He did not believe anyone should do anything outside of psychoanalysis, because that would mean that that person was ambivalent about being a practicing psychoanalyst. This even involved teaching. I remember being interviewed when I was applying for matriculation at the Chicago Institute for Psychoanalysis by this seemingly dedicated, but humorless analyst. He asked me to sit down, and for about a minute we sat in silence. My anxiety built up as I sat in a dark, depressing room with a small window. Finally, he spoke and asked me a question. He asked me to tell him my name. I thought this was strange, because he had my application blank in front of him, but then I conjectured that maybe he wanted to hear how I pronounced it, because it is often mispronounced. I poised myself for the next question, which came after another moment of silence. A minute under those circumstances seemed as if it were an eternity. He asked where I lived. I answered his question but again, if he wanted to know the answer, all he had to do was look at my application on his desk. I did not know how to elaborate on his questions or free associate to them. I reasoned that maybe he was building up to something, that this was part of some Byzantine strategy. After several minutes, he stood up, shook my hand and dismissed me.

My peers were, of course, anxious to hear about my interview. When I told them, they were puzzled, but concluded that this analyst was subtle and shrewd, and had made me submit to some type of stress interview. I agreed about the stress, but I could not, in any way, understand the purpose of this silent inquisition without the exchange of any relevant information. I felt that I had absorbed some of the humorless, depressed atmosphere of that office and carried it with me for about two weeks. My spirits were lightened, however, when I received a letter announcing that I had been accepted for matriculation. I was still puzzled, not knowing what had happened, but I was willing to forget about the whole episode because the outcome was good.

About two years later, I had to face another administrative hurdle that once again required being interviewed. As the fates would have it, this analyst was once again assigned to interview me. I did not feel a great amount of trepidation, because at this advanced level of my training, no one, so far as I knew had ever been rejected. I also expected that being closer to being a colleague, that he might be more sociable and pleasant, and perhaps, even talkative.

I was partially correct. He was a little more talkative in that he added a sentence to our discourse that he had not included in our first interview. Otherwise, the interview was an exact replica of the first. This time I was even more puzzled when he asked my name, since I had been at several parties that he had attended and had introduced him to my wife, and on one occasion, someone had introduced me to him. In this second interview, before dismissing me, he enigmatically said 'Psychoanalysis is a serious business.' To this day, I do not know whether this was a rebuke. I certainly had not felt frivolous in his presence. Or perhaps he was sharing a bit of wisdom with me. In any case, as I had anticipated, I was again accepted.

I give these examples, because I believe that psychoanalysts are particularly prone to the 'Emperor's new clothes' phenomenon, a situation in which one attributes significance and importance to some event or phrase, but, in fact there is nothing there. My interviewer made me feel as if I were a masochist and, in spite of his reputation, I could not see anything profound in his conundrum "Psychoanalysis is a serious business." I could only perceive a humorless, depressed man who was substituting a misguided allegiance to psychoanalysis for living.

Many analysts have narcissistic problems that lead to unconscious but profound feelings of inadequacy. There may be accompanying problems in their capacity to understand and assimilate subtle and difficult theoretical issues. To compensate for their shortcomings and to bolster their narcissism, they construct theories in a ponderous, pedantic but serious fashion to cover up their lack of substance. I am not referring to any particular system, but suggest that the reader pick up a prestigious psychoanalytic journal, open it at random and pick out a sentence. Chances are that after the sentence is parsed and then put in simpler words, it will make no sense.

The older generation of analysts was different in that many of wrote in a lucid, elegant style. Still many of their writings were restating or extending Freud's doctrines. As emphasized, they did not tolerate deviations, and for a while, this stifled the creation of new ideas or paradigms. In the United States we have lagged decades behind Great Britain in that we are just beginning to recognize the importance of Melanie Klein and Winnicott. The Eastern establishment, in particular, has clung to the classical position.

As has been noted, many of these older generation psychoanalysts were depressed and among them were unusually large numbers of suicides. These were driven humorless men. Many of them would have considered a light-hearted approach to psychoanalytic concepts blasphemous, and anything that deviated from Freud would be labeled as capricious and irresponsible.

It is interesting, however, that Freud, although he frequently demonstrated that he was depressed, especially in his letters to Fliess (Bonaparte et al 1954), nevertheless had a keen sense of humor. He enjoyed jokes and was capable of turning witty phrases. He gathered a depressed group of followers around him, and many did not have his sense of humor, as was true of my interviewer who had been in Freud's group as a young analyst.

When the child has progressed to this stage, he has made considerable progress on the road to establishing object relationships and the recognition of an external world separate from the self. Winnicott believed that because of optimal mothering the child believes he is the source of his own nurture. The baby feels hungry and then is fed. *It is as if a need creates its own gratification* and there is no recognition of the mother as mother. Winnicott referred to this belief of self-sufficiency as omnipotence, but it is doubtful that infants could sustain such a complex phenomenon as omnipotence. Rather, they feel secure in that their needs will be met, and, at such a young age (around six months), there is not much of a concept about the source of nurture.

Because of maturational forces infants begin to make more discrete and accurate discriminations between inside and outside. Finally, the illusion of being the source of their own nurture, most likely a *primal illusion*, gives way to the recognition of the mother as the fount of gratification. However, under optimal circumstances, the illusion is not shattered. Instead, the child plays with it. These children can relinquish it, but they can bring it back by playing with it. Instead of omnipotence, as Winnicott postulated, they develop the capacity to play and can maintain equilibrium and mastery through play, and the deliberate creation of gratifying fantasies.

Play later in life is an extension of the primal illusion of self-sufficiency and complete autonomy. Within the context of play these beliefs are maintained, but at the same time dependent feelings and vulnerability co-exist. It is the pretended denial of such feelings or their satirical or caricatured exaggeration that constitutes humor.

Humor and the Transitional Space

Without attempting a precise definition, humor can be viewed as a human attribute that involves a mode of perceiving, and an attitude and outlook about relations between the internal world of the psyche and the external milieu. It contains both primary and secondary process elements as does creativity (Giovacchini 1960, 1974, 1993), and it is related to creativity. Certainly wit, as Freud (1905) refers to it, is a creative accomplishment and a good joke is recognized by its appreciative audience, a quality that Kris (1952) found to be indispensable for creative activity.

Play is associated with humor, humor always having a playful quality. Winnicott (1953) conceptualized a transitional space as an area in which play and illusion develops. I have conceptualized the creation of this transitional space as a developmental stage (Giovacchini 1996).

This transitional stage represents a watershed in which the child moves into the external world and simultaneously moves it into himself. Perceptions and judgments about inner and outer reality stem from inner stimuli, impulses and needs rather than from external sources and impingements. According to Winnicott, this is the area of illusion and omnipotence as well as creativity.

Humor and Clinical Perspectives

The child, during the transitional phase, is simultaneously living in two worlds through the use of humor. Humor is the product that permits harmony between reality and illusion as it introduces a viewpoint that can make potentially grave situations appear not only non-threatening but amusing. I have often stated that *the task of psychoanalytic treatment is to convert grim reality into playful fantasy and this occurs in the transitional zone*. Often this conversion is accompanied by humor, a by-product of this transformation. Putting this process in the form of a sequential progression, grim reality changes into playful fantasy and this produces humor.

In structural terms, the act of entering or creating the transitional zone also generates humor which in a positive feedback fashion contributed to detoxifying reality as it is replaced by playful fantasies. This introduces an observational perspective in which patient and analyst examine the patient- analyst relationship and if, on occasion, there is some light-hearted banter in their dialogues, it is in the interest of therapeutic resolution.

Humor is a developmental achievement, and involved in the establishment of object relationships. It is both a mode of relating and an adaptive technique. Freud (1905) distinguished between wit and humor; the former being a type of manipulation in which hostile feelings are mitigated. It is concerned with feelings of vulnerability and their mastery, and is the outcome of transitional relatedness.

The transitional space is a structural entity that represents a developmental achievement. It contracts and expands as it moves back and forth from the inner world of the psyche and external reality. The intermingling of fairly primitive interior psychic processes with secondary process perceptions and judgments of external reality occurs in both the production of humor and creativity.

As the psyche focuses on primitive layers, this might be considered to be a regression, but this would be a regression in the service of the ego as Kris (1950) described some time ago. He was describing the operations of the ego during creative activity, but I believe something similar occurs with the production of humor, which, as stated, is similar to creativity. At a clinical level, humorless patients are usually hard to work with and tedious. I find myself whenever possible giving them early morning sessions so I am still fresh and energetic and can look forward to the rest of the day, because they can be difficult to deal with and exhausting. In part, this is due to the fact that they are not particularly psychologically-minded. Their thinking tends to be concrete and mechanistic

and this makes it difficult to construct an observational platform on which the patient and therapist can stand. For the most part such patients are schizoid and narcissistically constricted. They have a paucity of object relationships, lack the capacity for symbolization and are devoid of imagination.

Their prognoses often depend on their capacity to develop humor, and to advance to a state of object relatedness that is compatible with the formation of humor. With some patients, even severely disturbed patients, there are occasional episodes when they, in spite of their misery and suffering, can poke fun at themselves or simultaneously view and evaluate a catastrophe in the external world as horrible but also as having a funny or ironic twist. Sometimes, this type of humor is black or Gothic.

Besides being a positive ingredient for the establishment of a therapeutic relationship, humor can also be a barometer that indicates the degree of ego-integration. As with other psychic processes it can lead to developmental advances or it can regressively degrade as the outcome of psychic disintegration.

For example a usually good-humored middle-aged salesman suffered a tragic loss when his wife was killed in an automobile collision when he was driving. He suffered considerable grief but in a clumsy attempt to console himself he said "It could have been worse; at least I had collision insurance. His therapist did not find this remark funny. In fact, he was offended by the crudeness of the statement, a failed attempt to make the best out of a bad situation.

It is interesting how the analytic attitude can dispel untoward reactions to a totally misfired humor. When this analyst told a colleague about this interchange, the colleague, who had some emotional distance from the situation, responded that he felt compassion for the patient. He sensed the underlying misery that the patient felt and which he was covering up with such a crass comment. What had the semblance of humor had misfired because the patient was overcome by his loss, something that he wanted to make light of. The pent-up hostility that was precipitated by the accident burst through to the surface; his attempt to contain it with a humorous twist failed. Some hostile narcissists might have found something funny in what was essentially sadistic, but the analyst's colleague's reaction was concerned with the patient's decompensation that was manifested in a weak defensive response that did not succeed in comforting him. The analyst's colleague was trying to explain the patient's misguided humor in psychodynamic terms.

Humor or lack of humor are characterological traits that, as mentioned, determine how persons adapt to the external world as well as how, as patients, they will progress in a therapeutic context. There seems to be a direct correlation between the degree of psychopathology and the lack of humor. I believe this generalization, though there are notable exceptions, is more than the equation that the more severe the psychopathology the less capacity to effectively function. Some very disturbed patients from a characterological viewpoint can be eminently successful, at least financially.

Countertransference and Playful Analytic Exploration

Therapists have discovered that the analysis of the countertransference has become as important as the analysis of the transference. The treatment process has become more of an active interaction than previously, emphasizing that therapy as well as emotional development has to take place within an object relation context.

No longer do clinicians adhere to the model of the neutral participating analyst who keeps himself emotionally isolated, in a sterile field as Freud (1912) recommended. The interplay of the patient's and analyst's feelings and the interactions of their unconscious processes leads to insight reenactments of infantile constellations as dictated by the repetition compulsion. This is a far cry from the adversarial unilateral relationship that characterized the psychoanalytic relationship years ago. The analyst is much more than a receiver who unscrambles the patient's messages.

Ogden (1994) believes that an analytic "third" is an important element in an analytic relationship. He defines the analytic third as "the experience of being simultaneously within and outside of the intersubjectivity of the analyst-analysand which I will refer to as 'the analytic third.' This third subjectivity, the intersubjective analytic third is a product of a unique dialectic generated by/between the separate subjectivities of analyst and analysand within the analytic setting." (p. 64). Ogden is emphasizing that an interaction creates meanings which become essential ingredients of the therapeutic process, but it would have been helpful if he defined some of his terms such as subjectivity, intersubjectivity and dialectic. This analytic third can also be examined in terms of Sterba's (1934) self-observing function.

I also believe these concepts can be discussed in terms of countertransference which, As I have repeatedly emphasized, has become a crucial element in any analytic interaction. Focusing on the transference-countertransference axis makes conceptualizations about the treatment process relatively simple and clinically relevant. This does not mean that all feelings between patient and therapist are exclusively based on transference and countertransference, but as every thought and feeling can be viewed in terms of a hierarchy between the unconscious and conscious, there is always some degree of transference and countertransference clinically useful. It may not, however, be clinically useful

Ogden (1994) would qualify these statements about countertransference as relating to everything the analyst thinks and feels because it "obscures the simultaneity of the dialect of oneness and twoness, of individual subjectivity, that is the foundation of the psychoanalytic relationship" (p. 74). Again it would be helpful if he defined his terms, but I believe that if psychic processes are viewed in terms of a hierarchy based on a balance of primary and secondary process, it is more clinically useful to think in terms of transference-countertransference interactions than the philosophical concept of dialectic, which even in philosophy has different meanings. I believe Ogden may be somewhat in agreement about countertransference when he states "Neither of these 'poles' of the dialectic exists in pure form and our task is to make increasingly full statements about the specific nature of the relationship between the experience of subject and object, between

countertransference and transference at any given moment" (p. 74).

As Freud (1910) discussed, countertransference can be a hindrance and disruptive of the treatment process especially when it is operating at an unconscious level. When understood, however, it can become a valuable ally in the quest for progress and therapeutic resolution. This happens through the understanding the therapist gains and perhaps the enactment and resolution of the repetition compulsion. This does not mean, however, that analysts must disclose everything they feel to their patients. As Ogden would state, there are different levels of intersubjectivity that would determine whether analysts should reveal their countertransference feelings to their patients or if they should keep such feelings to themselves in order not to burden them. Such determinations should be made after carefully exploring different levels of patient-analyst interactions.

I recall a professional man in his thirties who constantly berated me for practicing psychoanalysis when I should be following the tenets of Gestalt psychology. I felt somewhat annoyed because I was being constantly criticized although I knew he had a need to put me down. However, I did not know exactly why. During a session, the patient accused me of having been gruff and discourteous the previous session. I had no recollection of such behavior but I was curious as to what had happened, so with a spirit of inquiry we started exploring what might have happened the previous session. Through the patient's associations and the fantasies he provoked in me, I learned that he made me feel that I did not exist. I had been suffering from existential anxiety that I covered up with reactive anger. Then I remembered that I had become edgy and tart in my tone. The patient had succeeded in projecting a depreciated father imago into me that had also become part of his self-representation.

His mother had treated her husband as if he did not exist, because, being a social climber, she was ashamed of his coarse Eastern European accent and what she considered to be his peasant manners. Nevertheless, he was able to support her extravagant life style and to pay his son's tuition for graduate school as well as for his analysis. The son had internalized the mother's picture of his father and succeeded in projecting it into me. I, in turn, reacted to his projections without being aware of what was happening. He was always depreciating me, as mentioned, but for the most part, I recognized that this was a transference phenomenon and I was able to tolerate what he was openly verbalizing. During the session I have been discussing, he let me make what I thought was a significant interpretation and then went on with his associations as if I had said nothing. I was not aware of this interplay but during the following session I had several childhood memories in which I believed I had made an exciting observation, which was ignored, and then I was placed in a perilous situation.

During childhood I had not seen the connection between creative jubilation and the following peril. Later I was able to see, at least, a sequential link. As in childhood, with the patient I was also not able to see such a sequence, but I, nevertheless, reacted as evidenced by my anger, a reaction similar to that of the patient when he compensated for the internalization of the depreciated father by angrily attacking me,

The two of us were looking at the interactions of the previous session as if we were on an observational platform discussing what was going on between us in a collaborative session. He acknowledged the shutting out of my interpretation and conjectured that I was having reverse Oedipal feelings, the older man being threatened by the younger man's vigor. I admitted that was possible, but that it did not feel right. Together, we were able to acknowledge that I felt something much deeper than Oedipal rivalry, that I had, in fact, experienced an existential crisis.

I had no impulse to tell him about my childhood memories that would have been irrelevant to his treatment and not at all connected to his infantile environment. I would have been bringing parts of my personality into the treatment that would have been similar to introducing a foreign body into a setting in which it did not belong, and would have had no therapeutic purpose. It would have been tantamount to dumping on the patient. The patient and I worked together on a problem that commanded our attention. When we both climbed on the observational platform, his anger was mitigated and replaced by investigative curiosity. I was enthusiastic about our pursuit and the atmosphere we created was now imbued with good feelings rather than anger, discomfort and guilt. Our observational platform was located in a transitional space in which we could playfully explore complicated transference-countertransference reactions and I could objectively tease out of the data that was made available those elements that I believed would be therapeutically useful. From being subjectively involved, I could step backward and view what had transpired from an objective and perhaps neutral fashion. It had been necessary, in this instance, to relinquish neutrality in order to gain objectivity.

Summary and Conclusions

For years, I have stressed that treatment is not a unilateral process. Two persons are involved and it is the fit between the two that determines whether the patient is treatable by that particular therapist, not the patient's psychopathology alone, as Freud (192) insisted. On the other hand, I also believe that provided the therapist remains in an analytic frame of reference, at least in his thinking if not in his behavior, he will be able to understand various structural configurations and react eventually in a proper therapeutic fashion. He need not have a particular psychic configuration that may be more in resonance with the patient's needs. This means that no special skills or forms of psychopathology are required to work with severely disturbed patients and schizophrenics. As always, this brings the clinician back to countertransference. In all therapeutic situations, countertransference is as inevitable as transference. The therapeutic task is to maintain a similar analytic attitude toward the countertransference as toward the transference, but there are, nevertheless, certain qualities analysts will find useful to make it easier to establish such an analytic viewpoint. I am referring to the ability to view feelings and events in terms of humorous tolerance, including idiosyncrasies and foibles that may be part of many therapists' personality make-up.

As long as such foibles are not too intense, they may lead to analytic progress although they may temporarily upset the balance of the treatment process. When analysts display

such attitudes, they are, undoubtedly, reacting to their own narcissistic needs and grandiosity. Rather than feeling guilty or defensively denying having such reactions, they should maintain a viewpoint of self-observation. This means that analysts are looking at countertransference feelings with benevolent tolerance in the same non-judgmental fashion as they view transference (see Searles 1959, 1961, 1986, Schulz and Kilgallin 1969). To condemn or to be rigid about the self is just as poor an analytic attitude as if they harbored similar feelings toward patients.

Being non-judgmental toward the self also requires a sense of humor. Human foibles are neither objects of derision nor subjected to superego condemnation or ego-ideal humiliation. Humor enables the analyst to look at himself as an object of interest, which allows him not to take himself too seriously. As stated, this is also an optimal therapeutic perspective as it is directed toward the patient, although therapists take their patients seriously. Still, analysts do not look at their patients as tragic victims who have been crushed beyond repair. Many patients may have been treated with inhuman cruelty leading to profound feelings of hopelessness and despair. Therapists can feel deeply about their patient's plight, but to be effective clinicians, they must have hope, not to be overwhelmed by despair and maintain cautious optimism. This is a serious but not grim attitude, and its purpose is eventually to construct a transitional space in which humor can play an increasingly significant role.

I conjecture that many analysts have narcissistic and grandiose configurations. What is important for therapeutic purposes is how the analyst reacts to such feelings, how he acknowledges them and otherwise responds. Narcissism and grandiosity are still, for the most part, considered in a pejorative fashion, although much has been written about healthy narcissism. I imagine that Archimedes may have chuckled when he boasted that if given a spot to stand on he could move the world. Einstein and Bohr playfully related to each other in a competitive childish fashion as they constructed brilliant hypothetical experiments in which Einstein tried to undermine some of the fundamental principles of quantum mechanics. String theory which deals with bubbles and sheets is impossibly abstract, vastly grandiose in scope going way beyond the fourth dimension and, yet, it seems to be the result of a playful and quirky imagination Feynman (1989a, 1989b) could be deadly serious as well as devastatingly playful as he illustrated by playing bongo drums and safecracking (Gleich 1992).

Grandiose theories are formulated by grandiose persons. Sometimes grandiosity goes astray and becomes offensive and disruptive, especially in a therapeutic setting. However, if it is kept in a humorous context, it is not necessarily an overcompensatory stance for damaged self-esteem, but simply a state of feeling good about the self, it can lead to creative accomplishments and analytic progress. Humor and creativity are essential ingredients of the analytic interaction.

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