COUNTERTRANSFERENCE: A CHARACTEROLOGICAL APPROACH

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FOREWORD AND FOREWARNING

This is a technical book written for the therapist in practice who wants to deepen his understanding of himself, his practice and his patients. It can be used merely as a reference manual to be consulted periodically but its main purpose is to awaken in the therapist what I hope is a new approach to counter transference. It is not an attempt to systematize that which by definition defies systematization, a human interaction. Rather, it can only hope to act as a catalyst, offering a new perspective, a new way of looking at counter transference. Hopefully, after having read this book, the therapist will start thinking along the broad guidelines here suggested, without limiting himself to those specific interactions and defense mechanisms herein described. Knowing his own characterstructure, its etiology and characteristic defenses should, according to the premise upon which this work is founded, be helpful in appreciating how he affects the patient as well as how the patient affects him. It should help him spot trouble quickly, perhaps even foreseeing it (sometimes).

Of necessity this is all based on the "model" system; that is, it uses "models" that are theoretical constructs to begin with and therefore do not replicate exactly actual clinical, real-life situations. It is an abstraction but one that I have found very useful to know and keep in mind during my practical, day-to-day practice. It has kept me out of a lot of trouble, but fortunately not ALL trouble.

Before 1905 Freud postulated the need for a system that would "characterize" patients, making it easier for the therapist to understand, at least along very broad guidelines, his patients. Many attempts have since been made but I believe the most successful to date is Alexander Lowen's important book "PHYSICAL DYNAMICS OF CHARACTER STRUCTURE". It contains the basics of the bio-

energetic theory and describes in detail each of the character structures herein descussed. For maximum clarity I would suggest that the reader familiarize himself with it before he reads this book. Throughout the book the assumption is made that the reader has some familiarity with this particular model and constant reference will be made to it.

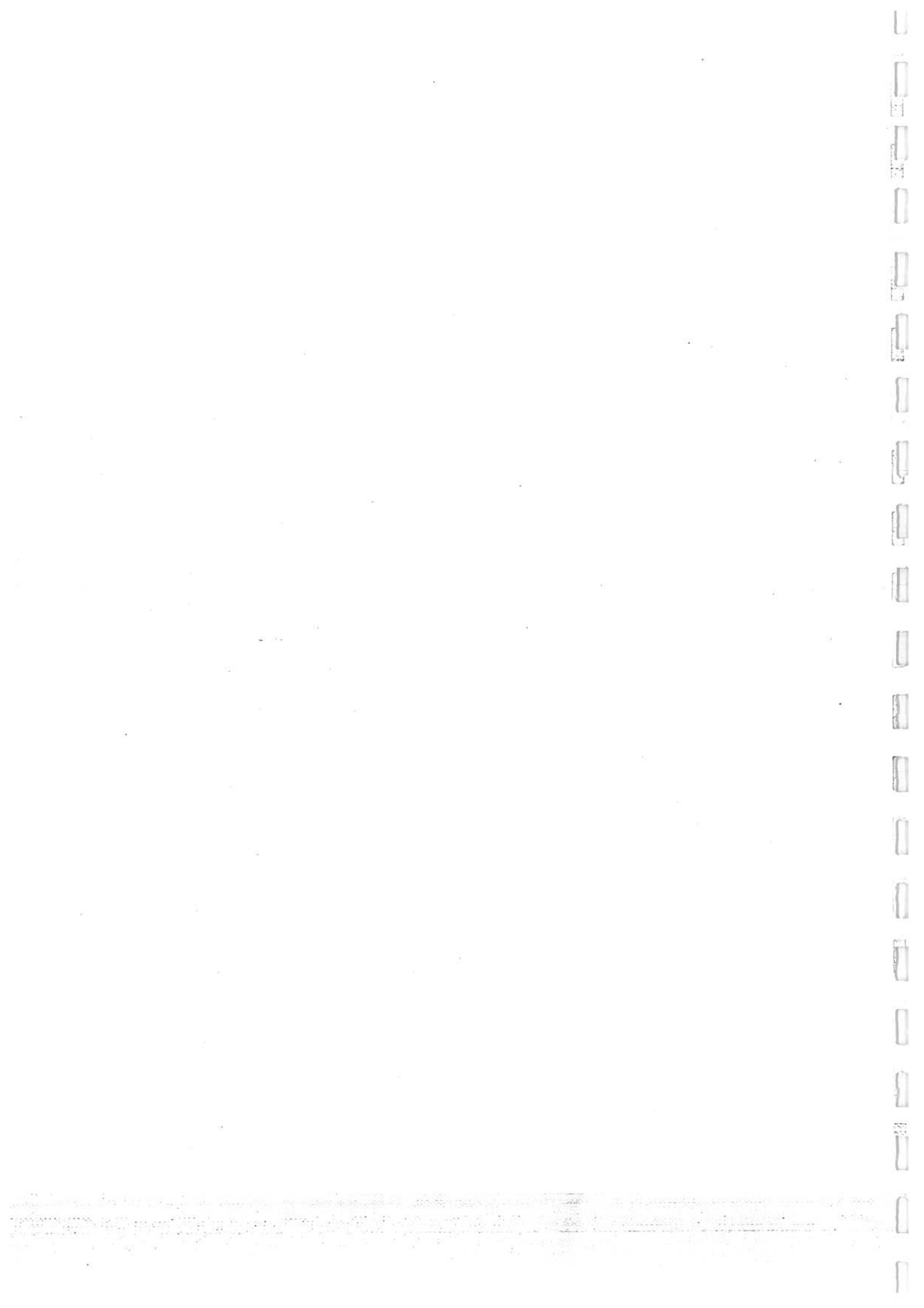
For the therapist without a background in body oriented therapies, I would suggest reading "THE BODY REVEALS" by Ron Kurtz and Hector Prestera. This is an excellent presentation of the basic underlying theory behind the hypothesis of psychosomatic (mind-body) identity, which is in turn the pillar upon which the entire bio-energetic approach rests. It is simple, clear, straightforward, rare qualities indeed in a book that deals with such a complicated subject. It is an excellent bridge.

Certainly to develop a deep, comprehensive knowledge of characterology in general and characterological counter transference in particular much reading and experiential work is required. However, for the reader interested in acquiring a quick, skeletal, yet surprisingly complete intellectual understanding of the bio-energetic model of characterology and its use, I believe that careful reading of these three books, in this order, would be fruitful. 1 - "THE BODY REVEALS" 2 - "PHYSICAL DYNAMICS OF CHARACTER STRUCTURE" and 3 - "CHARACTEROLOGICAL COUNTER TRANSFERENCE". Of course, nothing can replace the experiential work as yet (again, fortunately) in my opinion. It still constitutes 80% of learning, but most of the other 20% can be hopefully grasped with these three.

Characterology is a wonderful tool if it is used wisely. It can be compared with a good power saw; an excellent, powerful tool that when well used saves much labor, but if misused can become dangerous. Characterology becomes abused and dangerous whenever the therapist uses it to "classify" or "pigeonhole" his patient. That is, when the <u>person</u> becomes a "schizoid" or a "masochist" or

an "hysterical" and the therapist assumes and therefore expects and may even unknowingly elicit, a certain behavior. This immediately blanks out the uniqueness of the person the therapist is helping and therapy in the best sense of the word, disappears to be replaced by a dry, mechanistic and impersonal approach that is very limited. For the heart of the work, the heart of the two persons involved, patient and therapist, is gone.

Finally, I would like to clarify my position. I am not a bio-energetic therapist although I am trained in bio-energetics. I am a core energetic therapist. Core energetics is a new approach developed at the Institute for the New Age of Man under the leadership of Dr. John Pierrakos. I have used bio-energetic characterology because it is the most accurate and comprehensive one I know, in addition to being the one I trained in. However, as a therapeutical, operating modality I prefer Core energetics which is the integration of the four aspects of man - the emotional, intellectual, the physical and the spiritual.



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INTRODUCTION

Transference is defined by the psychiatric glossary of the American Psychiatric Association, 1975 edition, as "the unconscious assignment to others of feelings and attitudes that were originally associated with important figures: parents, siblings, etc. in one's early life. The transference relationship follows the pattern of its prototype. Psychiatrists utilize this phenomenon as a therapeutic tool to help the patient understand his emotional problems and their origins. In the parent/patient/physician relationship, transference may be negative/hostile, or positive/affectionate." Countertransference is then defined by the same glossary as "the psychiatrist's partly conscious and partly unconscious emotional reaction to the patient." Harry Stack Sullivan, the famous psychiatrist, used a different term to define the same phenomenon. He called it "parataxic distortion" and it was defined as "certain distortions in judgement and perception, particularly in interpersonal relationships in accordance with a pattern backed by earlier experience. Parataxic distortion is developed as a defense against anxiety."

Dr. Sullivan indeed defined the subject of this paper very precisely, for we are going to deal with countertransference as it takes place on the characterological level; the basic hypothesis being that, just as the characterological framework allows us to predict with some accuracy the type of responses that can be expected from our patients under specific stimuli, so can we expect the same action-reaction pattern from the therapist. Therefore, if we can create a model to describe interactions at the characterological

level between therapist and patient, we could help the therapist under stand, at least intellectually, the dynamics of a specific counter-transferential sequence he/she may find himself/herself involved in, thus taking a very positive step toward clarity. Of course, it must be understood that we will be describing a model only, and a partial model at that, since not all interactions can possibly be predicted. However, while clear differentiation must be made between a model and real-life therapy, where we relate to individuals and not to character structures, such models are useful if they are considered as general guidelines and not as an attempt to replace the deep intuitive understanding that is the hallmark of good therapy. Considering the basic characteristics of each character structure, we can attempt to establish how "pure", hypothetical models would react to each other, on this level.

We have defined characterological defenses as the most primitive defense mechanism available to the ego. Their disintegration leads to regression and psychosis: primary process material would invade an ego which has completely relinquished its characterological defense. Hence, a psychotic attack may be defined as a state in which the character defenses have broken down to the point where primary process material uncontrollably invades the ego. The term "dissolution" or "resolution" of character defenses must be understood as a partial, tentative attempt to regain some of the flexibility the ego compromised in the past in exchange for the defense. For the more rigid the defense is, the less flexibility is available to the ego -- and the more limited the choice of responses available to the individual. This is the reason for the tremendous, and completely unjustified fear experienced by our patients whenever they are coming close to an

attempt at partial resolution of a defense deeply embedded in the character structure: subjectively, the ego is experiencing dissolution of a defense that staved off, successfully in the past, an important threat, and of course the biggest threat of all is dissolution of the ego barrier that protected it from primary process.

In present-day reality, a characterological response is an automatic response, a response that is not questioned by the ego and, therefore, may remain partly or totally unconscious. When a cháracterological response from the patient impinges directly on the character defense of the therapist, an automatic response is triggered, and the therapist begins to react personally; he is involved, is "hooked" and will respond in a way that will probably trigger once more the patient's character defense -- and so on, until a deadlock is reached where the two individuals, no longer objective, are reacting characterologically to each other.

At this point, therapy stops. Basically, there are two ways in which this manifests: the first one is when the therapist gets angry, assumes an authoritarian position (which might be withdrawal) and in some way, directly or indirectly, overtly or covertly, attacks the patient. Anger is the hallmark of this countertransferential position. The therapist has lost his objectivity and his ability to see through the patient's defenses, has personalized the patient's attack and can no longer interpret or understand. The second possibility is that the therapist, at a conscious or unconscious level, refuses to deal with the issue that the patient is presenting, probably because he has not resolved the issue for himself. Denial is the therapist's defense; it leads to collusion with

the patient and eliminates the possibility of dealing with the real problem at hand. The patient will happily collude in this case as obviously he does not want to face that which he has refused to face all his life. The therapy can continue for a while, dealing with more or less superficial and irrelevant issues, by-passing the real problem which remains unexplored.

It is obvious that all of us, at one time or another, collude with our patients and all of us, at one time or another, get angry with our patients. This is not new. This work is designed to help us perceive some of these interactions a little more clearly, by typifying some of the grosser characterological interactions so that, when you are in your office and are faced with the uncomfortable feeling that you either do not want to explore an issue or get angry and do not know why, you may see the specific interaction that is taking place at the characterological level.

To return to the definition of transference that we had used previously, it is my belief that transference involves projection. This is always true of character defenses that are projected outward in a classical paranoid mechanism. In other words, archaic images are projected onto the image of the therapist who, hopefully, is not involved personally and can point out the inappropriateness of the projection, so that the patient can then see present-day reality more clearly. Countertransference must involve, of course, a similar projection. And, as we have seen in the definition of Sullivan, it also involves an attempt at a resolution of anxiety. Anxiety due to what?? Most probably to unresolved conflict whose resolution is barred by a resistance. It would seem therefore, that we are really dealing here

with an issue of resistance: resistance on the part of the therapist to go through his own problems, whether in the context of the session that is taking place with the patient or in the context of his own therapy, as well as resistance on the part of the patient, who is tentatively and somtimes covertly bringing up an issue which, due to resistance, he has not been able to work out in his every-day life. Therefore, both the patient who brings in the unresolved issue and the therapist who, because he has an unresolved issue, is dealing with a countertransference, are really dealing with resistances. In this context, countertransference may be seen by the therapist as an expression of the need to resolve something within himself, an unexplored frontier, as it were. If this attitude is maintained, the work of doing therapy will result in an ever-expanding resolution of the therapist's problems, and a decrease in resistance and counter-transference. It is the difference between a flat, boring job and an exciting professional life in which the countertransferences are understood as indications of areas that need exploration and resolution within the therapist's own psyche. Countertransference and its full understanding can therefore be used as a tool to expand and grow.

When we place our patients under sufficient stress, they will respond characterologically. But each individual will use, first and foremost, the characterological defense that is typical, well-known, secure. And when this occurs, reactions are always automatic and out of control. It is not unnatural nor unusual for a patient, in an attempt defend himself against confrontations that occur within the therapeutical framework, to "smell out" the characterological

defense of the therapist and directly impinge upon it. This the therap perceives as too threatening, as a demand to leave himself completely open and vulnerable to the patient's attack. It is not a false perception. The distortion lies in equating vulnerability with weakness, helplessness, threat to life or sanity itself. But isn't it equally true that a significant part of our work as therapists is to teach our patients that in vulnerability lies true strength, that growth requires abandonment of the protective, yet confining shell of our defenses? If there is no better teaching than example then we can see the need for the therapist to be well rooted in his own reality and to trust his own process, in order to be able to experience such an onslaught and yet react rationally to it.

Countertransference occurs on many levels. It can be initiated at a very superficial, easily identifiable level, or remain completely outside the therapist's consciousness. However, as the therapeutical relationship develops any apparently small, initial countertransference will eventually show its perniciousness.

Eventually, interaction at the characterological level can lead only to stalemate and ultimately rejection by one or both persons. The stalemate can end only when one of the participants is willing to give up his particular stance. This kind of interaction happens between therapist and patient; husband and wife; parent and child; teacher and pupil -- generally in any diadic situation. Some diads, however, are more threatening than others -- for example, marriage and therapeutical diads. As closeness grows, the threat grows, and so does the characterological reaction.

A few points need clarification. The characterological defense

is only a defense and should be viewed as such. A patient is a person, not a defense, nor a series of defenses, nor a character structure. These last are only a series of guideposts that experience has found to be useful to know, but the therapist who classifies his patient as a character structure will be making a serious error. Human being are vastly complex and most people present most character defenses at one time or another. The interaction described, as well as the case histories, must therefore be considered as one of the many photographs that make up a film. By no means are they the film itself. Just as identification of specific, important photographs help to understand the whole film, so the recognition of characterologica resistance, defense, transference and countertransference might be useful. The interactions are models and are not to be applied indiscriminately, but rather as typical examples.

This paper is an initial and therefore partial effort to describe the diadic interaction between therapist and patient. Although initially I planned to describe the interaction between the five dominant character structures, it became obvious that such an enormous endeavor would lead inevitably to sacrifice of depth in exchange for coverage. Therefore, I have decided to limit this paper to the interaction between the rigid structures and their subdivisions. Later papers will, hopefully, extend the work to include the other character structures.

Meanwhile, I have included in the Appendix, in schematic form, the "Baseline" and "Secondary" responses that can be expected from all five major character structures. By comparing the sheets for the specific character structures that are being considered, and

imagining them interacting upon each other, the reader can have a general idea of what can be expected. The model to be used is, of course, developed in the paper itself.

The reader is reminded that:

A) I am a white male therapist, primarily surrounded by white patients on the east coast of the U.S. in 1976. The observations and conclusions reported in this paper are necessarily limited by these parameters, and further work is needed to determine the perspective of other groups, such as women or blacks. I do feel, however, that the models described will apply, with perhaps some modifications, in most cases.

B) The terminology used is basically the standard one in psychotherapeutical literature, except whenever bioenergetic concepts are used.

The idea for this work crystallized at a workshop led by Drs. Robert Hilton and Renato Manaco in 1973. They have done, and I understand continue to do work on countertransference. I also wish to thank Drs. Goodwin Watson, Dr. Barbara Hogan and Dr. Steve Adler for their steady support during the "gestation" of this work. A special "Thanks!" to Dr. Robert Zimmerman, friend and colleague. But for Dr. John C. Pierrakos, my friend, master and teacher, without whom none of this work would have been possible, I know of no words that can express clearly enough the deep love nad gratitude I feel. It is with his love of life, of his patients, and of his work that he taught me. And the message is clear: The true healer is love, however unprecise that may seem in the context of an academic paper.

Two more people stand out among the very special, to me, group

of people who have become my most trusted and beloved friends. Clare Solomon, who has so patiently and lovingly helped me along my path, and who has had to deal with many countertransferences herself; and Eva Pierrakos, whose spiritual guidance, coupled with brilliant logic, deep knowledge, and constant loving support, has been a basic cornerstone in my development. From Eva and John and Clare I have felt a continuous, uninterrupted love -- not the unconditional love that leads to symbiosis, but the adult love that leads to expansion. No technique can replace this, nor can any technique be effective without it. Perhaps a better understanding of countertransference will help us understand better our patients, thereby reaching into the depths, beyond the defenses, where the core of man lies full of love and creativity, waiting to be helped to release itself.

THE RIGID STRUCTURE - A GENERAL OVERVIEW

The general classification "rigid" has been used by different authors to include various subclassifications that differ somewhat in their defensive systems. Among these, we can consider Lowen's "phallic narcissistic" male and "hysterical" female; Baker's "chronic depressive", "manic depressive" and "paranoid"; F Lake's "hysteric" Reich's "genital", "phallic", and "hysterical", etc. We will use here only Lowen's characterology in order to maintain consistency in our descriptions.

All these character structures are post-oedipal. The fixation took place during or after the Oedipal conflict, and is characterized by the fact that the libido (energy) has anchored itself in the genitalia, after traversing the oral and anal stages, with some exceptions, as discussed in the chapter on "Agression as Formative Agent in Rigid Structures". In any case, however, sexuality has been recognized and identified by the child, although he has not differentiated between sexuality and love. This is in fact the source of the trauma: the parent of the opposite sex, having split sexuality from love in his own being cannot tolerate the expression of an integrated feeling, one that flows smoothly between love and sexuality. The parent finds himself reacting sexually (and therefore unacceptably) to the child's (sexual) expression of love. He blames the child for provoking it and suppresses the child's manifestations brutally, either through overt rejection or covertly through the threat of rejection. Hence the fear of rejection will become, in later years, a predominant characteristic of the rigid. The rejection

was translated by the child as a rejection of his total being at first, but later he comes to associate his sexuality and/or love with the rejection. The essential word here is and/or, symbolizing the split between sexuality and love. Before sexuality his love was fully accepted, afterwards it was not.

Sexuality becomes the culprit, the cause of the rejection. At this tender age he is still able to control it. And although the trauma is deep and extremely painful, the child can suppress the sexual expression of his love and pass into latency. However, the trauma exists, and when the child reaches adolescence and can no longer deny his strong sexuality, he is faced with an impossible choice: expressing his irreversible and undeniable sexuality <u>or</u> allowing his love to flow. His childhood trauma taught him that love and sexuality are incompatible, that love expressed sexually means immediate rejection.

A choice must be made, and since sexuality is emerging in full force, repression of love becomes the only viable solution if the mandate created by the trauma is to be observed. While in his infancy he was able to suppress sexuality and continue expressing love, in adolescence he is forced to reverse the process, this time permanently. The unacceptable yet inevitable choice between love and sexuality generates tremendous hate for the parental figure who created this dichotomy. The phallic narcissistic male and the hysterical female, during adolescence, deny their capacity to love and begin using the very instrument that they fought so hard to suppress during childhood as an expression of their hatred. The woman becomes seductive and flirtatious while the man becomes openly challenging to his "opponents".

Both of them use their sexuality aggressively to obtain whatever they desire from the opposite sex. Underlying this apparent usage of the other person is also a need to discharge overtly, almost, for the phallic and covertly for the hysterical, tremendous hate, which in turn is a defense against the expression of longing and ultimately, love. Hence sexuality is used sadistically for revenge; indeed, in therapy we find that "revenge" is a very strong motivation in this type of structure.

Now let us look at the Oedipal situation. As we have seen, the parent of the opposite sex was desired and loved, yet became the hated one, (the hatred being in this case a defense against longing as a result of rejection). But what about the parent of the same sex? If he/she is weak or absent he/she is hated by the child for not supporting it in its Oedipal struggle. If he/she is strong he/she is feared. If the same-sex parent is loving and supportive, permission is given to express aggression and hate, and the child will, in later years be able to do this freely (phallic male and masculine aggressive female), whereas if aggression is not permitted, or worse, suppressed, we will have the more passive rigid subtypes -- the passive feminine man and the hysterical woman. "More passive" is used here in a relativistic sense -- these subtypes are "more passive" than the phallic and the masculine aggressive but they are certainly not passive people; none of the rigids ever are, in the deeper sense of the word.

In the context of the classical Oedipal situations, the fear reinforces the initial suppression of sexuality during childhood. But at adolescence the male and female react differently. The male develops

castration anxiety, and if aggression was also suppressed he may fall back into the passive feminine structure. Alternatively, and if a reasonable amount of aggression has been permitted, he will reaffirm his sexuality and become arrogant, defiant, contemptuous -- the true phallic narcissistic. The female attempts to deny her sexuality and may become frigid -- more or less temporarily, more or less completely. However, frigidity is not a characterspecific symptom, and should not be considered as such. The attitude of the mother here is critical, and may produce either frigidity or excessive promiscuity. The amount of aggression permitted will define if the adult will become a masculine aggressive subtype or an hysterical subtype.

Rigid types are usually very integrated. Their limbs are well proportioned, they are frequently attractive people with a very high energy level, able to function well in society. They are successful socially and economically, and very often married with apparently acceptable and meaningful relationships. However, if one looks closely at these relationships, one finds that they are based on sexuality and convenience, where both parties are using each other to satisfy specific social, sexual and economic needs. Frequently there is an arrangement wherein both partners overlook temporary deviations from the marital relationship with external partners. It is difficult for a rigid structure to admit defeat, especially in the field of interpersonal relationships, since defeat is equated with rejection, which rigid structures will go to extremes to defend against. For example, typically they reject before they are rejected; or they "perform" and become so "perfect" that their partner cannot possibly reject. A classic fantasy of the rigid structure is that if

that if he makes enough money, or if she is pretty enough, everything will be all right. In other words, the lost love can be regained by personal achievement and success, instead of true involvement, which requires the sexual expression of love. And this means risking the original characterological pain. As we will see, this is a most important facet in the counter-transferential problem manifested by rigid therapists.

As mentioned before, both male and female are very attractive. Their movements are gracious, although frequently they give the impression of a tight body. Underlying the apparently fluid motions are frequent deep spasticities which Reich has identified as "muscular armor". Reich postulated that the armored structure is precisely the post-genital one, who is able, due to the fact that the libido has anchored at the genital level, to distribute the energy throughout the body and create a muscular armor to protect himself from the world. Reich describes two types: the armor plate-like type, in which large groups of muscles function simultaneously and create plates of armor around the body; and the "mesh" type, in which the muscles apparently are very free-flowing and operate smoothly. The mesh type of armor is extremely difficult to penetrate, and at the psychic level, the individual's defenses will be extremely fluid and quick. Even if the defense is momentarily penetrated, it is almost immediately closed up again. The individual is able to parry the thrusts that come at him, rebounding like a well trained gladiator who is able to side step, deflect, absorb and return the thrusts of the opponent. If the plate-like type can be compared to the armor of a knight, the mesh type has a net of stainless steel wire surrounding him/her,

which is almost impenetrable and extremely resilient. These analogies may sound superficial and banal, yet I find them very useful in trying to imagine how the defenses of my patients function, during therapy. Of couse much more in-depth and sophisticated descriptions exist, and the interested reader may explore the definitions of armor in the writings of Reich, Lowen, Boadella and Lake.

The phallic narcissistic male uses his sexuality aggressively against the woman. He is trying to recuperate a lost mother, regain her from his father. He is also trying to prove that sexually he is as potent as the hated father and that he can now compete and win in the very terrain in which he found himself incapable as an infant. He also uses his sexuality to directly express his hatred of the woman, who in infancy rejected him because of this sexuality. He does not love the woman, and considers her a sexual object to serve his needs, sexual and social. His heart was broken by a woman -- he is not about to try again and re-experience his feelings of pain which he thought would overwhelm him in infancy. He does not realize that as an adult he can indeed bear the pain, and that it is only this pain which will help him resolve the conflict and allow him to establish a close interpersonal contact with a woman.

The hysterical female uses her sexuality seductively, only to reject coldly any male who approaches her. She is outraged by the male's proposition to in fact execute what she has been unconsciously proposing. She does not realize that her undulating hips, her flashing eyes, her fleeting smile are continuously seducing all the males around her and is furious when a man approaches her. She then feels that men consider her as a sexual object only, that they

do not see the person underneath the sexuality, and that men desire her for one purpose only. Nor does she see that her seductiveness is geared to attract men precisely so that she can justifiable reject them and discharge her suppressed hatred. This hatred cannot be discharged without a justifiable provocation, so she engineers the provocation, to allow herself to freely discharge the hatred. But she is never conscious of this, nor of the fact that she provoked the male in the first place.

The masculine aggressive female and passive feminine male have been described in detail in their respective chapters. The reader is kindly requested to refer to them.

Although these structures are sexually very active (except in the most traumatic cases), it is also true that they normally do not achieve true orgasm in the Reichian connotation. For if they did, they would be "genital" characterstructure -- that is, a non-neurotic, idealized model conceived by Reich and his followers, which apparently does exist in reality as a rare occurrence.

Orgasm implies a total energetical release of the organism, similar for men and women, ejaculation being a sex-specific characteristic of males. Total release implies a momentary dissolution of ego functions, a true abandonment to involuntary process -- and, therefore, to the partner. In this context male and female rigids have great difficulty reaching orgasm, as they rarely are able to truly abandon ego control. This is even more significant if we consider the fact that both structures use their sexuality in an aggressive manner, to compete against the opposite sex and obtain revenge for the pain that was inflicted on them during childhood. Because the

libido has securely anchored itself in the genitalia, this structure has enormous drive, opposed to the consequences of giving over to the partner with its corresponding resolution of the primary Oedipal conflict, created such a strain on these individuals that they prefer to repress and deny their sexuality. Some of the sexual energy is sublimated and becomes used in their social, economic or professional life. Since the drive is very intense, the suppression that takes place must be equally intense, and other defense mechanisms, such as displacement and somatization appear. In the first case the individual becomes a sexual pervert; in the second case the repression becomes so strong that psychosomatic difficulties appear. These were indeed Freud's first cases, in which he treated hysterical women. It is significant, in my opinion, that although the type of symptom that Freud encountered at the end of the Victorian age is seldom found in our society,women still have some of the same problems, some of the same symptoms of dissatisfaction and unhappiness in spite of being sexually dynamic and continuously functioning. It is not sufficient for the sexual apparatus to function separately from the totality of the organism, in fact, to be involved in a simple sexual act of intercourse. It is necessary for an individual to attain fulfillment to integrate the entire organism into an activity that climaxes in the sexual act, that becomes symbolized by sexuality. This means true giving and love. Integration of love and sexuality is the generally accepted terminology used to describe what I am trying to say here. This is still an impossibility for the rigid structures, in spite of the sexual liberation that has taken place on the physical and social level. I believe that true sexual

independence and liberation takes place only for those people who are truly able to trust their partner totally during coitus, who try to express themselves fully, with every possible means at their disposal. This means truly giving oneself -- letting go of ego-control, literally trusting and giving completely, Simply said, it is called loving. The basic pitfalls the rigid therapist must beware of are:

- Pride and arrogance, that are expressed in contempt for the patient ("he is stupid" or "he doesn't understand" or "I know", he doesn't"). Pride usually is a defense against fear.
- Anger or rage. This usually is a defense against love.
- Desire to reject, which is a defense against a possible rejection.
- A need to perform. This is a defense against low self-esteem or fantasied inadequacy that is subjectively perceived as leading to rejection. The same is true when a desire is felt for quick resolution or for brilliant sessions with major breakthroughs. These may be manufactured by the patient to satisfy the therapist's narcissism, but will be of little, if any, therapeutical effect.
- A need for control. This is a defense against helplessness and originates in the therapist's lack of trust.

I will describe, in separate chapters, the specific circumstances that lead to the development of each of the four main rigid subtypes -- the phallic narcissistic and passive feminine males, and the hysterical and masculine aggressive females.

To close, I would like to remind the rigid therapist that one of his greatest weaknesses is his fear of opening his heart -- and

good therapy always requires, in addition to understanding, a true love of the essence of the pationt. If such a love is absent, the therapy becomes a painful procedure for the therapist and an unproductive one for the patient, whose resistances will only be exacerbated. The therapist who does not really care about the patient, will find his/her work to be arid and unrewarding, no matter how clearly he/she may understand the psychodynamics involved.

ETIOLOGY OF THE PHALLIC NARCISSISTIC THERAPIST

If one could trace the etiology of a character structure to a single basic trauma, then we would say that in the case of the phallic narcissistic male it originated in the brutal repression of the expression of sexuality. As in the case of all rigids, the little boy reached the Oedipal stage relatively free of major fixation at the previous levels. In the Oedipal stage, however, he suddenly met a brutal repression of his sexuality. Until then, the little boy had been expressing his feelings freely and openly and these feelings had been received lovingly by the mother. When the little boy reached the Oedipal stage and began to have overt sexual desires for her, she could not tolerate the situation and either cut off or directly repressed. The little boy, whose sexuality until then had been experienced as a total organismic reaction, pleasurable and diffused over the entire skin surface, could not understand that the mother's reaction was only to his sexual overtures and identified her rejection of his sexuality as a rejection of his total being. However he had reached an advanced level of development before this trauma happened, so he did not abandon the struggle for his mother's love easily and developed resources at his disposal to actively promote his struggle. He turned around, became competitive with the father, envied him, then hated directly. The father's reactions then became crucial to the further development of the child, for he had two options -- either he tolerates the child's aggression or he represses it. If he represses it too much, the child may become terrorized, castration anxiety may exceed the tolerable level and the child falls

back into an earlier stage of development, with a much higher anal component (that has been called the "passive feminine male" and developed in another chapter). If aggression is not excessively inhibited by the father and/or mother, in later life the man will be able to express it even if his sexuality is, in the true sense of the word, inhibited. (In other words, even if he is erectively potent, he may be orgastically impotent). And this is the hallmark of the phallic male-hostility coupled with erective potency and orgastic impotency.

Frequently, however, the hostility has been displaced to women, compounding the rage already existing there, and the phallic man consciously perceives himself as ambivalent towards women -- he wants them and hates them at the same time. He perceives his need of them as purely sexual -- he needs women (not _a_ woman) to discharge his overly charged sexuality, never even seeing them as friends or companions. He tries to hold back the rage against both men and women, and develops a very tight musculature that is designed to dissipate excessive energy, contain the rage and help him hold back the violence he feels and is so afraid of at a deeper level.

The father, meanwhile, has been sufficiently in contact with the child so that identification can and has taken place, in spite of the little boy's hate, which becomes quite virulent at this state. The phallic narcissistic adult, therefore, has grown up, having received a considerable amount of nurturance from both parents, having been loved and taken care of and having been allowed to express himself and move out. The four developmental stages as described in ego psychology were traversed relatively successfully. It is only when sexuality and the Oedipal complex appear that the trauma ensues, and

results in hate for mother for having denied his sexuality, and hate for father for being competitive with him and being at the source of his mother's rejection. We frequently observe that the phallic, while he has almost overt hatred toward the woman, is still able to have warm feelings and to love her. We also see that this hatred for the woman covers deeper, more repressed problems with the father.

Driving hate for the father, coupled with a very high energy level plus the great ability that these people usually have, results in a very competitive character, who believes he is entitled to take anything he wants; to exaggerate, we could say that the phallic unconsciously believes he is the king and that the world is his fiefdom. Phallics are arrogant, narcissistic, dominant, very aggressive. They are highly organized, physically and psychically. Their defenses are flexible and powerful. They can use almost any defense during the course of therapy and they will do so with incredible agility so that they frequently confound the therapist. They are extremely persistent and will relentlessly follow their objectives, once they have defined them. However, partially because of the narcissistic pride, plus the success, plus the energy, they frequently suffer from massive intellectual distortions, at the ego level, that may seem preposterous to other people.

From a physical point of view, the phallic structure, like all rigids, is very harmonious. The body is well proportioned, symmetrical and responsive. The individual has a highly developed sense of spatial relationships, and can usually identify the position of any given part of his body with closed eyes. This is diagnostically useful, especially when one has trouble identifying a phallic -- this may be one of the

tools. The peripheral extremities -- hands and feet -- are usually quite warm and energized. They are strong and sensitive. They are, in a word responsive. The phallic is usually successful in life and narcissistically considers himself attractive to woman; in fact, he is attractive. However, his success with women is partially because he really is attractive and partially because he is experienced by women as an "angry" man, who offers a challenge. Frequently, sado-masochistic relationships develop with women who adopt a masochist position against the phallic's sadistic attitude, and this is frequently one of the bases of relationship. If anything, the phallic has contempt for the woman which, of course, covers up his underlying dependence and longing. Personally, I consider that if a phallic is able to ackonowledge his true longing for a woman directly to her, considerable therapeutic progress has been made, and this may be a gauge of the evolution of the therapy. Such a resolution of narcissistic pride is indeed a big step for this type of personality.

In the counter-transferential situation such a man is particularly attractive to women with unresolved father conflicts -- and this includes many patients! It is easy for such a man to be trapped by flattery, or to accept a challenge at the sexual level; or to sexualize his love for his patients -- thereby transforming the single most useful therapeutic tool into a very destructive situation -- or to be caught in anger, impatience, contempt, This last, contempt, is almost a given with such a structure. Humility, and therefore compassion, are a difficult problem for the phallic.

Contact at a deep level is quite difficult for a phallic. The reason is simple: Subjectively he feels he lost the battle for his

mother (although he's never really given up) because he wasn't good enough. His father was better, simply bacause he won. So the childhood experience is one of low self worth -- which is confirmed in adulthood, as, when he has these negative, hateful, contemptuous and arrogant feelings, he also has, at an unconscious level, guilt and pain for having them. Close contact means risking having all this brought out in reality/consciousness. Realization of low self-worth, and its irrational, archaic components leads to resolution of character defense -- and the phallic, like any other structure, will defend his character structure with all the resources at his disposal.

From the above, one could conclude that a phallic therapist is virtually a monster, a negative being that should be avoided. Quite the contrary, for the energy, commitment, strength and sincerity usually found in these people helps them resolve to a large extent their characterological problems. If a phallic is able to go through at least some of the hate and reach some of the narcissistic pride, he will have re-opened his heart, and he will become warm, loving, intensely committed to his work. The positive counterparts of the negative characteristics previously described can flower. Sex and love become balanced, he can establish a creative, sound relationship in his own life and, from this solid base, understand deeply his patient.

ETIOLOGY OF THE HYSTERICAL FEMALE THERAPIST

Like her counterpart, the phallic narcissistic male, the hysterical female's main trauma, the one that fixated her, is the rejection suffered at the hands of the father during the Oedipal stage. Indeed, when the little girl tried to climb on her daddy's knees and became sexually excited, when she expressed this excitation to him, she found suddenly that her beloved father rejected her in a totally -- for her -- incomprehensible way. Until then the feelings between her father and her had flowed uninterruptedly. Her father had accepted her unconditionally and his love for her was deep and great. However, as the little girl approached the Oedipal stage and sexuality became an issue for him, her father found himself unable to tolerate the seductive approaches of his daughter and suddenly, abruptly rejected her. The little girl could not understand this nad repeated her attempts to gain her father's attention and love, becoming even more seductive as little girls are prone to. This in turn increased the father's anxiety, who reacted by further rejecting her. Eventually, when she had been repeatedly disappointed, she began to personalize and internalize the rejection, blame her mother as the successful competitor for her father's favors, feel unworthy, identify her sexuality as the culprit that has broken the paradisical state in which she found herself prior to its appearance. Eventually she developed the ambivalent love-hate tie to the man that will dominate her character structure for the rest of her life.

The problem centers around the child's belief that her sexuality is the culprit, the cause of paternal loss. For indeed the little

girl perceives that prior to the appearance of sexuality, contact with her father was unbroken and unmarred. Conflict existed but to a limited and resolvable extent. However, her father's definitive rejection is, subjectively, associated with the appearance of sexuality. Whether the father did indeed, in real life, reject her or not is immaterial. What really counts (here like in all other subjectively experienced trauma) is that the child believes that he did reject her. The rejection may be associated with a momentary absence of the father at a critical time -- or the child may have withdrawn as a consequence of guilt derived from the Oedipal taboo (which then involved the mother in a very prominent role). No matter, the loss of father (love object) is directly related to the appearance and expression of sexuality. The temporary solution is to repress sexuality, which, when successfully achieved leads the little girl into the happiness of the latency phase, during which she re-establishes contact with her daddy.

During adolescence, when sexuality will again take on a preponderant, and this time definitive, importance, she is faced with a choice between sexuality and love. And here is where the main difference between her and her male counterpart, the phallic narcissistic character, takes place. For he chooses sexuality above love; where she chooses love above sexuality. In later years this will express itself, in his case by phallic anger, and in her case by hysterical seduction and inhibition of sexuality. This is not to say that a hysterical can successfully repress sexuality -- she cannot, for her libidinal energy is much too strongly anchored in her genitalia. What she does achieve is to hate her sexual need, the

cause of her conflict and pain. Eventually the hate becomes hate for her own genitalia, which she considers "dirty", "inferior", etc. Another factor in her choice between sexuality and love may be that, as aggression was severely inhibited and sexuality is an active, aggressive expression of self, she repressed both active modalities -- but I am not sure of this.

Seduction for the hysterical female forms an integral part of behavior as an adult woman; she is almost always unconscious of this or the message that she in constantly broadcasting to the men around her. She is horrified when men approach her sexually, believing herself to be, consciously, not interested in him at "that" level. Seduction is a tool that is used to cover up her insecurity, her fear, her longing. From a psychodynamic perspective, what happened was that she learned that men (daddy) were attracted -- and therefore vulnerable -- to her seductive behavior, while, at the same time she had to suppres the conscious realization that her actions would lead directly to the taboos of the Oedipal situation.

Hysterics, in the sense that Freud defined them, almost have disappeared as a consequence of the sexual revolution. In Freud's time, hysterics somatized their symptoms and frequently became bed-ridde or completely incapable of functioning; today, when woman's sexuality has been released from its XIXth century bondage,. they can utilize this normal avenue of energy discharge quite freely. However, like her male counterpart, the split between her heart and her sexuality remains and while she may give in sexually to the man, she will never give him her heart. Conversely, she will fall in love with a man who is sexually impotent or not available in one way or

another, either by being married, having another relationship or being in some way sexually unavailable (the "Impossible Dream"). Either one of these choices leads to anxiety. one of the hysteric's hallmarks is the ability to sublimate this anxiety and transform the energy into a positive manifestation, such as success on the career or social level.

Like all post-genital structures, the hysteric's body is well integrated, highly efficient, functional, strong, and usually very attractive. Indeed, one finds that surprisingly small, petite women with this character structure have unexpected strength, a strength incompatible with appearance. The reason for this strength is the high level of integration that allows her to use her entire body to fulfill particular functions. The integration is not limited to the physical body, but extends itself to the intellect, to social functioning and interchange and to virtually all the activities of her life. This is particularly evident during aggressive exercise -- great strength is suddenly mobilized.

The problem of the hysteric is to unify her heart and her sexuality, to give herself completely to a single cause, to devote her entire energies to one purpose. Like the phallic narcissistic male, she tends to cover many functions, many careers, many objectives. And this may be her downfall for as she spreads herself thinner and thinner, she can eventually lose the pleasure of her endeavor and try to compensate by continually attempting to do more, do better, be perfect.

Expression and eventually abreaction of her hatred against the

man is further inhibited by her physical fear of the stronger sex. For she is terrified of physical contact of any kind which, at the deeper levels of her unconscious, is associated with sexual intercourse. The image that comes to mind is the little girl hatefully observing her big, omnipotent father -- source of frustration, longing, love -- and frustrated love that becomes hate. She can become defensively arrogant, contemptuous, and dominant.

In a therapeutical situation, the hysteric's therapist's beauty and seductivity may create problems. Indeed, the man she is treating may find himself extremely attracted to her and her almost unconscious seductive attitude may work against her. In the context of bio-energetic therapy, where the patient may be working scantily clothed, while the therapist is fully dressed, this may become a significant factor.

If the hysterical therapist successfully faces and resolves her outstanding problems, she can be exceptionally efficient, understanding, deep, for she has the integration and the strength to go into many areas of the unconscious. She also represents, frequently, the idealized image that has been so popularized through the media of what a woman should be: loving, understanding, pretty, attractive, seductive, and to some extent naive. The accomplished therapist must be in this case, as well as in all other cases, conscious of the image she projects and how this image affects the patient, how it corresponds, or, on the contrary, conflicts with the patient's images of what the woman should or should not be. A well resolved hysterical-type therapist has connected in some degree her heart and her sexuality. Thus she is able to deeply empathize, and have the

warmth and the love that is our hallmark of excellence. Her firm, yet gentle and loving attitude, that is possible for this type of woman, is indeed a great asset.

INTERACTION BETWEEN AN ORAL PATIENT AND A PHALLIC NARCISSISTIC OR HYSTERICAL THERAPIST

In this case our phallic narcissistic/hysterical therapist is faced with a system whose ego boundaries are well established and anchored in reality, but has a very low energy level. So the therapist's need to perform, to obtain results, to move quickly, may become counter-transferential. The oral patient lacked nurturing and attention, and will go to any extreme to obtain gratification, or pseudogratification of this unfulfillment. The modality generally used is an apparently passive attitude, that is really very active in that it is designed to provoke (spite) the therapist. The oral patient believes, in a distorted way, that provocation is the only way to obtain attention and, eventually, love. There is an incapacity for direct expression of real needs at the adult level -- so the attempts at gratification are always indirect, passive, roundabout. They therefore result in very little, if any, real gratification. This has only served, in the patient's life experience, to confirm the neurotic premise that his/her needs will never be fulfilled. And so, ironically, this attitude creates the conditions that further the emptiness that is the dominant trait of this type. Parenthetically, this is always the case -- in its defense against the re-enactment of initial trauma, the character structure in effect re-creates precisely that against which it is defending. The counter-transferential danger, at the characterological level, is in this case that the therapist with his/her high energy system and expectations of results, becomes angered and exasperated at the low energy, passivity, and apparent unwillingness of the patient. The anger, exasperation and impatience will be perceived

by the patient, who will then have confirmation that his continuous self-abasement and very negative self-image is objectively exact. He is truly unlovable, worthless; there is no hope, he should not waste his time and energy -- and he allows the underlying depression to surface.

On the other hand, if the therapist realizes that he/she is working with a very low-energy organism, that progress will be slow, and that the main purpose of therapy in these cases is to increase the energy available to the ego, breakthroughs become possible. The patient becomes capable of expressing his own needs directly and take whatever steps are necessary to satisfy them by himself. This is the central issue of therapy with these patients -- they generally do not lack intellectual capacity, insight or ability to experience feelings. The liberation of free, available energy is paramount. This should be accomplished simultaneously, through the usual means but also physically by increasing lung utilization through dissolution of the extremely tight chest blocks that are the most dominant physical problem of this type.

Interaction with this kind of patient is particularly frustrating since the constant indirect expression of the oral needs of the patient, the constant attempt by the patient to establish a dependent, symbiotic relationship, may become almost intolerable, for a "rigid" structure, where castration anxiety -- with its concommitant fear of closeness -- is extremely powerful. Subjectively, the therapist will experience that the patient is trying to "suck him in" to "suck his/her energy". The therapist's supercharged system finds an immediate avenue of release in the oral needs of his patient, and the illusion

that he/she can indeed fulfill the patient may lead the therapist to fall into the trap set up by his patient. The therapist must never forget the oral patient does not have a real need to be nurtured and fed from the outside, for he is now an adult -- he only pretends he does. The patient's real need is to counteract this illusion and move out in the world and satisfy his needs by himself. As long as the oral patient continues in the belief that he can get the absentee parent to finally deliver the love and nurturing that he missed as an infant, he will not move out from his defensive position and the therapy will not progress. It is therefore necessary for the rigid therapist to convey that it is impossible for the patient to obtain fulfillment from the external world/reality. Only then can the patient begin searching inside himself -- and this is of course where the real fulfillment can be found. The therapist must abandon all expectations give up the illusion that he can "cure" his patient, for only then can the patient, having realized this, make a real attempt to move out to the therapist. The ability to move out to the therapist will frequently be paralelled by the establishment of a new relationship or consolidation of the existing one, as well as significant physical changes -- such as an increase in breathing and/or energy level.

As previously stated, for the oral personality, the need to be "fed" from the outside is paramount. Sometimes oral women (especially those that are physically attractive) tend to transpose this need and use their sexuality to be "filled", in which case they become very seductive. This is a trap for the phallic narcissistic therapist with his own strong sexual drive. It will be equally dangerous for the hysterical therapist, for there the appeal is to be "mothered" and

this is equally true, of course, for oral men.

Oral men also use sexuality to try to fill their inner void. However, this is not an issue for the dyads under consideration. In the case of homosexuality many other factors intervene, which usually override this aspect (such as submissiveness, castration fantasies, revenge, hate, etc.).

INTERACTION BETWEEN A MASOCHIST PATIENT AND A PHALLIC NARCISSISTIC AND/OR HYSTERICAL THERAPIST

Here the phallic narcissistic/hysterical therapist is faced with a very highly energized character structure. We must differentiate here between "free available energy" and "total energy" of the organism. The first is that amount of energy available to the ego for action resulting from conscious, volitional functions. It does not include the energy required by the automatic nervous system to both sustain life functions and psychic equilibrium. Free available energy is therefore that energy available for motility, creativity and pleasure. "Total energy" is the energy of the entire organism, bound or not. In this sense the masochist character structure has enormous total energy and little free available energy -- for it is all bound in the massive musculature, whose purpose from earliest infancy is twofold. The musculature contains his own anger and rage (by dissipating the enormous energy generated by these feelings through a chronic spastic musculature) while at the same time developing an insulating layer of flesh to protect him from the exterior.

The masochist learned not to express himself, to remain passive, to bear, contain within his massive body all needs to protest, all desires for independence, all capacity to assert himself in an aggressive outgoing way. If the therapist reproduces these demands he will meet the characterological defense head-on. The basic problem of the masochist is that freedom and permission for self-expression was denied, and he has contained within his body the unexpressed protest that this denial engendered. It is therefore the task of the therapy to help the patient come out of this shell, to release the bound energy in

in the heavy musculature, to help him learn how to express himself directly, to permit him to scream out the protest and repressed rage that is bound in the muscles. For in childhood this freedom of expression was systematically repressed -- either overtly or covertly -- and the masochist is terrified of his own need for expansion/expression. Only when he realizes that it is possible to express negative feelings without dire consequences, can he begin the expansionary process of selfassertion that is the key to the de-repression process for this character type. However, this is tricky, for the means used to deny freedom and expressive action was an overprotection, overconcern with the physical needs of the child in detriment of his emotional needs for protest, expression, risking and individuation. The therapist must beware of reproducing this neurotizing ambience and, as usual with neurotics, the slightest inkling that the basic trauma may be reproduced triggers off the characterological defense.

Therefore, the therapist must keep in mind that any direct impingement upon this type of personality is experienced by the patient as re-enactment of the repressive (and humiliating) methods used in his childhood. Two of the most traumatic conditioning experiences were forced feeding and application of enemas, both of which resulted in fixation at the anal stage. Subjectively, these were experienced by the patient as a violation of his physical and emotional self, a true invasion of his boundaries and privacy. Therefore, if the patient percieves that the therapist has a need to force issues, however subtly, this need may express itself (for instance, by excessive interventions, or by expecting results and breakthroughs), the patient will interpret this as a reproduction of the parental

expectation that he eat, defecate and behave well.

Therapy with masochistic patients must be oriented toward teaching them to become confident that their need for expression will be well received. For a rigid therapist this means that he must very gradually and very carefully point out the characterological defenses that are brought into the session by the patient, without any expectation for results or breakthroughs or quick change. Character analytical methods must proceed in parallel with the bio-energetic work -- but it must have a didactic aspect also. For the masochist must be taught that expression and expansion are acceptable -- that in fact they are desirable.

The character defense, as is so well known and abundantly described by all authors from Freud on, is expressed by a whining, provoking attitude intended to attract aggression. The masochist, Freud said, derives pleasure from pain. This led Freud to postulate the "death principle", (Thanatos) as opposed to Eros, the life force. The existence of Thanatos was incompatible with Freud's own observations and deductions, and he later refuted it, without explaining the apparent pleasure some cases (masochists, in all probability) derived from pain. Now we know that the masochist's provocation is designed to create sufficient aggression so that, in turn, he may discharge his repressed rage -- thereby releasing (if only momentarily) the accumulated energy that is so painfully bound in his physical and psychic structure. Hence, the counter-transferential problem may express itself when the masochistic patient tries to provoke the rigid therapist into (apparently) helping him. This provocation, if accepted, will trigger the characterological defense, and the patient

will collapse and blame the therapist for "attacking" him. The masochist will attempt to drag the therapist down into his "masochistic morass" rather than use the proferred help to pull himself out of the morass. The steps will be: 1) He will provoke the therapist into "helping" or "attacking" him; 2) If the therapist accepts this provocation the patient will then collapse; 3) He will blame the therapist, identifying the help offered as an infraction of his independence leading eventually to humiliation associated with the control of food (nurturing) and excremental functions (discharge of negative feelings). The therapy in this case can be helped a great deal by the bio-energetic techniques, for the need to express himself and to protest can be particularly well channelled through bio-energetics. The therapist must, however, understand that the patient has to do it by himself. He must <u>teach</u> the technique to the patient and allow the patient to do it without any further impingement or suggestion. Where support is frequently recommended with other character structures, in this case the therapist must constantly remind himself that no support is necessary. No sympathy is required. The masochist's problem is to burst out of the containment he has created with his formidable defenses. If the therapist can indeed stand back and let the masochist work by himself, soon the patient will begin to produce material that can be analyzed in the usual way. It is very important to repeat once again that this material must be produced by the patient and not offered by the therapist, even though the patient may sometimes demand that the therapist help him.

INTERACTION BETWEEN PHALLIC AND/OR HYSTERICAL PATIENT AND PHALLIC AND/OR HYSTERICAL THERAPIST

The energy systems of both people involved in this dyad are similar and therefore this is not a consideration. The main problem lies in both people having similar defenses so that they may easily hook into each other. The patient can easily identify the basic defense system of the therapist and the therapist may, if he is not really aware and careful, interact with the patient at the characterological level.

Several attitudes characterize the rigid defense system. One is the seduction which is partially conscious at best; another is the difficulty in feeling and expressing love, tenderness, softness, and vulnerability, which are defended against by masking them with rage, hate, contempt. Still another is the pride and arrogance, the pervasive contempt that is virtually always present. There is also the withholding that gives the impression that the individual is aware of, but refuses to express, his feelings. This is of course erroneous and often masks an insensitivity that would seem incongruent to the untrained observer.

The main problem here, I believe, happens when the patient and the therapist are not of the same sex, for we must remember that seducti(is a basic defense system for rigid structures. It is almost uncontrollable, expressed in tiny, minute-gestures and glances, it permeates the behavior of the rigid personality and is constantly taking place. Since both people utilize the same defense mechanism, both people will be equally sensitive to the utilization of the same defense by the other. Therefore, when sex enters the picture, be it

homosexual or heterozexual, strong seduction may be taking place at the unconscious or preconscious levels. In addition, both people in this dyad have an inordinate fear of rejection, both have a need to perform and have difficulty exposing their real feelings, especially those of love and tenderness. It may indeed be simple and tempting for the therapist to collude and by-pass, as the patient may not bring the issues to the fore. There are at least two important guideposts to indicate collusion -- when the patient "feels good" over prolonged periods of time, thus not bringing new problems while at the same time not resolving the transference nor attempting to sever the therapeutical relationship -- or put another way, the sustained absence of negative transference and/or expression of negative feelings toward the therapist, parent or mate. The second one is the "good boy/girl" attitude where the patient adopts this position, and the therapist does not confront and permits it to go on. This last may take the form of promises or sexual seductivity.

In spite of the above, I believe that the interaction of therapist and patient having the same basic characterological structure is essentially a very positive one in that the therapist understands intimately the problem that the patient is facing. I would not like the reader to believe that the prognosis for this type of interaction is poor. Rather it is quite the opposite, for if the initial resistance is met and resolved, rigid structures can go very deeply into their feelings. Growth and change do take place, and working with this type is usually very rewarding for the therapist.

The seduction that is always initially present must be understood as a defense behind which lies a frightened little boy or girl who

lacks the courage to expose the need for love and the longing that were repressed in early childhood. If the therapist can accept and expose to the patient both the seductive game and what is behind it, he will be able to reach the patient's heart since in the case of rigid structures more than in other types, this is the key that opens up the whole personality. Rigid structures essentially have a lot of feelings that have been suppressed at preconscious levels, which can become quite suddenly available if the defense is exposed and worked through.

The genesis of the rigid structure's basic infantile trauma was the sudden, abrupt rejection of the child's sexual advances toward the parent of the opposite sex. This was experienced during the Oedipal phase and was so strong that the adult will go to extraordinary extremes to bypass any possibility of confronting any similar situation again. The facility for suppression is precisely the weakness and the strength of the rigid personality's defense system.

Rigid patients usually adapt well to life and accept a state of lovelessness by displacing their interest and energy on their career. While I have had the opportunity to work with women (hysterical type), I have had very little experience in working with rigid men (phallic-narcissistic character structure). So I am, at this time at least, unable to describe what the interaction would be. Hypothetically, however, it would seem that interaction between two structures of the same sex would create great conflict since competitiveness, anger and rage might be the dominant modality of interaction. The therapist may easily get caught up in the challenges that are normally put out by the phallic narcissistic male. He may also be caught in the contempt which is present when two rigid structures of the same sex

interact. Contempt, competitiveness, fear and hostility are basic modalities when two rigid structures of the same sex meet. Mutual rejection is always an underlying threat in any case.

When the interaction is between rigid structures of the opposite sex, sexual seduction becomes one of the dominant issues. For both people have learned to use sex; she will be flirtatious and unconscious (or even consciously) seductive; he uses sex in anger, aggressively; both use it to hide true longing, sadness, vulnerability -- their low self-esteem. For behind the powerful, organized character defense is a little boy or a little girl, sad and lonely, longing for the Oedipal object. So the counter-transference is dangerously easy in this dyad, and while the gross overt seduction/aggression interaction is easy to spot, the aware therapist must be on guard for the much more subtle modalities of seduction/promise that can take place.

The male therapist must also realize that for his female patient he represents an extremely threatening figure -- the powerful, angry, and, at least potentially sexually available, male. It might be very difficult to reach the deeply repressed rage, especially as it is probably mixed up with longing. Frequently the father rage was strongly suppressed in childhood, and has become virtually unreachable as it's expression is equated with loss of the love object. Rage was also suppressed by the mother, although here it is more accessible as the threat of loss was not serious. So for the male therapist it may be ver difficult indeed to reach this indispensable level. It may sometimes be wise to enlist the services of a female colleague, either on a temporary referral basis or by having the patient work simultaneously with both father and mother images. This will allow her to explore

her anger in a safer environment -- the one provided by the woman therapist. For the phallic narcissistic therapist this co-responsibility may involve letting go of some pride, as he must then accept that he is no longer the "great therapist" who is going to "save" his patient, and that he needs the collaboration of a woman -- his colleague. At the deep irrational level these are difficult things for a phallic narcissistic therapist to accept.

On the other hand, if the therapy is successful, then the hysteric's heart will have been reached. It will be like a beautiful flowing opening and giving unreservedly, the type of giving that little girls are capable of. It will be asexual, unthreatening, undemanding -- all that the phallic narcissistic therapist longs for in his heart of hearts. And at that moment he must begin resolving the transference, in effect sending her into the arms of another man, thus in some way re-enacting his own childhood trauma. Tragic? Poetic? Perhaps, but a beautiful expression of true, unselfish love that will expand the therapist's own horizons. And this is perhaps why most of us are in this profession to begin with.

INTERACTION BETWEEN THE MASCULINE AGGRESSIVE FEMALE AND THE PHALLIC NARCISSISTIC AND/OR HYSTERICAL THERAPIST

Here two important issues challenge the hysterical and/or phallic narcissistic therapist -- control and seduction. For these women are extremely powerful, manipulative, intellectually brilliant, frequently very attractive and sometimes quite ruthless in that they will use every means at their disposal to achieve their objective. If they believe that the therapist wants sex, then sex is what they will deliver -- in exchange for absolute control.

Their structure, as described in Pierrakos' seminal work on the subject presents large hips, smallish but beautifully shaped breasts, flashing eyes -- the social ideal of female beauty in our culture. They of course know this and how to use it to their advantage. The phallic narcissistic male, sexually potent, angry, himself seductive and attractive is a natural target for this structure. However, the therapist must never forget that behind the seduction is the need for control, and that sexuality is used toward this end. The masculine aggressive woman is usually intellectually aggressive to the degree that she is passive sexually. In extreme cases we find extremely brilliant, successful women, who compete and win in a predominantly male environment, while remaining quite unresponsive sexually. They are not frigid -- there is enormous energy in their pelvises and sexual organs -- it is more that they have lost a clear perception of sexual (especially vaginal) stimulation. They have in effect traded sexual pleasure for career, in an almost pure example of sublimation.

Once the seductive games have been exposed, the repressed rage

against men (father) can be dealt with. For this is one of the keys to successful work with this structure. And here the phallic narcissistic therapist can be very effective, easily representing the father figure, if he has been able to maintain objectivity. If he has not and has personalized his patient's aggression, control, or seduction, he is bound to respond in anger -- thus confirming the patient's belief that all men are hostile. Deadlock issues, often manifested overtly by endless discussions, intellectual arguments, disputes over trifles, direct opposition ("I'm right, you're wrong"), blame ("It's you who is doing this!"). The therapy can remain at this stage for prolonged periods, unless the therapist can overcome his pride, express his inability to break resistance and expose vulnerability -- a difficult task indeed for the proud phallic narcissistic therapist! Yet this is the key to reaching the patient's heart, and of course the key to therapeutical success.

The danger of collusion with this type is limited; however, a reliable sign that collusion is taking place is the lack of negative transference. For positive transference will be abundant -- and used defensively.

With the hysterical therapist, the issue remains control -- but the sexual push-pull dynamic is absent, Counter-transference is less likely, and, as previously stated, it is easier for the patient to reach her repressed aggression. However, the level of aggression that is easily reached in this dyad is the hostility towards the mother -- not the hate towards the father, which is one of the underlying basic problems for this type of patient. So just as in the previous dyadic interaction, it may be wise for the female therapist to seek

out the aid of a male colleague -- and this, in itself, activates the hysterical's characterological defenses of contempt and hate for the man as expressed by a self-sufficient attitude; it also requires the resolution of some pride to allow herself to acknowledge the need for help.

The masculine aggressive woman has, frequently, psychopathic and paranoid components. It is easier for her to trust a woman than a man, who, after all, is the one that rejected or abandoned her. Resolution of this paranoid component is very important, although it is sometimes a difficult and protracted endeavor. Alternation between male and female therapists is a valuable tool. Ultimately, however, the personality really changes if the heart is reached, if the person becomes capable of loving and giving instead of hating and taking. In this case, the therapist's awareness that the projected hat hostility, demand, mistrust are an expression of the deep suffering of his/her patient will yield invaluable results.

INTERACTION BETWEEN A SCHIZOID PATIENT AND A PHALLIC NARCISSISTIC OR HYSTERICAL THERAPIST

From the previous description it is obvious that the phallic narcissistic/hysterical structure represents, characterologically, a powerful, organized ego system with a great deal of integration and energy. On the other hand, the schizoid structure suffers from a lack of ego integration. The schizoid ego is too weak -- the phallic narcissistic/hysterical ego is too strong. Therefore one of the fundamental problems in the interaction between these two structures in one of different energy levels. Where the phallic narcissistic/ hysterical therapist has a tendency to move fast, efficiently, where he/she needs to resolve, to perform the schizoid is terrified that his ego boundaries will be destroyed. For his main problem is precisely that his ego boundaries are permeable, fragile and unstable. Should the ego boundary give way, massive decompensation is feared -- and not unrealistically so.

As an analogy to describe these two personalities, we could imagine an amoeba with a very rigid, inflexible membrane that assures the safe boundaries of the organism while simultaneously impeding its motility -- an indispensable requisite for pseudopodia extension. Supposing food intake was nevertheless adequate and sustained; the problem of this amoeba would be to move and discharge the excess energy built up in the protoplasm through constant intake of food and oxygen. On the other extreme of the spectrum, an amoeba with with a schizoid character structure would have a membrane which is too permeable, too fragile, perhaps even fragmented. There the danger is that the amoeba would lose its protoplasm through a membrane that cannot

contain it properly. Therefore, when a schizoid patient interacts with a phallic narcissistic/hysterical therapist, the therapist should always keep in the back of his mind the fragility of his patient. The therapist should remember that his need for quick, efficient resolution may develop into impatience, exasperation, even anger, all of which will re-enact the patient's primary trauma. The therapist must often act as a counselor, consolidating the reality principle and defective object cathexis common to these patients. Frequently, the schizoid patient needs an example of a strong alter ego on which to lean while he develops his own strength and object cathexis.

In other words, the schizoid personality needs a strong, but gentle, accepting and understanding ego on which to model himself. He must constantly be confronted with reality, all types of reality, in an unthreatening way. Repression has been defective -- regression is a constant threat. Of this the phallic narcissistic/hysterical therapist must be constantly aware, since it is very possible that one of the "tests" that the schizoid patient will put the therapist through is that of patience. The schizoid patient will withdraw, refuse to produce new material, and remain on a stable plateau for long periods of time demanding that the rigid therapist be patient, and able to tolerate the schizoid's need for a slow, progressive, reality-oriented therapy. The therapist must realize that schizoids are often life-long patients. The problem of the schizoid is his inability to sustain contact with the reality outside himself. Contact, with the therapist and reality, is perhaps the single most important issue for these people. The therapist must frequently act as a bridge, as a guide, to help his patient. No quick resolutions are possible, no "breakthroughs"

are going to take place over long periods of time. Real "teaching" must take place, sometimes at almost elementary levels.

The phallic narcissistic male uses anger and aggression as basic defense against his own vulnerability. Not so the schizoid, who uses withdrawal. This is exactly what happens if the phallic narcissistic therapist presses forward, becomes angry or impatient, or in any other way aggresses his patient. The patient withdraws, if not physically, at least emotionally "ad finitum", exasperating further the therapist. Eventually withdrawal becomes decompensation and regression may set in, leading in extreme cases to psychotic incidents. This is not as serious a problem for the hysterical female whose baseline defense is seduction instead of anger.

Bio-energetics is especially useful in a counter-transferential situation of this type, for by using physical techniques the therapist can help the patient re-establish -- or maintain -- the basic reality contact of his bodily perception. Simultaneously, the possibility of active, creative, innovative physical work will help the therapist satisfy his own need for results, for schizoid patients usually can work very, very hard physically. They love the feeling of being alive this provides them with. Bodily perception is a fundamental step in re-establishing object cathexis and reality contact. The schizoid usually welcomes heavy physical exercise. They are able to sustain many of the more active bio-energetic techniques far beyond other character structures and will benefit greatly from reaching the limits of physical tolerance, for it is at these limits that they most clearly perceive the reality of their body. It is a known fact, for instance, that many of the greatest dancers have strong schizoid components,

for this allows them to drive their bodies far beyond the tolerance levels of other structures.

It is, of course, indispensable to continually do analytical work as well. But again, the analysis should be oriented towards a consolidation of ego boundaries rather than an uncovering of archaic material. This last is precisely what the patient is constantly in touch with -- and fears, for he is unsure that it can be suppressed sufficiently to maintain equilibrium. All authors concede that an important step is the expression of negative transference, and here bio-energetics is again most useful as it allows controlled, progressive abreaction. But the skillful therapist must beware of pushing his patient too far too quickly -- for the schizoid structure fears, at a very primitive level, his own aggressive impulses that are subjectively experienced as all-destructive, uncontrollable id material invading the weakened ego. Herein lie the greatest counter-transferential dangers.

Sexuality should not be a problem in this particular dyad, although in general sexuality/seduction is a basic counter-transferential danger for the phallic narcissistic/hysterical therapist. The reason is that sexuality is usually not an issue for the schizoid personality -- either it is quite repressed and the patient has limited interest in sex or it is overtly used, in such an obvious and gross way that it is easily recognizable and dealt with.

However, contact may become a counter-transferential problem. For the schizoid needs to explore very slowly, make and break contact frequently; the rigid therapist needs to move, accomplish, and may fear the deep, soul to soul contact schizoid demands.

Defensively, the therapist may in some way become unreal -- and this is the worst thing one can do with such patients. For they perceive the other's dynamics at an incredibly deep level and were always lied to as infants. The most important things for the therapist to remember are:

1) He must above all be real and realize that his patient can almost "read his thoughts". It is pointless to lie.
2) He/she must teach the patient bits and pieces of reality that other adults assume are integrated.
3) He must understand the rage as an expression of the pain and frustation of being unable to maintain reality contact. Contact is the crucial issue. The therapist is the bridge to reality.

INTERACTION BETWEEN A PASSIVE FEMININE PATIENT AND A PHALLIC NARCISSISTIC AND/OR HYSTERICAL THERAPIST

As has been aptly described in the chapter on the passive feminine therapist, their basic behavior pattern is submissiveness. The passive feminine (male) character structure tends to placate, submit, to rationalize away all feelings which might in some way lead to direct confrontation. The rigid therapist, who tends to be much more direct, who may have some unresolved contempt, becomes impatient and finally angry. Whereupon the passive feminine patient will try to please the therapist. He will also withdraw, retreat into smoldering resentment and conclude he was right in the first place -- his characterological assumption -- that negative feelings, rebellion, self assertion are taboo, is confirmed. But he will continue for some time anyway, to please. Therefore the therapist must be very careful with the proferred "gifts" that the patient will almost continuously produce. These "gifts" may take any form, including production of dreams and very deep unconscious material that the patient believes (at a deeper level) the therapist expects. The patient is always anticipating the expectations of the therapist and will go to great extremes to satisfy these frequently fantasied expectations. On the other hand, this type of patient needs support and assurance from the therapist that he is accepted and loved. For the phallic narcissistic male this again proves to be a challenge, since one of his basic difficulties is to love in a genuine way, without manipulating. As the passive feminine patient is essentially a manipulator who demands and requires love and support, the therapist's tendency to hold back his love (experienced as "unnecessary demand from the

patient") will be exacerbated. This is not such a problem for the hysterical therapist. For one thing it is much easier for her to love the "helpless little boy" picture her patient presents. For another she is a woman, and the patient is more comfortable with women -- as long as they remain asexual -- than with men, who are more threatening. Let us not forget the passive feminine's main problem area is with the man -- not the woman. The problems with woman/mother surface, sometin violently, when sexuality appears -- but for this to happen, considerabl trust has to be developed and a good therapeutical relationship is indispensable -- at which point many counter-transferential situations will have been worked through.

There is a strong temptation for the therapist to collude with his patient and accept the "gifts" which are only a seduction on the part of the patient. However, should the therapist accept such gifts without analyzing their true purpose and meaning, and uncovering them as a resistance in a characteranalytical way, he will be playing into the characterological defense of his patient. On the other hand, should he/she confront the patient in too harsh a manner and point out the true irrelevance of this frequently useless material and how it is used as a defense against progress, the passive feminine patient will perceive this as a reproduction of his original infantile trauma and will withdraw further into passivity, resentment and fear. It is necessary for this type of patient to develop sufficient trust so that he can become self-assertive, move out and express his real feelings, anxieties and hatreds without fear of retaliation from the feared parent -- the therapist. Again the rigid therapist must realize that this type of patient will require a protracted therapy

and that while breakthroughs and turning points do happen, progress is slow.

The unconscious rage of the phallic narcissistic therapist will be interpreted, if perceived by the patient, as rage aimed directly against him, and again will re-enact the childhood trauma. The same applies to unconscious contempt. For the hysterical therapist, in addition to her anger and contempt, the issues of sexuality and mother-image may become serious. For if we refer to the etiology of the passive feminine character structure, we will see that the patient's masculine identification is not secure. The patient learned to survive by playing on his mother's protective instincts. He used seduction, helplessness and ultimately the promise of an asexual relationship with her -- and he hasn't forgotten! Of course, all hysteric have a secret longing for "prince charming" -- the perfect young boy whom they can love without the danger of his becoming a Real Man. And this is precisely the transformation that is required for a passive feminine patient -- he must become sexual and assertive -- he must possess his own anger fully. These feelings are defenses that the rigid therapist has developed instead of expression of his real love and concern. It is, of course, here that the solution lies. For the rigid therapist must truly have warm, good feelings for a passive patient before agreeing to work with him. Otherwise the therapy will be extremely difficult and the prognosis doubtful. If the rigid therapist perceives in himself/herself anger or contempt at his patient early, he/she should consider, after working through these feelings within his/her own framework, the possibility of a referral. On the other hand, if the warm, positive feelings do exist, then the dyadic

relationship established between these two structures can lead to a fruitful, productive and rewarding experience for both people involved.

INTERACTION BETWEEN A PSYCHOPATHIC PATIENT AND A PHALLIC NARCISSISTIC AND/OR HYSTERICAL THERAPIST

Here the rigid therapist is going to meet a real challenge. In the case of the psychopath he/she is meeting a patient whose energetical system is similar to his/her own in that there is a lot of free available energy. However, the psychopath has displaced his energy into the upper half of his body and has overcharged his mind. The ego functions are extremely active, perhaps even overactive. Psychopaths must always be right. Their receptivity is diminished; their self-assured assertion leaves no room for doubt or challenge. Therefore they have great difficulty accepting any suggestion from the therapist. They will also strongly resist many of the physical techniques available in bio-energetics, going through them mechanically and dissociating themselves from any perception of new, and therefore unknown, feelings. We must remember that the psychopathic defense originated through the extreme manipulation of a seductive mother which, through denial, resulted in an over emphasis of the ego to the detriment of all other perception. The fundamental problem is that they do not even attempt to challenge their own interpretation of reality, which has frequently been adaptive and functional in their exterior life (with the exclusion of their interpersonal relationships).

On the other hand, the rigid phallic narcissistic or hysterical therapist has great difficulty in expressing love directly. He/she fears the rejection that in infancy, created his own character structure. The resulting withholding or indirectness may resemble, to the psychopath, the manipulation, double messages, double binds, trickery and unreliability to which he was subjected. In addition, the psychopath

has a rejecting behavior constantly expressed at all levels which activate the rigid therapist's basic fear of rejection -- this is subjectively and consciously perceived as extreme frustration, which may lead to defensive anger. Further, the psychopath will probably reject any attempt by the therapist to reach him directly. All of which inevitably activates the rigid therapist's characterological defenses. In anticipation of rejection, the therapist will tend to withdraw, remain passive, let the patient gain the control he needs, and perhaps not even confront him when confrontation is appropriate. The therapist will feel that the psychopathic patient does not really want to change, that the motivation is very limited, and may fall into the trap of believing that his patient is not really committed to change. There may be some truth in this. The psychopath believes basically that he is right and society is wrong, that the rules imposed upon him from the exterior are the product of an irrational mother. In this way the therapist and patient collude and bypass the psychopath's main problem which is the need for control. By letting the patient gain control of the therapy, no confrontation -- with its attendant pain and risk -- is necessary. The patient will feel very comfortable if even a little acceptance or support is proferred, and may not even desire to leave. But this is not therapy. If, in this context, the therapist begins offering character analytic or didactic interventions that may alter the comfortable balance, in an attempt to re-activate the therapy, the patient will probably reject them. This of course activated the anger and contempt that are so easily used defensively by rigid character structures, instead of feeling and expressing the pain of the rejection (which is the best means of

really reaching the patient). If the therapist gets angry he/she will be re-enacting the psychopath's basic childhood trauma, that of loving parents suddenly becoming irrational, and betraying the trust the child initially gave unconditionally. Things worsen if the therapist attempts to repress feelings -- which he/she will almost invariable tend to do as both of these modalities are part of the rigid character defense, hence almost unconscious and frequently automatic.

To sum up, we see that the rigid structure needs to perform and obtain results; the psychopathic structure reflects; the rigid structure becomes enraged or seductive and confirms the psychopath's belief that the world is crazy and he is sane. This is one of the typical dynamics that may take place between a rigid therapist and a psychopathic patient. The solution is for the therapist to fully experience and express his/her helplessness, showing the patient the pain inflicted. Only then can he/she reach his patient's heart, which is the key to the resolution of the conflict. The therapist must always keep in mind that rejection is a normal operating modality for the psychopath, that contempt will be manifested at every turn during the therapy, that the psychopath really believes that he is right and others are wrong. Perhaps then the therapist can understand and accept rejection, doubt and contempt, which is so difficult for a rigid structure, where pride is one of the dominant features.

ETIOLOGY OF THE PASSIVE FEMININE MALE

This character structure has been amply described by Reich in his book "Character Analysis," where he discusses a successful case history, using precisely the following approach.

Physically, the passive feminine male has a heavy, masochistic, lower half and an oral upper half that vary strikingly one from the other in that there is a powerful diaphragmatic block. This physical structure corresponds exactly to the psychodynamic development of the patient, who identifies predominantly with his cold, seductive, powerful and (apparently) successful mother. The generally valid rule of thumb stating that identification takes place with the most threatening parent also holds true here; the mother is experienced as completely dominating, and as such certainly more threatening, than the father.

The mechanism is usually an adaptive mechanism, and this case is reinforced by the fact that the mother is also the parent of the opposite sex in the oedipal conflict, becoming therefore not only the love object but also the model from which the child introjects, and, later, the one he identifies with. This conflicts directly with his normal psychodynamic development. The father was either absent, physically or emotionally or both, or else was experienced as very weak and unable to counteract the strong mother. The father was also felt as covertly threatening, a derivation of oedipal guilt accentuated by a powerful, although strongly repressed castration anxiety.
The result is generally an inhibited, although genital, character structure, who is afraid of the male and dependent on the female.

The fear of the father, the castration anxiety, the guilt, and the inappropriate ego identification result in:

1) a strong, quite evident and sometimes violent hatred of the woman,
2) an apparent submissiveness to the male -- a "nice boy" attitude -- that covers the very deep, brutal hatred of the man which has been repressed and which is displaced upon the woman.

The woman, overtly dangerous, was in reality less threatening than the covert, unclear, weak and unknown father who lurked in the backgroun-

The developmental history is most important in understanding people with this structure. A typical scenario might resemble something like this:

The child probably developed within a safe, although repressive and smothering framework, and had relatively little fixation at early stages, except for the very early oral stage during which the domineering mother, seductive yet cold, was not experienced at nurturing and loving. This is the underlying causality of the oral component which, although very strong, did not dominate. The child did not fixate definitively at this level and continued in his development more or less normally. He reached the oedipal phase, at which point he sexualized his feelings toward his mother and expressed as such. The mother overtly rejected the child's advances, while covertly being seductive and provoking. The child reacted first with confusion at this double message, and then with fear. For in the background lurked the unknown figure -- the father. It was his father to whom he turned for support and identity, only to (subjectively) perceive a weak man. The father's expressed attitude toward his wife was probably conciliatory, or outrightly submissive; therefore the father

could not be used by the child as an identity model.

The problem is later manifested as an undifferentiated, confused, sometimes completely reversed identification. The woman was experienced as strong, assertive, outgoing and dominating. The man was experienced as weak, submissive, fearful. The normally male values of assertion, strength and order were ascribed to the female and the normally female values of softness, receptivity and warmth were connected to the male. Often, the father was also the loving and nurturing figure -- which further complicated the identity problem of the oedipal stage infant.

To summarize, the cold seductive mother and unassertive father combined to generate, on the one hand, a very strong, unresolved, oedipal conflict and on the other, a hatred against the father for failing to protect the threatened infant from his own instinctual drives by providing a suitable ego-ideal.

The expressions of this hate were tolerated to a large extent, but the child perceived the pain he was inflicting. Guilt ensued. Eventually the overt aggression against the father was suppressed and later displaced on the woman, for, as a known entity, she became less threatenin than the unknown, unreal father.

So, in addition to strong oedipal guilt, we find guilt associated with love from (and therefore to) the father. We also find guilt linked to the expression of the aggressive principle, as this very aggression -- met by tolerance, patience, and even love -- was suppressed because it was (again, subjectively and therefore not necessarily accurately) perceived as the cause of the father's pain. Here we must understand that the healthy assertion was exaggerated into hatred and ultimately murderous impulses as the father provided,

ultimately, the Oedipal threat. Assertion became confused with aggress -- both were repressed. The resulting modality of behavior is one of apparent submission to the male. This serves a double purpose -- it bypasses the risk of confrontation (with the threat of release of the murderous impulses) and it is used as atonement for the guilt that is such an important component of this character structure.

The repressed hatred, exacerbated by the continuous submissiveness towards the male, is in present-day reality displaced on the woman, where it becomes manageable. But the pairing process suffers severely, and this is often one of the presenting complaints.

Frequently the individual remembers his childhood role as the "real man of the family" -- and this, to some extent, may have been true. His weak father, retreating before the assertive mother, may have used the child as a buffer. Conversely, the unsatisfied mother may have displaced her sexuality on the unthreatening child. Either -- or both -- maneuvers resulted in the child experiencing that he had to "fight the father's battle," was "the man of the family," etc.

The child defended against this in several ways; at first he tried repeatedly to reconquer the lost mother love to which he had had free access prior to the development of his sexuality. As the rejection continued, he identified the change in his mother's attitude with his own sexuality and tried to suppress it. He used denial as the basic defense mechanism. Later on in life this will be manifested physiologically, by a layer of fat and/or spastic musculature that surround, as if to insulate, the pelvis, where the sexuality originated; this effectively stops the energetical flow throughout the bottom half of the body, resulting in a masochistic

configuration in the lower half.

He also attempted (partly successfully) to identify with the mother. It is she that he longs for and with whom he has had a very intimate and sometimes symbiotic relationship prior to the manifestation of his sexuality. Therefore, the identification with and the introjection of the female figure is partially adaptive, especially since there is no compensating male figure.

These two maneuvers serve to maintain the hope that someday he will recover the lost intimacy with the mother, while, again, placating the real threat, the father, by, symbolically, castrating himself.

The total result is a submissiveness which is interpreted as a "good little boy" attitude by the family and welcomed when the individual is a child. This attitude becomes perhaps the most striking manifestation of the character structure later on in life. We find in the passive feminine male a lack of spontaneity and directness, and a strong inhibition of the capacity to express needs and wishes.

The energetical level is not as high as one would expect in a post-genital character structure. As previously mentioned, physically this type has a heavy masochistic lower half and a considerable degree of orality in the upper half.

Overtly, the adult is kind, understanding, submissive and passive; covertly he is full of hatred, resentment and rage against both the man and the woman, that is usually expressed by constant manipulation. He is usually successful in his career, as the characteristics of manipulation, indirectness, submissiveness and cunning are valued in our society. On the other hand, his interpersonal life is usually

dominated by the woman, as the same submissiveness which is prized in the business world is cause for contempt within the family structure. He is often subject to sexual problems. He may have spells of erective impotency and is always orgastically impotent (in Reich's sense of the word). Since he is always attempting to please the woman, he will find some way to satisfy his partner, whether the satisfaction comes from direct sexual intercourse, or through alternates, such as financial social, political or similar successes.

This desire to please the woman originates, of course, from his need to please his mother in order to obtain her love. The drive and ambition, which these people very often have, result from the child's attempt to compete with his father in order to gain the promised, but ever unreachable mother love. The child understands that the father is the provider and protector of the home. The child equates social success and material power with emotional weakness, fearfulness and submissiveness to the woman; since the father has financial power as well as the love of the mother, obviously the way to conquer mother is to obtain financial power in turn.

However, the child thinks that he must have more financial power than his father so that the choice for the woman will become obvious. This distortion, carried into adult life, persists as an unconscious drive to obtain ever more wealth, in the hopes that eventually a sufficient amount will be obtained and the long-lost mother will finally be regained.

We may now understand why the basic fear of the passive feminine male is to express, directly, his assertive feelings both toward man and woman. The continuous need to perform and to ward off any possible

confrontation, as well as the tendency to manipulate, are really the basic problems which a therapist, with a dominant passive feminine character structure, should be conscious of.

In what follows I will attempt to describe some typical interactions between the passive feminine therapist and other character structures. I will necessarily have to be succinct and partial, as a human being is always primarily an individual person, as previously stated on several occasions, and therefore can never be completely described by any characterological system, which must always be used, at best, as only a guidepost.

THE PASSIVE FEMININE THERAPIST AND THE SCHIZOID PATIENT

For the schizoid patient, whose basic needs are to reintegrate his perception of the external world and consolidate his ego defenses, the passive feminine therapist may be very adequate. For the therapist's own castration anxiety (fear of destruction) parallels, at least partially, the schizoid's fear of total annihilation -- both being experienced as physical threats to existence, The therapist's fear of acknowledging his rage and hate also parallels the schizoid patient's terror of his own rage -- which is, sometimes barely preconscious for the schizoid. He will understand the patient's need for nurturing, support reality testing. His ego is sufficiently integrated to serve as a model for the deficient ego of the schizoid. The dangers lie in the therapist's need to manipulate, please and escape confrontation. The schizoid patient, perceiving this, may attempt to provoke confrontation -- which will probably bring an exaggerated reaction from the therapist, whose makeup is to swing from non-confrontation to exaggerated aggression. Should this happen, it will be experienced by the patient as an attack, which reproduces his own basis infantile trauma. The patient will become very defensive, possibly even regressing into very early stages. There is a danger that the regression may initiate a decompensation. In any case, he will resist all attempts at interpretatic and in general block all the efforts that the therapist may make. This becomes very frustrating to the therapist who feels that he is not pleasing the patient, experiences his own fear and overreacts by increasing his efforts to help the patient. This in turn will exacerbate the previously mentioned situation in the patient, who will then

proceed to become more and more defensive. If this process continues, unchecked, eventually the patient will probably leave. If, on the other hand, the therapist becomes aware that he is pleasing the patient, that he is not expressing his own feelings, that he is being "unreal" while what the patient needs is patience, support, understanding and, most of all, contact with a "real" alter ego, that can help the patient gradually re-establish contact with reality, the therapist will then be able to relinquish his countertransference, understanding that the patient's apparent rejection is merely a defensive maneuver, that it is not necessary to appease or submit, that he is only required to express his own true feelings.

This understanding will make the necessarily long that is to be expected with this type of patient much easier for the therapist, as he will be able to evaluate the patient's needs from a different perspective. Naturally, the patient will benefit as well.

INTERACTION WITH AN ORAL PATIENT

In this case, the passive feminine therapist is faced with a patient who remained fixated at the oral level. This means that the psychodynamic development, although it may have continued beyond the oral stage, did so with relatively little success. The patient's body cannot support much energy, and as a result, he does not have much energy. The libido remained mostly at the oral level; the sexuality is generally used to obtain closeness, intimacy, and assure that the dependent relationships which this structure requires is present; there is difficulty in experiencing any kind of real gratification directly from sexual intercourse. Frequently, it happens that oral patients are quite promiscuous; this does not stem, however, from direct sexual desire, but rather from the need to be in somebody else's arms, to be close, and to be warm and held.

The oral patient is rarely able to express his need directly. In fact, he defends against this need by expressing the opposite -- an apparent independence which is experienced in the therapy as an attitude of "I don't need you." Of course, underneath, the rejecting attitude comes from oral need, which is repressed until the patient experiences the rage of the frustrated original need. The suppression of this rage involves the suppression of the need itself; hence the previously described position that the patient adopts.

In addition, since these patients are usually low in energy, the "I don't need you" may very quickly change into a passive attitude which in effect transforms the same statement to "You do it for me." The therapist must be forewarned of this maneuver as these patients are extremely adept at creating this type of dependency.

The passive feminine therapist experiences these patients as bottomless pits which can never be satisfied. There may be some reality to this, as indeed the oral need is unquenchable; but in countertransference the therapist experiences himself/ herself as forever attempting to please his/her patient and never quite accomplishing it. This triggers off the rage. Both of these connect directly to his/her own neurotic makeup, at the characterological level, as he/she experiences his/her patient attempting to depend excessively on the therapist's energy/feelings/resources. The therapist deeply resents this dependence, as his own oral component deprived him of the very thing the patient is now demanding that he give. The therapist unconsciously may believe that he/she only has a limited amount of "that" (love/ energy/warmth/feelings) which the patient demands, continuously,inexorably. The therapist may experience the patient as "sucking" (this is a symbolic but very descriptive word in this particular case) his strength, and he may be right. However, it is the therapist's own oral deprivation that is activated and it is his own oral need which the patient is <u>not</u> gratifying that are creating the countertransference. If these, usually unconscious, feelings are not resolved, they will be acted out on the patient, either as irrational aggression or cold withdrawal, that will reinforce the patient's essential belief that sooner or later he will be deprived of the love object.

In the course of the therapy it is most important that this negative countertransference be continuously dealt with -- even if this means exposing, after careful self-examination, these irrational feelings directly to the patient. If done properly, this disclosure will eventually lead to the patient's developing enough trust in the therapist to express his own negative transferential feelings directly --

and this marks the beginning of a successful therapeutic alliance.

The therapist must also be able to gently frustrate the patient's demands for motherly love and support, while accepting his defensive hatred and rejection. The hatred and rejection will appear whether or not the therapist accepts to "mother" the patient, as in this case we are dealing with the expression of undifferentiated hate that is a consequence of the frustrated oral/infantile needs. These negative feelings are the ones that most require expression; and eventually, differentiation. Therefore, the passive feminine therapist must learn to tolerate, and accept fully, the patient's hatred, rage andrejection.

INTERACTION WITH A MASOCHISTIC PATIENT

Here the passive feminine therapist is confronted with an altogether different problem. The masochistic structure is usually highly energized although the energy has been imploded.

Lowen describes the masochist as the result of a smothering environment where all the child's material needs are excessively supplied and his emotional needs completely disregarded. As we know, the physical body structure is characterized by heaviness, chronic spasticity in most of the major muscles, a shortening of the neck and extreme tightening of the gluteus. The famous "masochistic morass" is experienced by the patient as a hopeless feeling of being unable to move out into the world and assert his needs. Very frequently we find that masochistic patients, when they do come close to becoming assertive and expressing their aggressive impulses, collapse into this "morass", from which they cannot move.

The whining and complaining of the masochist, which is almost always evident in the sound of the voice, serves to hide a desperate cry for help. The masochist wants somebody to come and help him, raise him out of the morass in which he thrashes. In other words, the masochist is asking the therapist to alleviate the pain in which he lives, by helping him discharge the excessive energy that is the cause of anxiety.

We should not underestimate the patient's pain -- it is there, as a result of an almost chronic and permanent spasticity throughout the voluntary muscular system, frequently encompassing some of the involuntary musculature also (see Gerda Boyesen's seminal work on psychoperistalsis). This spasiticity is the physical expression of

the defense that the patient built around himself as a child, and which served several important functions:

1) It contained, and dissipated, to some extent, the energetical overcharge resulting from the excessive food intake and deficient emotional contact.

2) Later on, during the oedipal phase, it served to protect his genitals from a fantasied possible castration.

The full explanation of these dynamics can be found in the chapter on the masochistic therapist; to understand the diadic relationship, suffice it is to say that the masochist finds himself imprisoned within this musculature which he now wants to leave in order to partake in the pleasures of life he sees around him. The masochist still adheres to the pleasure principle, but cannot tolerate the energetical build-up to the point of pleasurable discharge. Therefore, he never really experiences a g nuine discharge and will always stop befor a climax is achieved. This is particularly true in his sexuality -- the subject rarel able to obtain a release of tension through sexual discharge, in spite of having excellent erective and, respectively, lubricative potency. The male may have trouble ejaculating, and the female in achieving orgas Sometimes, the masochist ejaculation is not accompanied by pulsating contractions, but is rather a continuous flow semen, very similar to urination. This results in a lack of sexual gratification that is not really perceived as such. Therefore, the presenting complaint rarely includes expressions of sexual disturbances. However, the working throug of sexual problems often becomes one of the keys of the therapeutical process.

To return to the interaction with our passive feminine therapist,

the demand of the masochist to be helped is very difficult to resist as our therapist's character structure demands that he "help" and "nurture". However, should the therapist do this, the patient will collaps into his morass, thereby proving the therapist was wrong. For what the patient really needs is to do it himself, to take that step out into the world, which as a child was forbidden -- to feel freedom from the overconcerned mother who "smothered" him. The therapist must provide the tools but the patient must use them himself. We must now remember that our therapist's two basic weaknesses are submission and passivity, originating from fear of the male figure; both result in extreme difficulty in confronting directly. Our patient in this case is continuously, though covertly, threatening to leave, therefore rejecting the therapist if he/she does not comply. He/she is also aggressive at times, and the therapist may feel himself/herself in the presence of an organism with more power than his/her own. In addition, should the therapist really try to help the patient, as we have seen above, he will subjectively be perceived by the patient as re-enacting the "smothering" relationship he had with his mother. It is therefore necessary for the therapist to adhere very strictly to the reality principle, remaining objective and real, not accepting the patient's challenges or threats or seductive behavior, while confronting him continually and using character analytical techniques (Reich). The therapist must be aware that he/she cannot possibly resolve the patient's conflict; it is entirely up to the patient to do so if and when he/she wishes. The therapist must also face his/her own fear of the primary object, which is defended by rage -- and must beware of attacking defensively (and in countertransference) his/her patient. The therapist's role in

in this case is simply one of reinforcing the reality principle constantly, pointing out the patient's character defenses, while maintaining enough distance (so that the patient can move out to him) without breaking contact.

Bioenergetics is an especially useful tool in working with these patients in that frustration of the physical expression ofnegative feelings is precisely what inhibited the patient so much. When this expression is permitted within the context of therapy, the patient in effect decreases his inner tension, using physical means, simultaneously perceiving that it is all his own doing, that he will not be punished and that his negativity is not really as destructive (hence threatening) as he imagined. It is important that the therapist allow this perception of self responsibility in action to take place unihbitedly -- otherwise the patient will return to his old fantasy, namely that he cannot do it by himself. This is indeed difficult for a passive feminine therapist who needs approval, and who cannot, though successful, claim the fruits of his work. Pride is especially dangerous here, as its smallest manifestation will negate the therapeutical effect obtained.

INTERACTION WITH THE MASCULINE AGGRESSIVE FEMALE

The masculine aggressive female has been described recently by Dr. John Pierrakos quite extensively, so I limit my description to a brief summary. I suggest that if the reader wants to develop further his concept of this most important character structure, he refer to the appropriate literature.

The masculine aggressive female has a very specific physical appearance. Her hips and the lower half of the body, including legs, are heavy, masochistic in nature, and present deep spasticity covered by layers of fat. There is heaviness in the lower half, a lack of motility, often a lack of feeling and perception. This heaviness manifes in difficulty while jumping or running, or in any other way leaving the ground. The person's physical motility is impaired -- not so her emotional one. The upper half -- that is, from the waist up -- is generally oral and seems to be sitting squarely on the lower half. The upper half has a weakness in the chest, and may be very fine and delicate when compared to the lower half. The discrepancy between the fragility of the upper half and the great strength of the lower half is extremely striking to the trained observer. The head is quite often beautiful and energized. The eyes are bright, the person is intelligent, quickwitted, sharp and capable at the intellectual level. These women are quite often successful in their careers; as they have enormous energy which has not been able to find normal discharge through the sexu channel, it is sublimated and utilized to compete in the world of men. Developmentally, the woman with this character structure generally has an excellent relationship with her father until the oedipal conflict

appears or sometimes until shortly after. In any case, nurturing was provided by a loving and tender father who suddenly, for some reason, disappeared. Sometimes this disappearance may be a physical absence, suc as divorce or death, or sometimes it may simply mean an emotional withdrawal. The mother most probably dominated the weak father, and was experienced by the child as cold, strong, and frequently rejecting. This subjective experience may be the result of a lack of emotional contact between the mother and the child (hence the orality). The father was the nurturing figure, not the mother.

The spasticity of the pelvis and the legs, plus the layer of fat, were utilized by the little girl as a defense, having developed very intense feelings for her father, which were interrupted as a consequence of his sudden withdrawal or abandonment. Left with these feelings, she attempted to resolve them by decreasing as much as possib the awareness of her genitality. The spastic structure and fat served to render as difficult as possible the perception of her pelvic area. This is the purpose of the heaviness, of the tightness.

In adult life, these women very often submit, passively, to masculine sexuality without having much feeling. They may be very good sexual partners in that the physical response to the man may be extremely intense, although this response is often blocked from consciousness. She may be lubricating intensely without feeling very much. When her sexual desires do not find the appropriate discharge via orgasm, she sublimates and utilizes the energy to compete in the external world. This she does very successfully; she is very often a career woman.

As the reader may have perhaps already imagined, the passive

feminine therapist is here confronting his exact counterpart. A similar family constellation makes him passive, while erectively potent, and her aggressive, while sexually inhibited. It is therefore a difficult situation for our therapist. Countertransference comes easily in any structure confronting its exact counterpart. The woman knows how to provoke him and instinctively knows how to retaliate; both interact at a very basic subliminal level. This could be the typical pair in the war of the sexes; the woman attacks and dominates the man intellectually while the man uses and humiliates her sexually. In any case, the transference and countertransference may be very strong; seductive and sado-masochistic traits may well appear in the therapeutical relationship. Reality may become difficult to perceive, as mutual distortions contained in both structures usually include a strong psychopathic component.

In this situation, the therapist should beware of any provocation, whether it be sexual, intellectual, emotional or a combination of the three. What may first appear as a simple intellectual challenge, may result in a competitive deadlock. The woman in this situation will go to incredible extremes to overcome her male counterpart, as this is her basic pattern of relationship. If the therapist falls into his natural passivity, strong countertransferential desires of vengeance are bound to appear. Therefore, the therapist must maintain objectivity and distance as much as possible, focusing the patient's negative transference directly on the parental situation that originated it. The problem here is not to establish contact (which will come too easily) but rather to maintain sufficient objectivity. The therapist must be wary of all challenges; he must bring them back into the context

of reality. It is important for him to remember that a patient must express a provoking and challenging behavior if she is to reach any negative transferential material at all. For therapy to progress it is essential that the woman be allowed to challenge the therapist and perceive that her provocation does not lead to any kind of relationship. This presupposes that the therapist can remain immune to the provocation, and objective, while maintaining contact with the patient. The therapist should be very conscious of his own countertransferential desires (which may become sexualized) of vengeance against the provocative female. He must become aware of the sadistic undertones of his desires. He must beware of any attempt to appease his patient, as this is a sure sign of countertransference.

THE PHALLIC NARCISSISTIC MALE

This post-genital character structure arises as a defense against the pain of the mother's rejection when the child manifested sexuality during the oedipal phase. Again , the child had a satisfactory relationship with both parents to the point where the dominant fixation did not occur at the pre-genital level. However, when the child attempted to manifest his love through his new-found sexuality, in other words, when the child tried to express himself with the totality of his being, which includes his body and/or latent manhood, the mother, afraid, rejected him. This rejection, not understood, was experienced as totally devastating. Later on, in therapy, one of the deepest cries that the phallic narcissistic male expresses is "Why?". This sudden rejection induces a dissociation between the sexuality and soft, loving feelings that the child experienced previously; the sexuality, which until then had not appeared, becomes the cause of the mother's rejection. The patient will, therefore, try to repress his sexuality and will most probably successfully do so during the infantile stages of development. However, during adolescence, as the libidinal energy was well anchored in the genitals, the sexuality asserts itself strongly. This sexuality may often be subjectively experienced as unwanted, yet irrevocable. And so, because of the dissociation between love and sexuality, the individual is forced to suppress his capacity to love rather than his inevitable sexuality. It is therefore characteristic of all genital character structures to have difficulty loveing. Particularly in the case of the phallic narcissistic male, sexuality is used as a weapon of vengeance against the primary love object who inexplicably

rejected him. He also uses his sexuality to compete with the father, who possesses the lost love object -- the mother -- because he has a powerful penis. Subjectively, the father is frequently experienced as cold, powerful and most threatening, and therefore is used as a model to identify with. This identification promotes further the dissociation between the female principle, which is perceived as hard, dominant, conquering, unfeeling, and yet powerful. As a possible neurotic derivative, the phallic narcissistic may be frequently defending against latent homosexuality by an exaggerated expression of his genital power.

The phallic narcissistic male is physically a very well integrated being; he functions smoothly, is well coordinated and proportioned, is successful in sports and almost all activities in which he participates, and is usually extremely attractive. He poses a challenge to the female as he struts and exhibits his masculinity. He is usually intelligent, quickwitted, efficient and financially and socially successful. He has no trouble obtaining willing subjects upon which to discharge his rabid hatred of women. He uses his penis in a sadistic fashion, symbolically, to perforate the woman and gratify his desire for vengeanc However, as women flock to him, he also experiences them as aggressive and, eventually, as threatening. He then further retreats into his narcissism, while continuing to serve them sexually, simultaneously increasing his hate of them. For this is the other side of the exaggerated aggression and sexuality the narcissistic male exhibits. Let us remember that his attempt to reconquer the lost mother love consisted of developing his sexuality to the point where it would compete with his father's successful conquest of his mother. In other words, he experienced his father's sexuality as acceptable to the mother whereas his own was not. Of course the only difference was a question

of potency. Therefore, the phallic narcissistic male develops a very high level of potency to compensate for his fantasied childhood deficiency. Frequently, these males have distorted perceptions as to the adequacy of their genitalia, although they are erectively very potent; they frequently have doubts as to their ability to really function sexually. Premature ejaculation or incapacity to ejaculate is quite common. All of this may hide deep homosexual tendencies which are often so successfully repressed that the patient does not manifest even a normal level of homosexual unconscious material.

Our passive feminine therapist is faced in this case with a character structure that is more highly energized than his own. He is also faced with a male who has successfully accepted an aggressive position in the world and who has strength where the therapist has weakness. The passivity and the female identification of the therapist are no match for the strong, virile male he is facing. This may trigger off a deep fear, associated with the therapist's unresolved parental associations and may block the patient's expression of the negative transference, as the therapist will collude with the patient to bypass this indispensable confrontation.

Ultimately, the patient's willingness to perform, his ability to do so and his desire to please the therapist and be successful in his therapy may also be used for collusion as well as to mask the deeper problems, which are the oedipal conflict and the castration anxiety. These problems coincide with the therapist's own and it is possible that therapist and patient will tend to stay away from exposing these threatening layers. The manifestation of this collusion will simply be a continuous production of apparently very significant

material on the part of the patient, with a continuous interpretation and working through of it on the part of the therapist on the level presented by the patient. As previously stated, both patient and therap will go to great extremes to bypass the castration anxiety, the hatred for the woman and the unresolved oedipal conflict, which are problems they -- characterologically -- have in common. It is important therefore, for the therapist, to be on his guard and aware that the patient may produce all kinds of false trails with the purpose of hiding the true conflicts.

The discharge of the hatred for the woman is one of the keys to the successful therapy of this character structure. Initially, the hatred will probably be experienced as ego-syntonic, and much will have to be done for the patient to unearth it; his whole life will manifest a continuous exchange, sexually and otherwise, with women. Therefore, the presenting complaint will rarely include an expression of this hatred and instead will offer superficially good relationships which may even be a successful marriage that has lasted for many years.

The patient's impression that he has successfully established a relationship with a woman may be furthered by his continuous erective potency; it will only be through the expression of his hatred and the realization that this has been a "pattern" in his life, that the patient will begin to see the true perspective of his relationship with the opposite sex. For the passive feminine therapist, the expression of this hatred for women is again touching upon his own primary problems, so this may be another countertransference stumbling block.

The patient may appear as very contemptuous and judgemental. This will provoke and threaten, simultaneously, the passive feminine therapis

-- leading him to withdrawal and passivity. In this position he will stop confronting, or do it partially, equivocally, hesitatingly -- which, if perceived by the patient, will only increase his contempt. Eventually the patient will feel superior to the therapist and, of cours leave.

So the therapist must not hesitate, in this case more than any othe to confront directly. He must not be afraid -- his patient is so powerful that, under the proper conditions, he can bear practically anything. The difficulty is more to <u>reach</u> the patient -- for much of the patient's energy is devoted to keeping people away.

INTERACTION WITH A HYSTERICAL FEMALE

Hysterical females were the first patients treated by Freud and the literature abounds with descriptions of them. However, as this paper presented from a bioenergetic viewpoint, I think it is pertinent to describe briefly some of the outstanding traits of this personality.

The hysterical female is physically extremely attractive, integrated, beautiful and seductive. Her movements are flowing and usually quite harmonious; the body is well proportioned, and remains in relatively good shape even after child bearing and into later life. There is harmony in the body and a seductive and socially attractive quality about the woman. She is beautiful and will maintain her beauty even into advanced age.

Again, as in previous character structures, frustration came only after she started expressing her sexuality, this time towards her father. Previously, the psychosexual development was such that it encountered very little conflict with the outside and so was harmonious. Although some fixations may have occurred at early phases, it is only when the child tried to express herself with the totality of her being -- including, of course, her sexuality -- that she was rejected. This rejection may never have been understood, and in any case never accepted, by the patient. She was allowed to express her rebellion abundantly, but became frustrated as she perceived it was not understood. Her defense against the father's rejection was to further develop her sexuality; she saw the successful mother figure obtaining her father's love, and identifies the basic difference between herself and her mother as a sexual one.

After the oedipal phase, the entire seductive component of this character structure becomes unconscious, and so the hysterical female, while permanently seductive, is never conscious of what she is doing. When men respond to her sexually, therefore, she immediately rejects them, not understanding why she has been approached, and blames men for their exaggerated sexual desires. This whole mechanism serves to protect her against her own sexual incestuous feelings for her father, which she has never acknowledged and which constitute the basis of her problem. As in the case of the phallic narcissistic male, whose female counterpart she is, she will be intelligent, successful, beautiful, and will not hesitate to manipulate whoever and whatever are necessary for her objectives. She will continually hold back her feelings, without expressing them, and will use sexuality and others as tools to further her ends. However, where the phallic narcissistic male, when confronted with the choice between love and sexuality chooses the latter, the hysterical female chooses the former. So she believes she loves everybody, men and women alike -- and is astounded when men respond to her sexually and women repudiate her as a "flirt" or "vixen" or "whore". Her war with the woman has long been accepted -- and efficiently dealt with. It is the man's sexual response to her unconscious flirtation that she cannot accept; for she feels she just "loves" them in a "nice" way, without sexuality. She becomes the "sleeping beauty" waiting eternally for the "charming prince" -- daddy, of course. In denying her seductiveness she perceives men as sexually demanding, as doing to her precisely what she does to them which is to use them. She becomes, ironically, heartless -- having committed herself and her heart to the unreal father image. The response to the continuous

advances of men is to become sexually frozen, cold, unresponsive. And that means blocking sexuality, the normal energetical discharge vehicle As a consequence, although the body is well integrated and quite flexib she has successfully somatized her conflict -- hence Freud's observations, and the difficulty of treatment.

This is only the expression of her emotional trauma. The infant girl would have liked to suppress entirely her sexuality, which was experienced as the interfering factor between her and her beloved father.

From our point of view, she presents a formidable challenge to the passive feminine therapist, as she will use her sexuality to try to seduce him and keep him from facing the crucial issues. She will, when confronted with this maneuver, accept it and probably try again; eventually she will begin to produce unlimited amounts of unconscious "red herrings" to cover up the essential oedipal anxiety. She will also express contempt for the therapist who, if he is able to tolerate it without rejecting her, will then be confronted with her real hatred for men and, eventually, her unconscious desire to castrate them. It is this hatred for men which is the key to the patient's problem. And since this is also the key to the therapist's problem, collusion may very well take place.

If this happens, the negatice transference is never expressed and the patient remains on a seductive level, continuously producing material for analysis. This may include dreams, everyday problems, etc., but the purpose of much of this material will be to direct the therapy away from the real issue of the neurosis.

However, the hate/rage of the woman against the man may also

threaten the therapist. Let us not forget that his own mother was subjectively perceived as cold, distant, yet dominant, seductive and successful in controlling the father. The passive feminine therapist spent his childhood fighting the aggressive female -- and lost. So the hysterical's regression may frighten him; and he may react by not confronting her. Collusion is, indeed, the major problem the therapist faces -- for his hysterical patient will be only too happy to present as we have previously said, unlimited material whose purpose is simply to get away from the central issue.

Strangely, hysterics use denial and projection continuously. The essential countertransferential problem here for the therapist is the continuous unabated seduction by the patient, which may even persist after she has been directly confronted -- for the seductive component is unconscious.

ETIOLOGY OF THE MASCULINE AGGRESSIVE FEMALE

Like all rigid structures, the masculine aggressive famale's basic trauma was one of abrupt withdrawal or rejection or abandonment by the opposite sex; in this case, the father. The little girl exchanged a lot of feelings with her father, sexualized some of them and was suddenly cut off. Until this point she has a common background with the hysterica female previously described. However, in the case of the hysterical female the resulting aggression and hate were repressed by a disciplinary mother and social environment; while in the case of the masculine aggressive female the mother was weak, so that repression of hostility (aggression, hate, rage, anger) was much less, and much more direct expression was permitted. Sexuality was repressed, but aggression was allowed to some extent. Total repression of feelings was less for the masculine aggressive female than for the hysterical; the child may even have thought of herself as perhaps achieving the oedipal fantasy -- in any case, she actually became "the little woman" of the household. She was stronger than her mother, more aggressive, more forceful and (as probably the mother's weakness resulted in a deficient relationship with her man) she became the "favorite." Eventually, of course, repressi of aggression did take place, but meanwhile the sexuality had been anchored very strongly and so had to be repressed equally strongly. This is shown in the body by heavy hips, presenting an almost "masochistic" appearance.

This "masochistic" formation is an attempt by the organism to decrease the sexual impulses and feelings originating in the super-charged vagina, by in effect insulating the "super charged" area with

fat; another, equally effective way used by the body is to create severe muscular spasm around the offending area, binding the excessive energy into the permanently spastic muscle -- this leads to decreased sensitivity and perception, effectively protecting consciousness from having to deal with unwanted impulses. The excessive pelvic development of the masculine aggressive female is a typical example of this phenomenc Very deep muscular spasm is typical in the masculine aggressive female pelvis, and gluteal area. The spasm is covered by a layer of fat and flacid muscle, giving the visual impression of softness -- which in reality covers a deeply hidden hardness. And this has a direct expression in the behavior of the individual -- the masculine aggressive female is soft, seductive, promising, on the surface. And hard, competitive, demanding, powerful at a deeper level. As stated, the heaviness around the pelvis is a defense against the sexual feelings developed during her interaction with her father. The mother is manifested in the patient's chest and/or legs, where some degree of orality is always present. The mother was perceived by the child as ineffectual, weak, perhaps absent. And here we must remember that whether or not this was actually true is immaterial -- it was true for our patient's subjective perception of her reality during her developmental stages, and is therefore true for the individual that has come to treatment with us.

The structure is therefore split -- masochistic pelvis and/or an oral chest. The legs will be either masochistic (heavy) or oral (very thin) depending on the degree of dominance of either parent. The greater the oral component, the greater will be the degree of psychopathy that is always present in this type.

Later on the pelvic holding will manifest in an inability for orgastic release while at the same time the energetical charge in the vagina will be so excessive that frequently it will act upon the male penis, leading to premature ejaculation and/or loss of erection. This is not to say that the woman's "problems" are responsible for the man's -- rather, the excessive energy of the woman can frighten a man who is already insecure in his own sexuality. A strong, well defined male who is secure in his sexuality would not have this problem; for it is true, I believe, that each individual is wholly responsible for his/her sexuality.

The head of the masculine aggressive female is always highly charged these are women that are intellectually active and creative. They sometimes have considerable distortions misperceptions based on archaic trauma and generalizations (i.e., "father rejected me, therefore all men will always reject me") that frequently lead to paranoid attitudes. They are, realistically I believe, called "headstrong". They are very willful (which is of course connected to their psychopathic component) and very successful; they compete well in the man's world, have very beautiful strong faces, bright eyes, well proportioned and attractive features. They have a brightness about them/ they are "handsome" women. They have sublimated some of their sexual energy and used it for social accomplishments.

In a sexual relationship the psychopathy of these women becomes exacerbated -- she considers herself the victim of her partner, while in reality she victimizes him. She sees herself as being "done to" by the man and blames him for her troubles. "He" is not sexually adequate, "he" is not considerate, loving, caring, etc. It is very

difficult for the masculine aggressive female to recognize the principle of self responsibility. For this would mean, on a deeper level, the full acceptance of her sexual desires towards her father and hatred towards her mother. Both of these feelings are very deeply repressed on the emotional level, and contained within the physical structure, as previously described.

Physical work with the masculine aggressive female is very rewarding, for with their extremely high energy they can reach deep feelings quite readily. Many feelings are deeply locked in the holding patterns around the pelvis, in the tightness of the chest, and in the areas of willful holding in the back of the neck (sternocleidomastoid and occiput -- the entire "ocular segment" as defined by Reich). Indeed much physical work has to be done; the "grounding" function, as described by Lowen, is usually a problem area. The massive pelvic block and the concurrent deficiencies in the legs, whether it be oral weakness or masochistic holding, is the causal agent behind this, and makes it difficult for them to perceive the ground under their feet. Classic bioenergetic theory states that when a person is not "grounded" there is a concommittant difficulty in reality testing. The masculine aggressive female tries to compensate this deficiency by an aggressive attitude towards the world which is expressed directly through her ego. She reinforces her ego to the point where it becomes her main tool for contact with reality, so that whenever this contact is challenged the entire defensive structure comes into play. Hence, the development of paranoid tendencies, the extremely willful attitude, the need to create their own reality, the great difficulty in being receptive and and developing a receptive principle, while the aggressive principle is

highly over developed. The need to impose their will, the deficient receptivity, the need for results, which is common to all rigid structures, and the strong paranoid tendencies are some of the counter-transferential problems a therapist with this type of structure may encounter. As we shall see in the interactions these themes come up repeatedly. There is, in addition, another kind of countertrans-ferential problem that merits special attention, whose origin is the oral component. Our therapist needs to be "fed," "nurtured". This orality is physically expressed in the chest, and psychologically as a need for narcissistic ego gratification -- a need to be "nurtured." The combination of narcissistic need and willful, strong, extroverted ego becomes dangerous when a therapist with this structure is faced with a patient who endows the therapist with authority, entering a transferen relationship and therefore weakening himself or herself. For the therapist may tend to make the patient nurture her, either by seduction or manipulation.

The masculine aggressive female is particularly adept at verbal manipulation (sophism). For the combination of her psychopathy, plus the aggressive, outgoing, extroverted attitude, plus the need to be right and "perform", added to her need for "nurturance" (through ego satisfaction) makes her needs very important, and the means at her disposal for satisfying those needs formidable.

She is intelligent, bright, aggressive, outgoing. Her receptivity may be deficient and she may have difficulty in perceiving clearly the other person's reality due to her own deficient receptive principle. In trying to achieve clarity, she may twist her patients' data while not even being aware that she is doing it. Her forceful attitude may

sometimes lead the patient to accept her authority even though the patient does not really believe what she says, for it is easier to accept than to face or confront this very strong authority figure.

The masculine aggressive female needs to control, and if she feels that her patient in any way challenges this need she will use the resources at her disposal to counteract and regain the control which she believes is indispensable. She especially may tend to transform a healthy directive therapeutical approach into complete control, that may lead to submission.

The reader may infer, from the above, that the masculine aggressive female is a monstrous creature that should be avoided at all costs. The reality is, of course, quite the oppsite. For when a masculine aggressive female has, through her own therapy, resolved some of the problems that are typical of her structure, she can be brilliant, energetical, clear and loving. She has an abundance of feelings and energy. She has a warm heart, deep understanding, courage and facility of expression. The correction of her initial distortions and misconceptions leads to clarity and perceptual acuity. Balancing of her active and receptive principles leads to honesty, straight forwardness, reliability. Release of her blocked sexuality leads to full appreciation of the importance of pleasure and the means of achieving it. Relaxation of the need for control and of the paranoia leads to deep trust in her patient's process. As always, resolution of character structure and defenses leads to the flowering of the heart and the mind. And the reader is reminded that, of necessity, the emphasis of this work is the description of the defenses as expressed characterologically -- it is not a description of the beautiful being that resides within those defenses, in the heart of (wo)man, in the core of humanity.

THE MASCULINE AGGRESSIVE THERAPIST AND THE SCHIZOID STRUCTURE

In this case the tremendous difference of energetical levels is to be considered carefully by the therapist, both when making any evaluation and during any kind of self examination. For while her energy is essentially extroverted, assertive, and tends to impinge directly on her patient, the schizoid's energy is contracted, withheld at the center, and frozen. We know the schizoids defense is to present a mask, however fragile it may be, that is rigid, stiff and unbending and is used to defend against tremendous hostility and fear. The perceptive masculine aggressive therapist will be able to see through the mask and to reach the aggression that underlies the defenses. She must be careful not to impinge on these defenses too strongly, she must understand that the schizoid has a need for an alter ego upon which to model himself and that this alter ego must maintain a respectful distance and must not be too demanding, nor have high expectations, nor expect the patient to drop his/her defense quickly. The therapist must realize that her oral narcissistic needs will not be fulfilled by her patient: that the patient needs to learn about primitive forces of contact, where no ego gratification existed; that she must allow the patient to make contact in whichever way the patient may choose; that, while remaining a solid, concrete symbol of reality, she must relinquish control to a large extent. She must realize that the schizoid's deep understanding of the essential issues at stake is often clearer than her own and she must accept -- and, of course, clarify -- the schizoid's frequently real, but grossly distorted perception, and challenge her own ideas in the light of the information she is receiving from her patient. The schizoid

needs a very receptive therapist who can in effect decode the distorted reality that is, in a strange way, quite accurate, yet, at the same time, very distorted. The therapist must remember that the schizoid has a deep perception of the real issues at stake yet cannot organize them or present them in an organized fashion, as the expression of the perception becomes distorted through the defective ego. It behooves the therapist to clarify these distortions, to be receptive to the information given by the schizoid patient and be able to reinterpret the message that she is getting from the schizoid in a logical, realistic, orderly framework. Essentially she must be real at the deepest level, in the deepest way. Here her intellectual brilliancy is most useful, but she must be careful not to close off her receptive principle and impose herself, for the schizoid will usually rather accept than challenge the powerful authority he/she is facing. This would lead to further suppression of rage and negative feelings, and, later to further withdrawal into protective mechanisms or defenses.

The paranoid tendencies frequently found in schizoid structures may also concur with the therapist's own. This might lead to collusion.

Perhaps the most important things that the masculine aggressive female must keep in mind are that the schizoid's process is slow and gradual, that excessive confrontation is interpreted as violation and defended against by withdrawal and that the crucial issue is always contact -- both <u>inter</u>-personal and what I will call <u>intra</u>-personal -- contact with self, with his/her feelings, with his/her body and therefore reality.

THE MASCULINE AGGRESSIVE FEMALE AND THE ORAL STRUCTURE

In this case again, the therapist's own energetical level is considerably above that of her patient. However, she does not have to worr about a defective ego, or defective ego barrier which may be broken down as in the case of the schizoid. The basic problem here is for the masculi aggressive therapist to withhold her energy, contain it, and in a prudent way allow the oral patient to come out, to express both aggression and need, to learn to express his or her feelings; this is the basic problem or orality -- the inability to come out and express directly the feelings that are contained there. This withholding of feelings leads to spite, which will then trigger off the masculine aggressive female's defenses on two levels: the paranoid component will be activated by the withholdir If the masculine aggressive female accepts these two challenges, the patient is in complete control of the therapy, and the countertransferenc may be so strong that the therapist may find herself becoming systematically angry at her patient. This anger may at first be diffuse, unjustified, unclear -- but soon using her intellectual abilities the masculine aggressive female will be able to find an issue upon which to pin her frustrations and anger. Of course this is a major pitfall as the issue will not correspond to the real problem, which is simply that she is very angry at the patient's withholding, at the continually unexpressed demands, at the passivity and lack of response which the therapist perceives as "not giving" while she is "giving everything." This, of course, reenacts the therapist's orality trauma and gives her a perfect case to blame the patient and take no responsibility for the dyadic interaction.

If, in addition, the patient is male, the basic dynamics of the masculine aggressive therapist are stimulated at almost all levels, for while she can with impunity be aggressive at the ego level, she expects, unconsciously, of course, the man to retaliate at the sexual level. Since in the therapeutical context acting out of sexuality is usually precluded, she is in an omnipotent situation in which she does not have to fear any real sexual demands from her passive patients. She can be seductive without having to pay the price -- and this may suit her patients psychological makeup perfectly, for oral people tend to use sexuality as a means of achieving closeness. The collusion is ideal. From the patient's point of view, her contempt, her hardness, her aggression, her ability to manipulate, all of which the oral patient can usually see through will strongly activate the patient's defenses -- which are predicated on the belief that if he/she extends himself/herself reaches out, makes himself/herself vulnerable, he/she will be hurt -- either because there will be no one there, or because the quality of the contact will be unsatisfactory. We must remember that orality is generated when the baby cannot make satisfactory contact with his mother, and in spite of constant reaching out does not find her. Later on, this is expressed by a disbelief in the possibility of reaching out and obtaining satisfaction, as the total frustration which the child felt when he reached out for his mother and didn't find her is imprinted and triggers automatic reactions. In the case of the masculine aggressive therapist, the oral patient is confronted with a person who is continuously anxious to "do it for him." Should this be the case, the patient's neurotic defenses become adaptive, as he is being nurtured from the outside, which is exactly what the defenses were designed to obtain.

Of course, no resolution of the defenses can take place in this context; rather they are exacerbated. From the therapist's point of view it is very difficult to reverse completely her normally aggressive position and become patient, receptive, open so that whenever the patient extends himself a little bit, he or she will not be met by expectations, demands, and power, but by love and warmth -- and this, in the face of almost continual spite, withholding, passivity from the patient.

THE MASCULINE AGGRESSIVE THERAPIST AND THE MASOCHIST PATIENT

Here the therapist must keep in mind that the basic therapeutical approach with the masochist is to make them understand what their problem is, what their possible resolution is, and then stand back and let the masochist do it. For any attempt at all for the therapist to step in and "do it" to a masochist structure will immediately activate the defensive barrier, which in effect says "I can bear it, I do not have to give in, I can take anything you can dish out." If the patient perceives the therapist as assertive, directive, telling him what to do and so on, he will contract into his masochistic shell from which he is virtually impregnable. The therapist must remember that she must be patient, withhol her desire for immediate results; she must above all be straight and real with the patient, and give up her control. She must also remember that whenever the masochistic patient opens up, enormous amounts of feelings are there which will require the therapist's full brilliancy to become organized and integrated.

The therapist's contempt may become a countertransferential issue; for this feeds right into the masochists need to be provoked so as to be able to discharge energy. Contempt is a defense against the therapist's own unexpressed needs and is perceived by the patient as a mild provocation that is probably sufficient to make him/her withdraw into his/her defenses yet not strong enough to really make him/her come out into the open and discharge the negativity. The net result of this contempt may be a defusing of the patient's ability to express megative transference, thus reenacting his childhood trauma. We must remember that the masochist's etiology originates essentially when an over-

concerned mother takes physical care of her child and is completely unaware of the child's emotional and spiritual needs. An overly concerned dominating woman who is not receptive would almost duplicate the patient's mother. Another pitfall in this dyad is the therapist's need to control, which again leads directly to the patient's original problem as he was indeed controlled completely through excessive toilet training that was later followed by other similar impositions from the outside. This led to fear and mistrust of freedom, and an inability to express the many, strong, varied feelings that are contained, inexorably, within the massive structure.

INTERACTION BETWEEN THE MASCULINE AGGRESSIVE THERAPIST AND THE PSYCHOPATH

In this case the psychopathy of both therapist and patient interact and could be construed as the major countertransferential problem. Control will become a major issue and since both are equals they will try to out-maneuver, out manipulate each other. It is probably very difficult for the therapist to maintain objectivity in this case as the patient's ability to perceive her weaknesses, her characterological defenses, is very great and the psychopath's first attempt to defend himself/herself will be to impinge directly on the characterological defenses of his/her therapist. The patient is also brilliant intellectually, has his own oral needs, is equally willful and capable of manipulation, and has a terror of losing control which matches the therapist's own. Psychopathic patients are notoriously deficient in receptivity; they are difficult to reach because they never listen. If this is matched by the therapist's lack, we have indeed, a conversation of two deaf people, each listening to himself, neither being receptive to the other. The constant rejection and manipulation of the psychopathic patient will trigger the therapist's own defenses to the point where I must frankly say that I doubt that successful therapy can take place unless the therapist has greatly resolved her own problems. For the psychopath fundamentally needs a patient yet dogged attitude in which reality is continuously brought into focus, in which he/she is continuously challenged from the negative side; that is to say, his/her rationale, his/her perceptions, his/her ideas, must be constantly doubted and challenged; he/she is constantly put on the defense by the therapist. This is the normal therapeutical process for psychopathic patients

and must be carried out, if the patient is to be reached at all.

One possible resolution for this problem is for the therapist to work physically with her patient and avoid as much as possible any kind of verbal interaction, for this is the area where the therapist's greater knowledge will help her immeasurably. Psychopaths need to be grounded in reality; they need to have their sense of reality enhanced. Their deficient reality principle, which is of course a product of their deficient superego and lack of receptivity, has to be tested again and again. The physical arena is one where the psychopath's defenses are less effective, so if the therapist can systematically introduce physical work, she has a better chance of being able to reach her patient. The therapist must remember that the patient cannot be convinced of anything. He or she needs to experience repeatedly until the experience sinks in. At firs the ability to take in, be receptive, is so blocked that psychopathic patients can take long periods of time before developing any kind of transference. It is only through the constant development of trust that the psychopath can gradually begin to open up and give over to his therapist, and since in this case, the therapist has her own mistrust and paranoia, she must never forget that the issue of trust is a very difficult step for her patient. The physical work should essentially be concentrated on the grounding function, which means working on the legs, pelvic block, diaphragm, or all three together depending on the indivdual case.

If the therapist has at least partially resolved her own psychopathy, psychopaths can be a very strong, stimulating challenge that will be a major learning experience for the therapist. For her client will challenge her every step of the way, and she must challenge back without attacking.

INTERACTION BETWEEN THE MASCULINE AGGRESSIVE THERAPIST AND OTHER RIGID STRUCTURES

The masculine aggressive therapist must remember that aggression has been severely inhibited in rigid structures; she must also never forge that seductiveness is an inherent defensive mechanism in the rigid structures as well as in herself; therefore, especially when dealing with patients of the opposite sex, seductivity will be a major issue. If the therapist's need to control is not constantly monitored, the main results will be an inhibition of the rigid's need to express the repressed aggression and hate. The etiology of the rigid implies two basic traumas: 1) inhibition of sexuality and 2) blocking of the anger that arose from sexual inhibition. The rigid personality essentially is a "good boy" or "good girl" -- the forceful, extroverted, assertive, dominating masculine aggressive female may be too frightening for the patient to deal with at the beginning. She must be very conscious of these qualities perceived as dangerous to the personality whose own aggression is very inhibited. The masculine aggressive female's paranoia may also come in as a factor and she may further want to inhibit the expression of aggression to protect herself. The combination of her need to control, her extroverted attitude, her paranoid tendencies, may result, as previously stated, in a strong inhibition of the expressior of negative transference, which is of course a basic requirement in the therapy of rigid structures.

However, they are really well matched. Energetically they are equals; they have the same intellectual distortions arising frequently from the oedipal conflict -- and this may lead to collusion on specific issues. They are brethren -- and thus they understand each other deeply.

The masculine aggressive female has the advantage of her knowledge and training, and barring gross mistakes should be able to do an excellent job.

Perhaps the one thing to remember for the masculine aggressive female is that she must keep great physical space between her and her patient. For all rigid structures have considerable difficulty with contact -- in a peculiar way they resemble the schizoid structures. Lake has called them "equal and opposites" -- the schizoid responded to the infantile trauma by contraction towards the center, and freezing the periphery; the rigid responded to the infantile trauma by expanding to the outermost limits of his/her boundaries, which are highly energized and warm, and freezing their core -- their heart. Therapy for all rigid structures consists always of opening the heart, releasing the capacity to love and truly give.

Seduction between the masculine aggressive female and rigid males is almost certain to take place. It is very important to uncover and resolve this issue as early as possible. For the male rigid is accustomed to seducing as a means towards an end, and, if transference is taking place, is of course terrified that he might be successful and seduce, successfully, his mother image. The therapist must remember that, if Reich's theory of the "Emotional Plague" holds, she may very well resemble, at least attitudinally the patient's real mother. She must be able to meet the patient's overt expression of sexuality/seduction without reacting either positively or negatively -- she must be able to understand that these games are really tests, and that her patient differentiates between "himself" -- which usually means his elementary "being" -- and the accomplished adult, the successful adult, the sexual

adult which has a right to "mommy's" love because he has earned it." The masculine aggressive female must keep in mind that the rigid male's closed heart is in part due to low self-worth -- a self-denigrating mechanism originating in the split between heart and sexuality; the oedipal guilt is a strong reinforcer here.

With the female rigid, the countertransferential problem centers more around the mother's repression of aggression. Here the masculine aggressive female's authoritative personality, her excessive aggression, and her own contempt for women may render the therapy quite difficult. For the rigid female patient needs a supportive woman -- the opposite of her mother. And she needs permission to release her negative transference without being threatened -- either covertly or overtly. An indication that the negative transference is blocked is that the patient assumes an apparently cooperative mood for long periods of time in which things seem to go well -- and nothing much is really happening. Another indication is the lack of crying for prolonged periods -- for the rigid woman usually has a lot of feelings that are not too difficu to reach, if she is not caught in a "challenge." But if she is defiant and challenging, it is very difficult to reach her. Her defenses are usually powerful and efficient, and well organized. Defiance is really a contest of wills.

Pride is a big factor in all rigid structures. Resolution of this is a major, inevitable step in a successful therapy. Here both the patient and the therapist must relinquish their pride -- and this can indeed be a big countertransferential stumbling block for the masculine aggressive female.

A FINAL CLARIFICATION

As agreed at certification, the PDE is really part of a much larger book which will cover the five basic character structures described in Alexander Lowen's "PHYSICAL DYNAMICS OF CHARACTER STRUCTURE."

Therefore, in my mind the work is not completed and I have not included the customary summation that usually concludes a book of this type. In fact, I cannot as yet write it for I have not finished the book itself.

The amount of work required to describe the integration of all five basic character structures is very considerable and will take some time. Also, it is possible that I will find it necessary to create subdivisions just as happened with the "rigid" structures. The committee foresaw this during certification and so suggested that I drop my perfectionism (a basic defense of the rigid structure) and present this partial, yet very substantial amount of work as the PDE

Nevertheless, included in the Appendix are the baseline characteristics of all five main structures. If indeed you have begun to think along characterological lines, as I hoped you would, it should be exciting and rewarding to do your own extrapolations using the baseline characteristics. You will, however, need to know which is your dominating character structure, which defenses you employ most and where you are still partially unresolved. If nothing else, if this PDE has helped you uncover and acknowledge some of this material, it will have fulfilled its purpose.

APPENDIX I

EXAMPLES

The following "examples" substitute the "Case Histories" which would normally form part of this presentation. I have made this substitution because, in my opinion, it is more useful and appropriate to show examples of diadic characterological interaction as they apply to the basic premise of the PDE rather than generalized case histories, where the point of countertransference might be lost.

I am especially interested in the example of "Judy", where a specific case problem led to uncovering a general characterological problem that was obviously affecting Judy's entire practice. This kind of realization is the best type of supervision, I believe.

EXAMPLE No. 1

Phallic Narcissistic Male Therapist and Oral Patient

Ron is a phallic narcissistic therapist and Paul is an oral member of his group. Paul is homosexual, young, attractive. The group went generally well, yet Ron felt irritated, unsatisfied, and specifically blamed Paul for maintaining a passive, uncooperative attitude. Ron felt that Paul was not motivated to be in the group, did not contribute, was disliked by most of the group members and should therefore leave. Ron's face showed anger when he spoke about Paul -- yet when questioned, he denied feeling any anger -- it was obviously unconscious.

Fortunately the group had access to Ron's wife, through one of the

members. And the feedback she got differed considerably from Ron's version. She heard that the group liked Paul, and, although it was true that he did not give much, the group thought he did what he could, that he benefitted from the group and they wanted him to stay. Ron was confron- in Supervisory Group. The result of his work, summarized, seemed to be:

1) Ron deeply resented Paul's passivity, which he personalized to some extent. He suppressed and denied his anger, and retionalized it away. He projected his desire to be rid of Paul onto Paul; he blamed Paul, concentrating on his defenses instead of seeing the person underneath and using his knowledge against Paul. The combined projection, denial and blame created guilt, further enraging Ron.

2) After realizing this dynamic, he also was able to see, that, most probably, Paul had been thriving on Ron's covert rage, which gave him a sense of power over Ron (father image), satisfied his need for attention/energy (he did in fact receive more attention than others in the group), and gratified his spiteful withholding. Paul had identified the rigid's need for "performance" and realized that, if he did not satisfy it, Ron would forever keep "trying".

3) By not confronting Ron, Paul gave no opportunity or justification for Ron to vent his backed-up rage. Ron had in fact become a source of energy for oral Paul.

Although the Supervisory Group stopped at this point, I would like to offer additional hypotheses that should later be verified.

It is obvious that Ron's rage is a characterological defense, connected to Paul's lack of "performance" -- which Ron interpreted as a deficiency on his, Ron's, part. And this triggered the deeply repressed self-doubt rooted in the phallic's low self-esteem, that goes

all the way back to his sexuality, his manhood, his potency.

There is an added factor here. Paul's orality (the source of passivity) must have been expressed as need. This, combined with the overt homosexuality, must have threatened Ron who may confuse (rigid's typical reaction) love and sexuality. Paul's real need for love and care may have been read by Ron as seduction, and confronted him with his own homosexual component. The sum of these factors became too threatening and frustrating for a rigid's limited patience, and he reacted in a charactertypical way -- by rejecting before being rejected.

The defenses of both Ron and Paul must be understood here as a cover against their real feelings for each other, which are simply, on Ron's part, care and concern, and on Paul's part, need for closeness. Both people are defending along charactertypical lines -- Paul by spitefully withholding, and Ron by rejecting.

EXAMPLE No. 2

Male Rigid Therapist and Passive Feminine Patient

Don is a rigid therapist, and Bill, his patient, is described as essentially passive feminine.

Don confessed he wanted to get rid of Bill. The therapy was not progressing. Don, after several months, believed that Bill's continuous need to please masked his hidden hate of the male/therapist/father -- but Don still wanted to interrupt.

In what Don thought would be the last session, he provoked a simulated fight with his patient, and much aggression was expressed by

both parties. Surprisingly (for Don) Bill wanted to continue the therapy after the cathartic discharge had taken place. But Don still disbelieved his patient's overt expressions of love, thinking that they were a seductive trick, a coverup.

In supervisory group, Don realized that this disbelief in the other's love for him permeated his entire life. He sometimes had the same reaction to his wife's tender approaches, and, as a child, had had the same reaction with his parents. This disbelief was rooted in his own lack of self-love, his low self-esteem, his unrealistic appreciation of his real worth. The unconscious statement then became "How can I believe that someone loves me if I feel unlovable?" -- hence the disbelief and mistrust of any expression of love. This of course was then interpreted by others as rejection, which in turn made them reject him, thereby validating the original premise -- that he is worthless.

We have here another explanation of the rigid structure's characterological fear of rejection. For rejection only validates his low self-esteem. This also explains the need for perfection, accomplishment, performance -- for the admiration obtained, in addition to fulfilling narcissistic needs, also bolsters their low self-esteem.

EXAMPLE No. 3

Hysterical Therapist and Schizoid Patient

Mary is a typically hysterical, rigid structure, of the intellectual type. Peter, her patient, has an essentially schizoid

personality, and has developed a massive body of masochistic appearance as a defense against the deep schizoid problem. Peter has been hospitalized twice in a psychiatric ward, once for more than a year. In Supervisory Group Mary expressed her dissatisfaction with the therapy, and the group decided to arrange a confrontation between patient and therapist (which is done only in very exceptional cases).

The problem, according to Mary, was that session after session Peter remained passive, unmoving, in an attitude that she interpreted as passively defiant. No effort on her part seemed to elicit and emotional response from Peter -- his responses were flat and unemotional. He didn't bring new material nor did he initiate anything. Mary was ready to abandon the therapy and refer him elsewhere. However, when she tearfully expressed this directly, in effect becoming very vulnerable, Peter suddenly started screaming (in rage) that she didn't know what had been going on inside him all this time -- how much she had really helped him -- how much his process had continued intrapsychically. He was outraged at her lack of faith in his inner process, which he hadn't externalized.

Mary was astonished -- then angry (that he hadn't expressed anything). The group encouraged her anger, which suddenly turned into fear of his massive physical power, and of the covert threat of Peter's glowering rage that had apparently been underlying the passivity. This passivity is, of course, a mechanism which Peter mastered during his hospitalization (where, as he says, "I learned how to pull myself together") as a defense against the schizoid rage of which he himself, was terrified.

At the group's encouragement, Peter expressed some of his rage,

which immediately became mixed with a plea for acceptance and "understanding without feedback" (which I interpret as the need for validation of existence that the schizoid lacked in infancy). This is a classic schizoid contact problem: the need for contact, through rage, acceptance, love -- but contact!

The countertransferential problem became clear. Contact -- at the levels needed by a schizoid structure -- is an unknown experience for a rigid structure. Mary lacked the intellectual comprehension of the problem, and fell back on her own experiential framework. A hysterical therapist found herself without positive feedback -- a typical, and almost intolerable, situation which directly infringes on her character structure at many levels. The therapist didn't see any "results," hence, did not know if she was "performing." Therefore, she began to feel her own low self-esteem, which could not be con consciously acknowledged and immediately triggered the character defense, which was first, anger; then rage. The rage was probably pre-conscious, and was suppressed as unacceptable (in view of her therapist role?). It had to find an outlet; thus, she began blaming, making her patient responsible for what ultimately her own low self-esteem.

The rigid structure's need for external validation is very great. I suspect, and this is still hypothetical, that this need is precisely the source of the dependency, both on archaic, fantasied parental figures and on present-day love objects. Low self-esteem in gross extremes must lead to self-contempt and self-hate. External validation becomes a temporary, although really unsatisfaying, solution. The hysterical flirts, seduces, becomes successful, powerful, strong -- all for the sake of external positive feedback which is, in reality, taken

as validation for existence, itself. What a drama -- all of which is enacted to cover up an unjustified low self-esteem!

EXAMPLE No. 4

Passive Feminine Therapist and Hysterical Patient.

The patient in question was a particularly beautiful 25 year old woman, recently divorced, with a varied, abundant sexual life and two children as a result of her marriage. In addition to being dominantly hysterical, there was a schizoid component so that, between both structures, she was really unaware of her extremely seductive attitude, speech, etc.

The therapist, a very accomplished psychiatrist, approximately 60 years old, responded sexually to her advances and very soon brought this out. Her response was to become angry and cold. At this point one would think that the patient would attempt another tactic: unfortunately she did not, alternating between the cold haughtiness and the seductive attitude she had initially brought to therapy. The therapist inevitably responded to her sexually in spite of having confronted her with her seduction time and again. At the end of the sixth session he told her that she had to come appropriately dressed and that she would now have to face away from him and not establish visual contact, at which point she became very angry and told him that he could not determine the way that she dressed or behaved. The therapist attempted to work with this anger and was only met by a cold, "understanding" attitude.

During the next sessions, the patient continued to alternate between the cold, rational understanding of her problem and the little girl that was trying to seduce her daddy. There seemed to be no way out of this impass and as the therapist was continually sexually stimulated, he finally decided to refer her.

In this case it was unfortunately impossible to resolve the countertransferential problem, which was seriously complicated by the sexual dissatisfaction the therapist was experiencing in his private life during this time. His decision to suspend therapy was the only honest one under the circumstances.

EXAMPLE No. 5

A Pattern For an Oral-Hysterical Therapist

Judy and Bert are co-therapists and have been working together for some time. They are both very experienced and have a great deal of background. However, lately, Bert has become aware that Judy is having difficulty with some of their common patients. In a training group, where therapists confront each other with their problems, Judy tried to expose what was happening.

Although the discussion was at first case-specific, it soon became apparent that several of Judy's patients were in the same situation. Most, or all, of these patients are characterologically basically oral, and Judy experiences them as "draining her energy," until she has to become defensive. During the work, it became apparent that she was quite conscious of the patients "draining" her

and tried to repress this, of course unsuccessfully. Judy herself has quite a bit of orality, with a dominant rigid hysteric configuration.

The oral hysteric configuration is confirmed both by her attitude in the group and her external life. For instance, although she loves her husband, and has a good marriage of twenty five years duration, sex has always been a problem and still remains so. Judy seems to be very dependent on her husband and, since this conforms to his needs of mutual interdependency they are quite satisfactorily paired off. I have given this background information to document my characterological analysis.

To return to the subject at hand, Judy became aware that she reacted to her oral patients both with her own orality, as well as with her hysterical component. Her orality tuned into the patient's orality, when she felt that she was being "sucked" dry and investing too much energy. She expected the patients to feed and nurture her just as she fed and nurtured them initially. This creation of dependent relationship is really an expression of both an hysterical component, which is fundamentally afraid of being rejected, and her orality that needs narcissistic gratification. Therefore, to guarantee that the patient will not reject her, Judy begins by promising love, affection, support, etc., which the oral patient, of course, takes. The oral patient returns nothing and keeps demanding more, at the same time becoming angry (oral rage). Judy continues "performing" so that her patient will not leave her. As the patient's thankless demands continue, Judy suddenly feels that she has given enough. Her own orality comes into play and demands the counterpart of her "gifts,"

and when nothing is coming forth and the patient continues to demand more and more, Judy feels rage and hatred, thereby perfectly justifying her rejection. The rage and hatred are repressed, not suppressed, so that Judy perceives that she has to deny a strong feeling in her, which she ascribes to guilt. This guilt is real -- it is the product of her irrational oral hate and hysterical desire to reject, which in turn was originated by the need to perform and not be rejected.

Practically all this was checked out with Judy, during the group and she responded affirmatively to questions such as, "What would you do if a patient rejects you?" The answer being, "I would feel very, very bad and would do anything to stop that."

She also acknowledged her oral need to be fed by the patient, and the fact that she felt very clearly that she was repressing feelings, which were not identifiable prior to the group.

The resolution came when Judy became aware of all these components and accepted that she did not really have to nurture a patient and that the patients could stay with her or leave her according to their own needs and problems. In other words, Judy became conscious that it was more important to allow the patient to develop, whatever the consequences of that development might be, than manipulate him or her into staying in the therapy to gratify Judy's own neurotic needs. A further step would have been to acknowledge that her own self-worth did not depend on keeping or losing a patient -- but she did not quite reach this point.

It is undoubtedly true that these insights may not become permanent. To expect this would be to be unduly optimistic, as they imply a partial, or total, resolution of her character structure

However, she did become aware of a very destructive aspect of countertransference.

EXAMPLE No. 6

Schizoid Therapist and Oral Patient

Eric is an almost pure schizoid type, practically seven feet tall, who resolved many of his own problems, to the extent that he is now a qualified therapist. He belongs to the rigid schizoid type; in other words, his body is stiff, rigid and threatening; the defense is against terror. Robert is his patient, small and predominantly oral.

In a confrontation within a training group, Robert expressed extreme rage and hostility towards Eric. Eric at first listened, then very quickly became defensively rejecting, almost immediately exploded into his own rage, saying that Robert was projecting without taking into consideration the reality of the therapy. Eric's behavior was aggressive, but Robert was nevertheless able to maintain his ground. Robert continued attacking and Eric became very very angry indeed. The group stepped in, trying to make Eric understand that he had to deal with Robert's transference of oral infantile images and demands, that in fact Robert's anger was not directed at Eric, the therapist, but rather the father image for which Robert had enormous pent-up resentment. The group also pointed out that it was Eric's responsibility to facilitate the transference and not to oppose it. Eric was able to accept this; he quieted down and let Robert continue with his rage. However, Eric was not passive -- before continuing, he expressed,

verbally as if reassuring himself, what the group had brought out. He was, in effect, examining his reaction -- seeing how irrational it was and how it affected negatively his therapeutical relationship. When he understood, he became very actively understanding, allowing Robert to express what eventually became violent rage, after which Robert broke down, expressing his real need for love. Robert was crying very deeply while reaching out to Eric, and Eric was ready to hold him (which, for a schizoid personality is very difficult) and exposed his own desire to help Robert and his own good, warm feelings turned toward Robert. This was an exceptionally beautiful resolution of a very strong countertransference involving the characterological defenses of the therapist, who, fortunately, was able to see that his behavior corresponded to his own character defenses so that resolution could take place.

APPENDIX 2

BASELINE CHARACTERISTICS

As mentioned in the introduction, what follows is an abbreviated version of the "baseline characteristics" that can be usually expected among the different character structures. Hopefully the reader will use this information as reference material when puzzled in his/her practice. For in this work I have attempted to cover only some of the possible interactions -- but by no means all of them. Also, this first part of the work is concerned only with the four rigid subtypes -- and the reader may wonder about the other basic character structures, which hopefully will be covered in a later paper.

RIGID THERAPIST

Baseline Characteristics

- Basic Trauma: Rejection of infantile sexuality resulted in heart/sexuality split in adult

- Basic problem: To express love; integrate heart/genital split. Sexuality denied by hysteric; used aggressively by phallic.

- Basic Fear: To be rejected, hurt; to feel worthless.

- Basic Defenses: Several. Seduction is one. Rage is another. Holding back is another. Defenses highly organized; frequently very flexible (mesh-type armor).

- Underlying Negativity: Rage, contempt, arrogance (pride).

- Covert Problem: Feeling of worthlessness, which results in dependence on others for validation. Excessive perfectionism used as compensatory mechanism.

Secondary Characteristics

- Must "perform" -- frequency and intensity of interventions may be excessive.

- Impatient.

- Very energetic.

- Repressed sexually.

- Seductive (hysteric).

- Aggressive (phallic).

- Gets angry defensively.

- Contemptuous. Arrogant. May lack compassion (especially phallic).

- Needs to "get results" for/from patient to compensate for low self-esteem.

- Difficulty with real expression of love/ longing need, even when appropriate.

- May have difficulty with "real contact" -- maintaining instead "pseudo conta t".

- May overemphasize expression of aggressive/seductive components in patients, as this is most familiar area.

RIGID PATIENT

Secondary Characteristics

- Withholds.
- Highly energized.
- "Performs" -- very rewarding patient.
- Arrogant <u>or</u> contemptuous.
- Uses justification abundantly.
- Very vulnerable to rejection, disappointment.
- Aggressive (phallic) or seductive (hysterical).
- Is affect blocked.
- Rage, used as defense, can cover up hurt, longing, love, need, soft feelings.
- Primary gain of sexual intercourse is genital discharge. Since vulnerability rarely exposed, contact/love is only of secondary interest. Thus, need/longing rarely felt.

Baseline Characteristics

- Basic Trauma: Rejection of infantile sexuality resulted in heart/sexuality split in adult.
- Basic Problem: To express love; integrate heart/genital split. Sexuality denied by hysteric; used aggressively by phallic.
- Basic Fear: To be rejected, hurt; to feel worthless.
- Basic Defenses: Several. Seduction is one. Rage is another. Holding back is another. Defenses highly organized; frequently very flexible (mesh-type armor).
- Underlying Negativity: Rage, contempt, arrogance (pride).
- Covert Problem: Feeling of worthlessness, which results in dependence on others for validation. Excessive perfectionism used as compensatory mechanism.

ORAL THERAPIST

Baseline Characteristics

- Basic Trauma: Abandonment or lack of emotional (physical) nourishment during oral stage.
- Basic Problem: Incapacity to reach out (for reaching function was frustrated by absence of parent).
- Basic Fear: To be abandoned; left.
- Basic Defense: Passivity; pseudo-sadness.
- Underlying Negativity: Spite; greed; unfulfillable need.
- Basic Statements:
    - "You do it for me."
    - "I am helpless."
    - "I can't do it."

Secondary Characteristics

- Passive.
- Covertly resentful, spiteful.
- Is "needy" -- wants patient to "feed" him.
- "Sucks" energy -- does not provide it during therapy.
- Low energy.
- Fears "reaching out."
- Has difficulty sustaining demands of support from patients.
- Fears abandonment. Basic infantile trauma. Therapist especially vulnerable here.
- Can easily become dependent on patient; collude to obtain financial/emotional/energetic "sustenance".
- Very rational, logical. Has exceptional intellectual clarity and very high verbal capacity (which can be used defensively).

ORAL PATIENT

Secondary Characteristics

- Spiteful.
- Low energy.
- Passive.
- Holds on (doesn't really let go).
- Feels deprived.
- Needy.
- Indirectly, through passivity, states:
  "You do it for me"?
  "You cannot do it for me."
- Extremely verbal. tends to block badly needed physical work with "verbiage".

Baseline Characteristics

- Basic Trauma: Abandonment or lack of emotional (physical) nourishment during oral stage.
- Basic Problem: Incapacity to reach out (for reaching function was frustrated by absence of parent).
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- Underlying Negativity: Spite, greed; unfulfillable need.
- Basic Statements:
  - "You do it for me."
  - "I'm helpless."
  - "I can't do it."

SCHIZOID THERAPIST

Baseline Characteristics

- Basic Trauma: Active hostility from parent.
- Basic Porblem: Defective ego.
- Basic Fear: Invasion of primary process material that is equated with madness/death leads to fear of being killed, annihilated, destroyed.
- Basic Defense: To freeze and hold together, maintain ego boundary and thus contain underlying violent negativity.
- Underlying Negativity: Homicidal intent -- desire to kill, destroy, annihilate.
- Basic Statement: "I am terrorized."

Secondary Characteristics

- Very rational; very clear, understanding intellectual grasp of problem yet may have totally distorted, "blind" area due to affect block
- Frequently has unresolved terror (of own unstable ego and consequence thereof).
- Low energy system. Can be fearful of high energy system.
- Low tolerance for frustration.
- Fearful of directly expressed rage (fearful of own violent rage).
- May overemphasize intellectual understanding of patient's problem, blocking affect release.
- Covertly hostile. Probably guilty because of this.
- Relatively cold.
- Has difficulty with contact, direct engagement.
- May have difficulty with body work (due to lack of contact with own body).
- Strong on imagery, fantasy, dream.
- Very spiritual -- needs to "incarnate, enter the body".

SCHIZOID PATIENT

Secondary Characteristics

- Very rational; very clear, understanding, intellectual grasp of problem, yet may have totally distorted, "blind" area due to affect block.
- Frequently has unresolved terror (of own unstable ego and consequences thereof).
- Low energy system. Can be fearful of high energy system.
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- Basic Defense: To freeze and hold together maintain ego boundary and thus contain underlying violent negativity.
- Underlying Negativity: Homicidal intent -- desire to kill, destroy, annihilate.
- Basic Statement: "I'm terrorized."

PSYCHOPATHIC THERAPIST

Baseline Characteristics

- Basic Trauma: Betrayal; double message; double binds resulting in defective super-ego upon which entire trust is based. Distrust of anything/anybody else.
- Basic Problem: To trust (himself, the other, reality, his/her "ground").
- Basic Defense: To control all. Manipulation is constant, including manipulation of self. Willfulness.
- Underlying Negativity: Distrust, even of his/her own life process. Fear of collapsing into infantile helplessness -- even schizoid unreality.
- Basic Statements:
  - "I'll control all."
  - "I'll have it my way."
  - "I'm right; you're wrong."

Secondary Characteristics

- Control is central issue.
- Is very mistrustful, doubtful. Accepts only own reality.
- Under stress, will manipulate.
- Is not "grounded".
- May be unaware of level-shifting -- in fact, mind-fucking.
- May fall prey to sophistry.
- Cannot tolerate seductive manipulation.
- Must always win if challenged -- great difficulty in giving in. While over-emphasizing self-assurance may weaken patient.
- Will provide support (which he lacks) in exchange for submission.
- Is vulnerable, and creates double-bind situations.
- Vulnerable to seduction from motherly women. (I _think_ applicable to both sexes?)
- Has severe authority problem.

PSYCHOPATHIC PATIENT

Secondary Characteristics

- Extremely manipulative
- Will attempt to confuse to gain control.
- Highly energized.
- Challenging attitude (different from masochist).
- Unreal.
- Constantly changes levels (mind-fucks). Does not follow sequential reasoning.
- Control is primary need. Can be overt or covert ("feeds" therapist, adopts seductive/passive -- yet extremely controlling -- attitude).
- Homosexuality -- expressed or underlying -- frequently present; may cause unspoken issue and covert countertransferential problem.

Baseline Characteristics

- Basic Trauma: Betrayal; double message; double binds resulting in defective super-ego upon which entire trust is based. Distrust of anything/anybody else.
- Basic Problem: To trust (himself, the other, reality, his/her "ground").
- Basic Fear: To be betrayed/controlled again.
- Basic Defense: To control all. Manipulation is constant, including manipulation of self. Willfulness.
- Underlying Negativity: Distrust, even of his/her own life process. Fear of collapsing into infantile helplessness -- even schizoid unreality.
- Basic Statements:

  "I'll control all."

  "I'll have it my eay."

  "I'm right; you're wrong."

MASOCHISTIC THERAPIST

Baseline Characteristics

- Basic Trauma: Freedom of expression and/or action was denied. Separation/individuation process severely impeded. Overconcern for physical well-being at expense of emotional contact. Violation and humiliation prevailed. "Smothering instead of mothering."

- Basic Problem: To release and express; to expand; to have hope and faith. Intimacy and freedom antithetical.

- Basic Defense: To bear all, until pent-up feelings become intolerable. Then provocation begins which, if successful, will justify explosive release. However, guilt follows which forbids further expression, resulting in "masochistic collapse" -- and vicious circle recommences.

- Underlying Negativity: Hate; smoldering resentment.

- Basic Statements:

  - "I'll bear it."

  - "If you help me (as I'm asking you to) you are really inhibiting my freedom. But if you don't help me, it means you don't care."

  - "I'm caught; there is no way out; it's helpless."

Secondary Characteristics

- Fears closeness. Identifies it with being "smothered." However, if this problem is resolved, can maintain exceptional contact with patient.

- Exceptional resistance. Must "bear" it. Enjoys stress.

- May become provocative to attract sadistic aggression (enjoys patient's attacks).

- Can be very supportive, loving, strong.

- Very intuitive; much feeling. Can take "intuitive leaps" that may or may not be censored by reason.

- Has sadistic remnants.

- Difficulty in dealing with humiliation, especially anal. This may take form of intolerance to criticism.

- Danger of communicating own hopelessness.

MASOCHISTTIC PATIENT

Secondary Characteristics

- Must "bear" it.
- Fears -- and needs -- freedom of expression.
- Collapses easily.
- Difficulty in aggression.
- Anal humiliation and holding.
- Provoking attitude.
- Covert -- never overt -- rebellion.
- Smoldering resentment.
- Complies, but does not give.
- Blames. Barely accepts personal responsibility ("was done to").
- Enjoys, and adopts, "victim" role.
- Deep hopelessness/despair.

Baseline Characteristics

- Basic Trauma: Freedom of expression and/or action was denied. Separation/individuation process severely impeded. overconcern for physical well-being at expense of emotional contact. Violation and humiliation prevailed. "Smothering" instead of "mothering".
- Basic Problem: To release and express; to expand; to havd hope and faith. Intimacy and freedom antithetical.
- Basic Fear: To be denied possibility of expression; to be constricted; possessed.
- Basic Defense: To bear all, until pent-up feelings become intolerable. Then provocation begins which, if successful, will justify explosive release. However, guilt follows which forbids further expression, resulting in "masochistic collapse" -- and vicious circle recommences.
- Underlying negativity: Hate; smoldering resentment.
- Basic Statements:
    - "I'll bear it."
    - "If you help me (as I'm asking you to) you are really inhibiting my freedom. But if you don't help me, it means that you don't care."
    - "I'm caught; there is no way out; It's hopeless."

APPENDIX III

THE ENERGETICAL COMPONENT IN COUNTERTRANSFERENCE

An essential factor that a therapist should consider when he is interviewing a prospective client, is the energy put out by the characterstructure of the patient as compared to his/her own. In other words, what are the relative levels between patient and therapist, and how does the interaction of these affect the therapeutical transaction?

For instance, a schizoid therapist who has not worked out some of his basic terror, will have obvious difficulty dealing with a phallic narcissistic patient, whose basic defense is to frighten away his opponent. The phallic narcissistic, being of a highly charged structure with a tremendous amount of energy, will probably overcome the energy level of the schizoid therapist, who, by definition, has a low energy level. The same would apply for an orally categorized therapist, when confronted by a psychopathic patient who absolutely must control and who will use everything in his power, including sheer force, to control the session. By this, I don't mean physical force, but rather psychic, emotional and intellectual force.

Conversely, the therapist with a lot of energy in his character structure must understand that when he is facing a schizoid patient, he is in effect confronting a structure that is much weaker than his own. Therefore, should the therapist confront the patient directly unde these conditions he will simply overwhelm the patient and either frighten him away or provoke a psychotic break. We are faced here with the issue of sheer psychic strength on one side and weakness and

fear on the other. Classically, the therapist must abstain from intervention during the therapy, but as most psychotherapeutic schools today have abandoned the practice of abstinence to a greater o or lesser degree, the therapist must be aware not only of the quality of his intervention, but also of its intensity and how the patient's structure will be able to meet this intensity.

This diagnosis is particularly valuable during the initial interview. If the therapist can accurately diagnose the character structure of his patient, and knows the dynamics of his own structure, he/she can immediately understand the energetical relationship that will be established and so attempt to counteract it if he/she feels that it is appropriate. He/she can also understand that he or she will immediately be thrown against his/her own character defense if he/she is facing a structure whose energy level is considerable higher than his/her own.

It should be emphasized here, that, hopefully, the therapist has become conscious of his characterological defense during the course of his/her own analysis and has resolved many of the basic traumas that created his characterological defense in the first place. Of course, under these circumstances any therapist can take on any patient. We are faced here with the recurrence of the concept that the therapist can only help a patient when he has worked through his own problems. However, for the beginning therapist especially, the concept of the relative energetical systems may be a most useful tool in making his diagnosis.

The energetical levels of each character structure are dealt with in the "etiology" -- the initial description that antecedes the

diadic interaction description of each character structure. However, for the interested reader who wishes to pursue this matter further, I suggest Lowen's classic book, Physical Dynamics of Character Structure.

Perhaps it might help the doubtful reader of I try to make a simple description of what I mean by relative energetical levels. Imagine that a frail woman therapist is confronted by a phallic, aggressive, large man, whose main problem is containing his rage. He has contempt for the woman in general and specifically contempt for the weak woman. The frail female therapist is an easy target and, however evolved her training may be, a small, but deep, primitive fear will lurk in her unconscious. She may try to reason the feeling away, she may try to understand it and assimilate it, she may try to integrate it. Yet the fear persists when she is confronted by the huge animal-like, aggressive male. There is a physical reality to this fear and she is reacting at that level. Somewhere in her deep unconscious, there is the primitive terror of being physically attacked and destroyed. This is bound to continually interfere with the therapy, and I seriously doubt that she would be able to really help her patient unless she adopted the original model of total non-participation and abstinence. This model is only valid within the framework of classic psychoanalysis, the results of which have become questionable in modern times. Even if she were to use the couch and abstinence rule as a shield against her own fears, it is certain that the patient will perceive it and not accept the condition of her non-confrontation. On the other hand, were she to confront the rage directly, he has an obvious, real advantage that can justifiable scare her.

While this kind of dramatic energetical difference between two structures is of course not very frequent, on the subtle level this interchange and interaction does take place. Evaluations of present-day reality are made, however subtly, by both therapist and patient, who both know they'll have to deal with the other's negativity somewhere along the way. The therapist should be conscious of this, as a diagnostic and later therapeutical element.

APPENDIX IV

AGGRESSION AS A FORMATIVE AGENT IN RIGID CHARACTER STRUCTURES

While the oedipal conflict is the determining factor in the rigid structure's etiology, I believe that aggression -- its degree of expression or inhibition -- is an equally important factor in determining character structure. Aggression should be distinguished from assertion -- the normal, healthy expression of need; aggression usually results from the frustration of either need -- expressed assertively, directly -- or love, expressed through longing or sexuality.

While in general the degree of expression, or inhibition, of aggression is a determining factor in all character structures, in the specific case of the rigid structures it takes on additional importance in that it is the defining factor that ultimately determines which of the four known possible subtypes will be adopted by the child. For under the general heading "Rigid Structures" there are now at least four subtypes: the phallic narcissistic male, the hysterical female, the passive feminine male and the masculine aggressive female. Each of these four subtypes presents very different clinical pictures; they react differently in life, have different body types and yet are all classified as rigids. The reason is that they are all the result of the trauma developed during the oedipal stage, while others -- pre-oedipal structures -- are not. During the oedipal stage the basic trauma is inflected by the parent of the opposite sex, who suddenly rejects the child's overt sexuality -- which the child experiences only as an additional, new expression of love. Therefore, the child at

first cannot understand, but later connects the development of sexuality with the unexpected -- and ofter brutal -- rejection suffered at the hands of the parent of the opposite sex. This rejection comes with the threat of loss of love, and conformity to the demands of the parent is an unchallenged expectation from the parent's side (although usually unconscious). It requires a very painful, difficult and sometimes prolonged adaptation by the child. Loss of love is a very very painful experience if threatened by one parent -- the oedipal parent -- but it is equated with death if threatened by both parents -- for the child believes that this threat is synonymous with physical abandonment.

In the classical oedipal model, the child longs for, and is rejected by, the parent of the opposite sex. He/she then hates this parent for the rejection, becomes competitive with the parent of the same sex for the love object and therefore hates this parent because of the competition and develops guilt resulting from the hidden intention to "take away" the opposite sex parent and the desire to kill the same-sex parent. The net result is that the child hates <u>both</u> parents -- and this is universally confirmed by direct observation.

How does the child <u>express</u> this hate? By becoming aggressive, hostile, demanding. These unpleasant discharges are represented by the parent, in different degrees! And the degree of repression will determine the final characterological development of the child. This, at least, is the basic hypothesis underlying this paper.

Let us examine the individual developmental backgrounds that lead to the different subtypes compressed under the general heading "Rigid Structures" -- according to the Bioenergetic model described in Lowen's book <u>Physical Dynamics of Character Structure</u>.

FEMALES --THE HYSTERICAL AND MASCULINE AGGRESSIVE WOMAN

In present day reality both secretly long for their "good daddy", both are competitive with and hate other women, both are attractive, highly organized, intelligent or even brilliant. Both are usually "successful", "accomplished", etc. Both have as common background the unresolved oedipal conflict -- yet they have very different bodies, approaches to life, attitudes. The hysterical has a very harmonious body, there are no major incongruencies -- while the masculine aggressive has a weak, rigid thorax, reminiscent of orality, and a very large, often massive pelvis, reminiscent of masochism. They are "split structures" as J. Pierrakos, who defines them brilliantly in his "The Plight of the Modern Woman", perceives. The hysterical is coy, sometimes even a little shy, rarely overtly aggressive -- in fact, she gives the impression of a perfect princess, regal, sometimes haughty, usually arrogant, aristocratic, always very seductive. The masculine aggressive can also be the princess -- but she is much more overtly aggressive. The difference in behavior are the different levels of expressed aggression -- the hysterical being much more inhibited than the masculine aggressive.

I believe that the reason for this is that the hysterical's aggression was severely inhibited, certainly by the mother, probably by both parents. But if only the mother (parent of the same sex) was repressive of her aggression, even if her father was not, she was faced by two rejecting parents -- her father rejected her because of her sexuality, her mother because of her aggression. Mother and father were closely knit, presented a unified front. The threat of loss, of

of love/abandonment came from both parents -- and she was forced to repress both sexuality and aggression. This leaves very little room for self-expression -- hence the manipulative, seductive, coy, withholding attitudes.

Not so to her sister, the masculine aggressive. Her mother permitted a much greater degree of aggression. Perhaps because she was weak or absent (physically, emotionally or both), which is expressed in the oral chest, or simply because she used the child against her husband. In any case the little girl's aggression was permitted to a much larger extent. Thus, in adult life, she will be a "go-getter" -- outspoken, grabbing, aggressive. She will be very competitive -- her mother permitted, even encouraged, this trait. She will have contempt for other women, and possibly for her own femininity and/or sexuality. For her sexuality was repressed and this is seen, physically in the massive pelvis and the lack of orgasm. The freed aggression combined with a repressed sexuality, which is the normal avenue of discharge of excessive energy, results in tremendous available energy, which she frequently tries to hold down, for she is afraid of releasing it. But the energy, and its aggressive expression, is barely suppressed -- as contrasted with the hysterical, whose aggression is much more inhibited, perhaps even repressed completely.

When the mother allowed aggression she also allied herself with her daughter, providing a secure environment. The child was no longer threatened by both parents, for mother was on her side. She may still have been competitive, hateful, spiteful with mother -- but underlying all this was a strong, secure alliance, a knowledge that mother would not abandon her completely, no matter what happened. Identification

with the female figure was possible even through the guilt of the oedipal situation. As previously stated, frequently there was an alliance of mother and daughter against father. Not so the hysterical, who met a "united front" -- mother and father were together and equally repressive. She had to repress both sexuality and aggression.

MALES - THE PHALLIC NARCISSISTIC AND THE PASSIVE FEMININE

The phallic male's father permitted, perhaps even supported, his son's aggression. While the child suffered from guilt for hating his father (classical oedipal conflict), he still attacked him in his attempt to conquer his mother. The father, often not understanding the dynamics, still tolerated, even supported his son, providing the security needed for the full development of the aggressive principle in the child. Later on the phallic man will have no trouble with expressing aggression - his difficulty remains sexual. While erectively potent, the phallic man is frequently orgastically (as understood in the Reichian sense) impotent. He can erect and ejaculate. But he hates the woman, is afraid of the destructive power he fantasizes himself to have, and suppresses, barely, his hate; thereby also suppressing his love and ultimately his true total orgastic discharge, which implies an involuntary abandonment of ego control. The phallic's father was frequently kind to his son -- and we find, clinically, that the adult phallic hates men overtly, and is very aggressive towards women -- all of which is used to hide his longing, his need, his capacity to give and love and be joyful.

In contrast, the passive feminine's father was his mother's ally

-- whether out of hostility, weakness, fear or other reason is immaterial But the father repressed aggression, and sometimes was quite brutal about it. Sexuality inhibited by mother and aggression by father created a need for much more repression than in the case of the phallic and frequently a regression to a prior, safer developmental stage is attempted. This explains the strong anal compulsive component of such men, who have in effect abandoned partially or totally the sexually aggressive position of the phallic; it also accounts for their masochistic (as opposed to the phallic's sadistic) tendencies and body configuration. Their passivity and latent homosexuality may be seen as an attempt to placate the male/father and assure him that they are not dangerous, sexually or aggressively. Of course, at a deeper level, they truly hate the man -- much more intensely than the phallic, whose aggression is overt and a cover-up for the deeper longing.

To summarize: Aggression then, is the determining variable in the rigid's final characterological stance. If allowed or supported by the same sex parent it can be expressed, the identification process can continue and the result is the phallic man or the masculine aggressive woman. If severely inhibited, a much stronger level of repression is required, and a more inhibited personality results. This is the case for the hysterical and the passive feminine male.

SEXUAL AGGRESSION ETIOLOGY

I. MAN

a. Seductive mother colluded with little boy, backed him up against the father, made him "her little man", transferred his

frustrated sexuality on him -- leads to phallic narcissistic. Father is disciplinary, stiff, but loving. Father inhibits aggression, mother redirects it against father and colludes with child.

b. Seductive mother is afraid of father, at first is seductive -- then frightened, she betrays little boy to father, allies with father against child, leads to passive feminine. Both parents inhibit aggression.

II. WOMAN

a. Seductive father colluded with daughter against mother, backed her up against mother -- leads to masculine aggressive -- one parent inhibits aggression, the other is weak/absent. Father redirects aggression against mother, colludes with child.

b. Seductive father at first promises, then betrays daughter -- allies himself with mother -- both parents inhibit aggression -- leads to hysteric.

Oedipal structures differ from pre-oedipal in that father is equally important with mother in creating characterological defenses. In pre-oedipal, mother clearly dominates, but in post-oediapl father and mother equally impinge on child.

Sexuality	Aggression
1. Father seduces child then cuts off.	a. Father and mother use child against each other. Father colludes with anger in child, redirects it against mother -- masculine aggressive woman, contempt for women, unresolved oedipal dependency with men.
FEMALE	b. Father and mother together against child; both repress hostility in child -- hysterical. Sex and aggression both repressed.
2. Mother seduces, then cuts off.	a. Mother and father use child against each other. Mother redirects child's anger against herself towards father, manipulated child. Mother colludes with child against father, promising (covertly) oedipal love -- makes oedipal resolution impossible as promis is constantly held out -- phallic narcissistic. Only sexuality repressed, not aggression, which is almost overt with women, barely suppressed (expressed as contempt) for men.
MALE	b. Mother and father both repressive. Don't allow negative emotions, child feels betrayed by her, still hates him, must repress both sexuality and aggression -- passive feminine.

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