INTUITION V. THE EGO IMAGE

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I. The Problem

An eight-year-old boy, vacationing at a ranch in his cowboy suit, helped the hired man unsaddle a horse. When they were finished, the hired man said: "Thanks, cowpoke!" To which his assistant answered: "I'm not really a cowpoke, I'm just a little boy."

This story epitomizes something which has to be understood in regard to a patient (or anyone else) to maintain rational insight into the interpersonal relationship when that is desirable. The patient who told it remarked: "That's just the way I feel. Sometimes I feel that I'm not really a lawyer, I'm just a little boy." Everything that was said to this patient was overheard by both people: the adult lawyer and the inner little boy. To anticipate the effect of an intervention, therefore, it is necessary to know not only what kind of adult one is talking to, but also what kind of little boy. This man came from Nevada, and he had a special system for avoiding depression when he was gambling. If he won, he would feel duly elated. If he lost, say $50, he would tell himself: "I was prepared to lose $100 tonight and I've only lost $50, so I'm really $50 ahead and I needn't be upset." Often, especially if he was winning, he would take a shower, after visiting one casino, before he visited another, as if to wash away his guilt so he could feel "lucky" once more.

It is evident that there were two kinds of arithmetic employed here: When he was winning, that of a rational adult; when he was losing, that of a child with an archaic method of handling reality (denial). The taking of the shower represented a lack of confidence on the part of the "child." He did not trust the rational, well-thought-out, and rather effective gambling system of the "adult." The shower was part of a primitive, autistic contract the "child" made with the powers of gambling, in order to obtain license to win again.*

It was difficult to deal effectively with this patient without

*The analysis of this behavior led directly into the areas explored by Bergler (Ref. 1) in his study of the psychology of gamblers, and does not concern the present discussion.

understanding these two different aspects of his personality. They were both conscious and both belonged to the ego system. One part of his personality faced reality as a whole, the other took it bit by bit and, by convenient manipulation, managed to find comfort in distressing situations, and anxiety in comforting ones. One part handled reality rationally, the other exploited it in an archaic way. There was no immediate question of the conscious versus the unconscious, or of ego versus id, in the sense of parapraxis or ego-dystonic behavior. Each approach made good sense in its own way: One was appropriate for the mature ego, the other was appropriate for a more primitive one. Conscious and unconscious, ego and id, were all involved somehow; but what was observed directly and what was most apparent to the patient and to the observer was the existence of two different conscious ego states: one that of an adult, the other that of a child.*

II. Clinical Significance

Now—to leave the corral and the casino and go to the couch—the same division into at least two ego states can be observed more or less easily, in every patient. Ned, the lawyer, was a sexually confused man who used to make remarks in his social life like the following: "Us girls have got to be careful not to drink too much." After he had been in therapy for some time and was becoming acquainted with his two ego states, he reported that he had had the following unspoken thought at a party: "If I were a girl (but I'm not a girl) I wouldn't drink too much." He understood what this meant. In the old days, the "child" had prompted the "adult" to say: "Us girls..." Now the "adult" objected to the promptings of the "child" in two ways: "I'm not a girl," and, "I don't intend to make remarks about it aloud in any case."

In this example, the patient conveniently offered material which indicated what was going on and what kind of "child" had to be dealt with. In other cases, the situation is more obscure, and it requires a considerable degree of clinical intuition to make the psychological dissection required to separate the "child" from the "adult."

In previous publications, the writer has discussed the nature of intuitive processes,[2] their functions in diagnosis[3] and in the

*This case has been discussed in more detail elsewhere (Ref. 12).

understanding of latent communications,[4] and their phenomenological reality as primal images.[5] The present communication is intended to bring these processes into focus, as constituting a specific feature in clinical psychotherapy. A similar process of bringing into focus was undertaken in considering "primal images," the therapist's perception of the mode and zone of the patient's instinctual strivings as aroused in the therapeutic situation and directed toward the therapist. The present discussion will be of "ego images," which are specific perceptions of the patient's active archaic ego state in relation to the people around him. An illustration may help to clarify this.

Certain patients appear in practice who may be characterized at the outset as "severe latent homosexuals," or "latent paranoid schizophrenics." The primal image activated by such a patient may give rise to the primal judgment: "This man is concerned about buggery." That means that his instinctual position in relation to the therapist is an anal receptive one; he symbolically turns or avoids turning his buttocks. This is valuable information and may have considerable predictive usefulness as a guide over a long-term course of therapy. But its value is limited in the initial situation and in various complex digressions which may arise. The "ego image" complements the ultimate orientation given by the primal image. It offers a much more useful guide in the preliminary phases of treatment and in diluted forms of treatment, particularly in helping avoid unnecessary hostile responses whose significance might be clouded by labelling them "unexpected transference reactions." The same man who evokes the primal judgment: "He is concerned about buggery," may also elicit the following intuitive impression: "This man feels as though he were a very young child, standing naked and sexually excited before a group of his elders, blushing furiously and writhing with almost unbearable embarrassment." This is an image of the patient's ego state, and hence may be called an "ego image," just as the image activated by his instinctual strivings may be called a "primal image."

The primal image, then, refers to an instinctual orientation; the ego image refers to an ego state. It is difficult to apply usefully the first piece of information, "This man is concerned about buggery." At the beginning, all one can do is refrain from threat-

ening him, either actually or symbolically; at the end, it becomes a highly technical and complex matter to use the information advantageously and therapeutically. The second message is more useful: "He is writhing inwardly with almost unbearable embarrassment." From the moment this message is perceived, it can be profitably applied in the immediate situation.

Doubts as to proper technique can be resolved by asking one's self: "What would I say or do if a three-year-old child who was writhing with embarrassment behaved the way this patient is doing?" This is a much easier question to answer than: "What do you do if a passive anal homosexual behaves in this way?" Furthermore, it seems simpler to detect and control countertransference tendencies toward an embarrassed three-year-old child than toward a passive homosexual adult, if only because the former is for most people a more congenial figure. Both the primal image and the ego image represent aspects of the "child," and together they form a useful guide at all stages of therapy.

Ordinarily, of course, one does not discuss such intuitions with patients until the footing is secure, if at all; but the therapist keeps them continuously in mind, and they control his behavior. Diana, a young housewife-student who was perceived in just the squirming way described, had had two psychotic breaks requiring hospitalization during a five-year period (1946-1951): one before she came to the therapist and the second a year after she had interrupted therapy. During her first therapeutic period, she was treated according to the principle: "This is a woman with strong homosexual conflicts and strong anal receptive strivings." For example, her heterosexual genital attitudes were encouraged; but this was not enough.

In the five years after the therapist focused on perception of her ego state (1951-1956), she required no further hospitalization. Furthermore, when she had broken down in 1949 after leaving therapy, the therapist had been involved in her delusions as a hostile conspirator. During the second phase, when she became disturbed on two occasions after discontinuing her treatment temporarily there were two differences from the 1949 break: First, the therapist was cast in the role of a beneficent conspirator so that she felt safe, because he was arranging for her to be safe at all times; and, second, her mature ego (the "adult") had been

strengthened sufficiently so that she did not break down, and so that she recognized her troublesome feelings as delusions, the revival of an archaic ego state (Cf. Federn[6]). As a result, she was able to carry on her work and her studies efficiently enough to keep her household going and to pass her examinations with a good grade, even during periods when she was engaged in an acute struggle with her paranoia. And there was something much more specific at work here than a mere orthodox shift from "id therapy" to "ego therapy."

In Diana's case, it became possible to investigate the accuracy of the intuitive ego image. After being treated once weekly for two years according to the principle, "Remember she is a child, writhing with embarrassment," rather than, "Remember the homosexual and anal conflicts," she was introduced to a therapy group. After a year in the group, it became possible to mention to her how the therapist perceived her ego state. A couple of weeks later she reported that she had been much impressed by this conception of herself and had given it a good deal of thought. The therapist had gained his insight one day by carefully observing her manner in the office, and thus far had no historical grounds for his intuition. She now offered the following material:

"I don't remember this myself but my mother told me about it. I was playing in our back yard. For some reason my diaper was off and I was naked. A group of men were watching me over the fence and laughing. My mother came out to see what it was all about. She got very embarrassed when she saw what was happening and hustled me into the house. I can imagine how embarrassed she was, because she still undresses behind a screen."

This story, which is most likely a second-hand account of a repressed screen-memory, was the first evidence that the ego image had a historical basis. Yet the patient's response to the therapist's revised attitude had already indicated that his intuition was correct.* The therapist, on his part, had had enough confidence in his intuition throughout to adhere to it, even when this made difficulties with the other members of the therapy group because of alleged "favoritism." But by treating each member of

*At the time of going to press, the patient has been married for six months and is functioning happily as a housewife.

the group according to the indications offered by his respective *ego* image, these difficulties were overcome. The real problem arose with members of whom he was unable to obtain clear ego images.

III. A Clinical Example

One may now observe in some detail how the attainment of a clear ego image improved a rather chaotic and unfavorable therapeutic situation. The case concerns a 40-year-old woman in whose case the primal image was clear enough from the beginning: She was wallowing in feces and was involved in a powerful conflict about how far she could go in defecating, with generosity as well as with malice, all over the therapist. The difficulty was, however, that at the time the treatment began, the therapist did not know about ego images; or in more ordinary terms, did not perceive the patient's ego state concretely enough, although it was sufficiently clear in an academic, inferential way.

This patient, Emily, was referred for treatment of severe, frequent, and long-lasting hemicrania, with scotomata and sometimes vomiting. She had spent a great deal of time during the preceding 15 years looking for and trying various remedies without relief, including a year of psychotherapy three times a week. For cogent reasons, she could only be seen regularly twice a week by the writer—occasionally three times weekly—hardly an encouraging program for such a refractory case. Nevertheless, after three years her condition was considerably ameliorated—the headaches rarely occurred—and she reported that she got along better in several types of situations.

For the first two years, however, the improvement had been superficial, unstable, and sporadic, because of lack of insight on both sides. It was only after the therapist obtained a clear-cut ego image that the course of therapy could be controlled with some understanding and precision.

This patient showed many depressive symptoms: weeping spells, suicidal fantasies, sensitiveness with resentment, and depression itself. She was tyrannically self-depreciating, guilt-ridden, passively aggressive, and masochistic. Her defenses were weak, spotty, and poorly organized: There was obsessive cleanliness combined with untidiness; there was a strong but inefficient effort to appear cultured and well-bred; and she was stubborn, yet panicky.

Demands for sympathy from her husband were easily smashed. There was sporadic alcoholism, and a continual quest for new medications, which she did not take regularly. She made aggressive threats, coupled with abject compliance; and she exhibited righteousness, combined with crafty deceptiveness. If these trends had been firmly established, they could have been dealt with, but they lacked stability and integration. The picture was not so "hard" as it sounds. The whole defensive system was "soft" to the point of mushiness, giving the clinical impression that it could not be dealt with, but only wallowed in.

At the slightest sign of danger, Emily relinquished one defense and sank into another. Interpretation failed, because she could see it coming. She experienced it as "name-calling," and would obviate it by calling herself names first. If interpretations were withheld, she felt lonely, neglected, and suicidal. "Support"—if she did not succeed in finding criticism in it—made her feel guilty and more depressed.

During this phase, the patient was much more satisfied with her progress than the therapist was. She did not want to transfer to another psychotherapist or another form of treatment.

The behavior of the therapist during this period was guided to some extent by an academic, inferential and rather stereotyped "ego model," which remained unformulated and preconscious. This model characterized the patient in a banal, barren, and obvious way in such terms as vulnerable, apprehensive, conventional—seeking justification for resentment, self-pity, and self-castigation. This perceptual skeleton, fleshless though it was, had undoubtedly exerted a helpful controlling influence on whatever progress had been made. But evidently its value as the basis for a live therapy was low, even if a new bone could be added to the frame from time to time.

Then one day she remarked: "I was a bloody mess when I was born and a disappointment to my parents because I was a girl." This report, typical for this kind of patient, was of little practical value. But later in the hour she added: "My mother told me that I disgusted her when I was wet, and she hated to pick me up. But she said my uncle Charlie would cuddle me even when I was dripping. He didn't mind picking me up at all." She

used to say to him: 'How can you hold her when she's in that disgusting condition?"

This was probably a second-hand account of a repressed screen-memory, as in the case, noted before, of Diana's nakedness. It immediately brought the whole situation into better focus. It told the therapist how Emily felt, and it told him how he must behave. Things began to go more smoothly. Everything was now more understandable, controllable, and predictable; that is, the treatment proceeded with only the usual errors and oversights on the part of the therapist. His groping and his feeling of inadequacy gave way to a well-oriented therapeutic plan.

The descriptive ego model was now replaced by a substantial ego image. Emily was no longer a set of verbal concepts but a clearly pictured personality. She was an infant with a dripping diaper, shrinking from her mother's disgust and tyrannical castigation, and looking for an uncle to hold her as she was. The therapist had only to be that uncle, and the situation would improve. He was, and it did. Counter-transference reactions became simpler to detect and avert. Transference reactions became easier to understand, to predict, to control, and to work with.

The therapist could now ask himself: "How does she expect this uncle to behave?" in order to know what to do and what not to do; and, "What does she want from this uncle?" in order to understand what the patient was doing in the treatment. There were, of course, many aspects to be tested. The ego image had to be refined in the crucible of experience. After a few months, the situation could be understood as follows: "The uncle who is holding this little wet infant must avoid a great many things, such as letting on that he knows she is wet. He must make it clear that he will hold her even when her mother will not—and that he will do so without betraying her, scolding her, seducing her. If he fulfills these conditions, she will gossip to him about all sorts of things and even tell him secrets more and more terrible that she could never tell anyone else."

This ego image was not mentioned to the patient, for that might have damaged its usefulness. Her account of the Uncle Charlie incident was allowed to pass without comment, and the therapist did not refer to it again. There was plenty of other

material available for the exploration of her urinary problems. In the ensuing months, her headaches lessened in frequency, intensity, and duration, she began to hold her own with other people, and was able to talk more and more freely about her early anal conflicts and even about her current anal masturbation; these were all noteworthy accomplishments for her. All this, of course, was related to "transference improvement."

It will be noted that this approach referred entirely to her ego state and took no account of her id strivings in relation to this uncle. It was clear, however, that sooner or later her desire to urinate and defecate on the uncle would have to be broached; that is, the ego image as a guide to therapeutic technique would have to give way before the primal image. The ego image served its function in the transitional stage between establishing a clear relationship and beginning progressive, well-oriented therapy, and one could always fall back on it in times of stress.

To clarify the situation in review: The ego image served as a technical guide in approaching the suggestive picture presented by the primal image. Three years of experience indicated that the only person to whom she could possibly reveal her wallowing in feces, her coprophilia, and her soiling impulses, was someone who treated her like an uncle; and then only when she was securely assured of his benevolent fidelity. In the hands of two different therapists, no other technique had succeeded with this patient. Nearly everybody agrees that special techniques are necessary in order to do analytic work with patients who are basically close to psychosis. On the other hand, this present technique was not a corrective emotional experience, in the sense of Alexander. It was a repetition of a good infantile experience.

A new phase began when the patient moved decisively from the urinary to the anal sphere. The old ego image then lost its value, and the therapist once more became uncertain of his position. He had to fall back again for guidance on an academic, descriptive ego model. An incident when the patient was put out on the doorstep for soiling her bed was not of much value since it merely indicated what was easy to see anyway, that she was afraid of being thrown out if she had "dirty" thoughts. This episode did not distinguish her as an idiosyncratic individual in relationship with other idiosyncratic individuals, as the Uncle

Charlie situation did. It gave no clear, substantial picture of her ego state and, therefore, could not serve as the basis for an ego image. Because no ego image came to light to serve as a guide during this phase, the third stage of her treatment proceeded in a less coherent way.

Incidentally, the accuracy of the primal image, in which she was defecating all over the therapist, was confirmed during the later phase. On two occasions when she had diarrhea, she soiled her husband slightly during intercourse just when she reached orgasm. She described her feelings as a mixture of great pleasure and great disgust. (The final therapeutic outcome of this case is not determined yet.)

IV. Ego Model, Ego Symbol, and Image

From the foregoing, it can be seen that the ego image comes to life with varying degrees of difficulty with different patients. Sometimes it never comes to life at all. Experience up to this point indicates that in general it offers itself most easily in cases of latent schizophrenia and least readily in cases of complicated character neuroses. The patient himself is probably rarely, if ever, aware of it, or at least of its significance, since in verified cases it seems to be based on second-hand accounts of repressed screen memories; and such things seem of little importance to the patient, because the affect is not accessible to him. But increasing experience gives the therapist more and more hints as to where to look in various types of cases. Such experience is worth cultivating, since, as Emily's case demonstrates, the attainment of a clear ego image in the therapist's mind may be crucial for the progress of the therapy, especially in regard to time.

How is the ego image picked out? This is a topic which is difficult to clarify. In the case of latent paranoid schizophrenics, as well as in other diagnostic categories if the same kind of archaic embarrassment is present, the patient's squirming may be observed in a larval form, and a question about erythrophobia may confirm the perception of the "child's" ego state. In a case such as Emily's, where the therapist has no precedent, it is simply the fact that all sorts of vague impressions and academic conceptions regarding the patient seem to crystallize, come to life, and become highly