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**Actualized Unconscious Fantasies and  
“Therapeutic Play” in Adults’ Analyses:  
Further Study of these Concepts**

by

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For the book honoring Veikko Tähkä

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One of the major contributions of Veikko Tähkä to psychoanalysis is his illustration of how some hallmarks of psychoanalytic technique, canonized by Freud's classical papers, have become blurred and require reexamination (1984, 1993). For example, he reexamined the concept of "interpretation," defined as bringing to the patient's awareness mental conflicts and their contents that were previously unconscious. Tähkä states that the classical definition of interpretation links it with the phenomena of repression and dynamic unconscious. Therefore, interpretation as a therapeutic tool can be utilized only for those patients with neurotic pathology whose main defense mechanism is repression. Since we as psychoanalysts have extended our practice to include patients who are more severely disturbed than neurotic patients, we need to seek new technical concepts. For example, interpretation in the classical sense cannot correspond to a borderline patient's subjective experience; even a borderline may grasp an interpretation intellectually. Therefore, Tähkä tells us, a borderline patient will not respond to interpretation. However, the borderline patient will respond to the analyst's catching and describing the patient's way of experiencing in a method that is analogous to a primary developmental object's (i.e., mother's) understanding of her offspring and conveying that understanding to the patient, who then can identify with the analyst's description as a step for further internal structuralization. For example, when an analyst understands how a borderline patient felt during a weekend break, the analyst "should simply try to describe it to the patient as fully as possible. It is not sufficient that he tells the patient that he understands how the patient must have felt, but rather he should try to convey that understanding in detail, to do it with respect and empathy" (Tähkä, 1993, pp. 355–356).

Tähkä calls his technique "empathic description" (p. 349). When it is repeated often enough—let us say in relation to a patient's many weekend breaks—it becomes the patient's own attitude toward him or herself during any breaks in treatment in the future and leads to selective identification with the analyst. Thus, empathic description essentially addresses a primary lack of structure, while interpretation deals with a secondary loss of available structure.

It is beyond the scope of this chapter to give further details of Tähkä's differentiation between interpretation and empathic description. His point is well taken

and can be summarized with a simple statement: interpretation, in the classic sense, is not an appropriate tool in the treatment of patients who are functioning at borderline or psychotic levels because they do not possess a cohesive sense of self and cannot fully utilize repression as their central defense mechanism.

The focus of this chapter parallels Tähkä's ideas about patients for whom the analyst's essential therapeutic consideration should not be—or at least should go beyond—interpretation in the classic sense. The patients I will refer to in this chapter need empathic descriptions *as well as* involvement in certain actions that Ast and I called “therapeutic play” (Volkan and Ast, 2001). As the patient carries out these actions, he or she develops certain nurturing, repairing, and integrating transference images of the analyst and eventually identifies with such images.

Once more, we need to reexamine some hallmarks of psychoanalysis and, like Tähkä, without removing ourselves from the mainstream of psychoanalytic practice, consider new tools for psychoanalytic technique that are designed for the specific psychological conditions of some of our patients: in this case, the conditions are related to the patients' early severe actual trauma or substantial accumulation of trauma. Interpretations, not actions, were considered to be the main therapeutic tool of psychoanalysis. Otto Fenichel (1945) summarizes the classical view of action as something that “impede(s) the ego from being confronted with unconscious material” (p. 570). He argues that action “relates to the present and does not make the patient conscious of being dominated by his past to be effective in the present” (p. 571). Fenichel is referring to “acting out” of neurotic conflict. Since “acting out” was considered an undesirable concept (Freud, 1914)—and in its classical sense, this is still true—it was not frequently mentioned or studied in the psychoanalytic literature. In recent decades, “action” or “reenactment” has become popular in certain circles. A close look at writings about these terms suggests various conceptualizations; some can be thought of as belonging to mainstream psychoanalysis, and others cannot be considered truly psychoanalytic. I will not review such conceptualizations here. But it is imperative that I clearly describe what I mean by therapeutic play in order to avoid confusing it with these other conceptualizations.

Patients involved in therapeutic play in order to fully recover from their mental problems are those who experienced *actual* traumatic experiences in their developmental years. Furthermore, these patients may “encapsulate” (D. Rosenfeld, 1992; H. Rosenfeld, 1965; Volkan, 1976, 1995) their traumatized self-images with their corresponding object images and affects. Some unconscious fantasies that link the real trauma in the external world with its perceived and/or experienced mental representation become *actualized*, as I will soon illustrate. Actualized unconscious fantasies do not respond to interpretation in the classical sense; they do not initiate new internal structuralization, even when the patient can understand intellectually the interpretations of the content of such fantasies. The patient needs to be involved in an action, a therapeutic play, in order to tame, modify, and master the influence of his or her concretized beliefs, even when they are no longer unconscious due to therapeutic work. The personality organizations of patients with actualized unconscious fantasies may be on psychotic, borderline, narcissistic, or even neurotic levels. Even if these individuals are on a neurotic level, because of the encapsulation of their traumatized self-images with their associated object images and affects, we should consider such individuals as not having fully cohesive selves. Before giving clinical examples, I will examine the two principal concepts I already mentioned: actualized unconscious fantasies and therapeutic play.

### **Actualized Unconscious Fantasies**

In 1908, Freud described two types of unconscious fantasies: “Unconscious phantasies have been unconscious all along and have been formed in the unconscious; or—as is more often the case—they were once conscious phantasies, day-dreams, and have been purposely forgotten and have become unconscious through ‘repression’” (p. 161). In this chapter, my focus is on the second type of unconscious fantasy: a child making an “interpretation” of an event that tries to satisfy both wishes and defenses against those wishes according to the phase-specific ego functions available to him or her and also contaminating this “interpretation” with primary process thinking. For example, a child who witnesses a primal scene may develop an unconscious fantasy that, when naked and holding each other, a man eats or chokes a woman. Obviously, unconscious fantasies do

not have a formed thought process, but they refer to a mental content that is initiated by an external event; that is a collection of the child's available cognition, affect, wish, defense; that is influenced by whichever psychological developmental tasks he or she is dealing with at the time; and that is contaminated with primary process thinking. In treatment, when the influence of this mental content on the patient become observable, then the patient and the analyst develop a "storyline," a content that transfers the unconscious fantasy into a formed thought process, however illogical it sounds, due to its absorption of primary process thinking. Once the storyline of an unconscious fantasy is found, the unconscious fantasy then resembles an ordinary conscious fantasy or daydream.

Most typical unconscious fantasies concern themselves with body functions, birth, death, sex, aggression, early object relations, separation-individuation, Oedipal issues, family romance, mother's pregnancy, father's penis, and siblings. Classical psychoanalysis states that the original mental content is repressed and, as a repressed "mental content," the unconscious fantasy exerts an interminable psychodynamic effect on subsequent perceptions, affects, behavior, thinking, responses to reality, and adaptive or maladaptive compromise formations (see also: Beres, 1962; Arlow, 1969; Inderbitzin and Levy, 1990). Some unconscious fantasies are common: for example, Ast and I illustrated the commonality of various types of sibling-related womb fantasies (Volkan and Ast, 1977). A storyline of such a womb fantasy could be: "I want to be my mother's only child in her womb. I will enter there and kill my sibling, but my sibling in turn may kill me." An adult under the influence of such an unconscious fantasy, obviously without knowing why, will have anxiety about entering a cave that symbolically represents his or her mother's womb.

There are unconscious fantasies that are very specific and belong *only* to the individual that has it. This occurs especially if the initiation of the unconscious fantasy is due to a trauma specific to the child or a collection of specific traumas. For example, Ast and I described the case of Gitta, a woman who had gone through multiple surgeries and extended hospitalizations as a child (Volkan and Ast, 2001). Her unconscious fantasy was that she had a leaking body and that as long as her body leaked, she was alive. For example, as an adult, at times she "believed" that her menstrual flow was constant.

*Actualization* of an unconscious fantasy occurs when the actual trauma is severe or a series of actual traumas are accumulated, and when they interfere with “the usual restriction of fantasy only or mostly to the psychological realm” (Volkan and Ast, 2001, p. 569). A girl’s unconscious Oedipal fantasy, in a routine developmental process, remains in the psychological realm and it will psychologically influence the individual as an adult according to its *content* (which only becomes fully available during analytic work). If the influence of the girl’s unconscious fantasy that is related to her wish to possess her father is very strong, she, as an adult, may have a tendency to marry an older man (a father figure). But as long as her unconscious fantasy stays within the psychological realm, as she grows up, she may use her unconscious fantasy to satisfy her infantile sexual desires mentally, to enhance self-esteem, to create competitor-mother images, and so on. In routine development, she will be able to further repress and modify the unconscious fantasy. But if, while developing unconscious Oedipal fantasies, the little girl is most severely traumatized, such as being sexually assaulted by her father or a father substitute, such as an uncle, her unconscious Oedipal fantasy becomes “actualized.” Because there is a strong link between the unconscious fantasy and reality, the little girl’s unconscious fantasy will exist in *both* the psychological and experiential realms. During her adult sexual relations, the actualized unconscious fantasy, as the heir of her severe traumatic childhood event, will be experienced as “real,” or at least “partly real,” and existing in the present time. For example, if a man makes sexual advances to her, at times, she will experience this man as the original traumatizing and victimizing father or uncle, even though in reality the man’s advances remain within socially acceptable patterns. The man is not someone behaving *like* the original assaulting person; in the patient’s mind, he *is* the assaulting person.

Besides incest or repeated sexual stimulation by parents or siblings, severe bodily injuries, surgeries, near-death experiences, drastic object losses, and exposure to massive destruction like earthquakes or war during childhood make an individual prone to developing actualized unconscious fantasies. Actualized unconscious fantasies link real events that traumatize a child with their mental representations. They also link patients’ developmental defects with their early object-relations conflicts. Early severe actual traumas or accumulation of such traumas may lead to developmental defects in mental

structuring. Whenever there are defects, there are also object-relations conflicts. I do not separate such patients in to those having only defects or only early object-relations conflicts. They have both: actualized unconscious fantasies deal with defects and early object-relations conflicts and link them.

If the individual encapsulates his or her childhood traumatized self with associated object images and affects, the actualized unconscious fantasy not only plays a role in recalling the original trauma and its mental representation, but also plays a role in safeguarding encapsulation. If encapsulation breaks down, the rest of the individual's self-system will be assaulted by the previously encapsulated part and the individual will experience anxiety. Effective repression of unconscious fantasies (the mental content) will take place among neurotic patients, but for practical purposes, I believe that actualized unconscious fantasies are not fully repressed. The individual usually is aware of a version of it, now more symbolized, distorted, and often disassociated from the individual's other mental phenomena. If a person with an actualized unconscious fantasy enters into psychoanalysis as an adult, through therapeutic work, he or she may become further aware of the storyline of his or her unconscious fantasy that was previously repressed and/or disassociated. But when this person's actualized unconscious fantasy is reactivated either in his or her daily life or in the transference relationship to the analyst, the individual will have difficulty differentiating where his or her (now conscious) fantasy ends and where reality begins. Such patients then experience symbols or objects of displacement representing various aspects of the actualized fantasies as "protosymbols" (Werner and Kaplan, 1963). That is to say, to the patient, they *are* what in actuality they *represent*. When the *content* of such fantasies is understood and interpreted by the analyst, this does not lead to therapeutic progress. To extend Tähkä's term, the analyst can make an "empathic description" of both the content and the *functions* of such fantasy. This may lead to progressive therapeutic movements, especially if there are occasions to repeat such emphatic description and if the patient identifies with the analyst's insights. In certain cases, however, empathic descriptions are not enough. In such a circumstance, the patient needs to get involved in therapeutic play—which will be described in the next section—in order to get well. The following case illustrates actualized unconscious fantasies.

*Anna: Detachable penises made of clay*

During the time that she was negotiating Oedipal issues as a child, Anna was in reality sexually assaulted by her father on many occasions when he was drunk. Once in treatment, in her thirties, she and I could put a storyline to her unconscious fantasy: men have detachable penises that are made of clay and men, by playing with the clay, can make their detached penises huge, hard and dangerous. The *content* of this unconscious fantasy was understood: little Anna loved her Oedipal father when he was not drunk, at which times he was indeed kind. By giving him a detachable penis, little Anna split her kind father image from her rapist father image by detaching or attaching a “good” or “bad” penis. Anna’s mother in actuality was a potter, and, as a child, Anna had played often with clay. By having her father’s detachable penis made of clay, she wanted to control the size of his penis or destroy it: when erect, it was monstrous, but she could make the penis smaller by squeezing off part of the clay or crumbling it like a dried piece of clay. Anna “understood” the meaning of her now-conscious fantasy. But, since her fantasy was actualized, she also *believed* that her analyst’s penis was made of clay, that it was detachable, and that it, as a “bad” penis, could enter her unexpectedly when she was not on guard. Even though Anna had been married twice, and thus, in reality, knew what a penis looked like and was made of, she still believed in the analyst’s detachable penis made of clay. In order to get well—that is, integrate “good” and “bad” fathers and her corresponding self-images and know the “truth” for sure—Anna demanded that the analyst show her his penis. The treatment for practical purposes came to a standstill in spite of the analyst’s interpretations and empathic descriptions. Some months later, Anna became involved in an action: she fell “in love” with a professor who was the same age as her analyst and who was teaching at the same university. Their sexual union was centered primarily on her “playing” with his penis for hours. Through such activity, she began putting together what she knew a penis looked like in reality with what she “knew” a penis looked like in another reality, her actualized unconscious fantasy. After such activities, she began to put her kind and rapist father images together, stopped asking her analyst to show her his penis, gave up her lover, and developed a “routine” Oedipal transference, which had good therapeutic consequences.

## **Therapeutic Play**

Human beings are constantly involved in actions and our patients routinely speak about their past, current, and planned actions. Consider a patient beginning his session with a description of an action that he was involved in the day before. The patient says that he had a toothache the day before and had to visit the dentist. Then the patient describes what happened between himself and the aggressive dentist and how the dentist hurt him. There will be several factors if the patient's reported action, his unexpected visit to the dentist, will be examined in the session. Imagine that the patient is in the middle of a transference neurosis in that he expects castration in the hands of the analyst/father and that, during his free associations, he links the analyst's image with the dentist's image. The analyst then makes a clinical decision to explain or not to explain this connection to his patient. For example, the analyst may decide to say nothing to the patient if the analyst feels that his silence will induce necessary anxiety in his patient so that the patient can therapeutically regress further and make his transference neurosis "hotter." If the analyst and the patient, with a close working alliance, are in the middle of collecting evidence of the existence of the patient's castration anxiety, the analyst may say something about how the patient's perception of the dentist was another piece of evidence of his castration anxiety. Or the analyst finds no connection between the patient's report on his visit to the dentist and what the patient is currently negotiating in his analysis, and what is "hot." Then, the analyst treats the patients' reported action as one of the routine events that does not merit special attention at the time.

When I speak of the concept of an adult patient's therapeutic play, I am referring to a specific type of action that continues for days, weeks, or months. The patient is preoccupied with it and reporting it becomes the central focus of his verbal communication from session to session. The action reflects a storyline and as the patient's action continues, it becomes clear that this storyline is related to the patient's actualized unconscious fantasy. The analyst's various images, especially his or her repairing and integrating images, appear prominently in this storyline. The action comes to an end days, weeks, or months later when the storyline, which first expressed itself in actions, also can be verbalized. At which time, the story is fully in the awareness of the

patient and he or she comprehends its various meanings. Such actions are not “acting out” in the classical sense; while they include elements of remembering in action and resistance to verbalization of the transference, their *ultimate aim* is to crystallize insights about one’s conflicts and/or to repair structural defects. To differentiate therapeutic play from acting out, let me first further describe the latter.

Acting out: The aim of “acting out” is the opposite of the aim of therapeutic play: “acting out” is part of resistance to verbalizing the current derivatives of wishes and defenses against them and they are in the service of preventing the repairing of defects or working through conflicts. Some “acting out” is short lived: when I went on vacation, a patient of mine, Harry, who had severe separation anxiety, left the town where we both lived, and went to a nearby place called “Peaks of Otter,” three mountaintops forming a triangle and surrounding a lake. He rented a room at a nearby lodge and sat in the window, from which he could gaze up at two of the three mountains. When both of us resumed our work together, the patient exhibited no anxiety or other feelings about my leaving him. When Harry told me of his trip and of his gazing at the two mountains, and when I realized that the two mountaintops side by side represented my “breasts,” I interpreted how his action “cancelled” his anxiety pertaining to the separation between us. Then, the patient brought his separation anxiety to the surface once more so that we could examine what it signaled within his sessions.

Another type of “acting out” on the surface resembles therapeutic play in that it goes on for days, weeks, or months. But close observation shows its dominant meaning: to resist working through a specific transference issues. This is exemplified in the case of a young woman, Linda, whose mother was her father’s second wife. Her father’s first marriage had ended with the death of his young child, but he never forgot his beautiful first wife or their dead son, and when my patient was born into this second marriage, he treated her as a representation of both of them. As an adult, my patient had a series of love affairs with married men, becoming their “other wife” in each case. Her analysis showed that in this way, she was responding to her father’s needs and experiencing Oedipal triumph until the guilt of “incestuous” closeness made her break off each relationship, only to launch herself into another.

When, in the middle of her analysis, Linda worked on these issues, she began to experience erotic feelings for me and proposed a liaison, changing her mind when she fell “in love” with another married man, a university professor like myself, and began to fill her hours with accounts of the many, sometimes frantic, activities in which the lovers engaged. Unlike Anna, who had become involved with a university professor as a part of separating the reality of a penis from the reality of a clay penis, Linda used her involvement with a professor as a means to resist working through her erotic transference feelings for the analyst. Linda and her lover’s activities took their own course and became one continuous event in what was a good example of “acting out” in the classical negative sense. She would not undergo structural change until this “acting out” was interpreted systematically and she abandoned the affair. It was only then that she could experience her erotic transference fully and work through it. But her “acting out” (in a negative sense) persisted over months and provided stubborn dominant resistance to the analytic process. It seemed at times even to threaten the process itself.

### **Three types of therapeutic play**

Now, let me return to therapeutic play. I first reported such actions in 1984 and named them “therapeutic *stories*,” or special aspects of a developing and resolving neurosis. Later, Ast and I differentiated “therapeutic stories,” which are exhibited by neurotic individual or narcissistic and borderline patients after their evolving more integrated self-representations, from “therapeutic *play*,” which is usually exhibited by individuals in treatment who do not have integrated self-representations and who, when interpretations in the classical sense are provided to them, do not utilize them therapeutically (Volkan and Ast, 2001). On a descriptive level, it is difficult to differentiate a “therapeutic story” from a “therapeutic play.” Both have the same characteristics that I described above. Thus, now, I prefer to call all such actions that continue for days, weeks, or months and that provide a storyline in relation to an actualized unconscious fantasy, as adult patients’ “therapeutic plays.” But, when I go beyond description of them and look at their *functions*, I divide them, for practical purposes, into three categories. The first two types of therapeutic play occur during the

treatment of neurotic-level individuals. They use repression effectively—even their actualized fantasies reflect an encapsulated area in their personalities. The third occurs in individuals below neurotic type, those with psychotic borderline or narcissistic personality organizations and structural defects.

The first type: The first type of therapeutic play takes place *after* the resolution of transference neurosis has begun—largely, in fact, *after* it has taken place. It is in the service of recapturing or summarizing the already properly interpreted transference neurosis. It is in the service of crystallizing mastery over the influence of (previously) actualized unconscious fantasy before the termination of the analysis.

William started his analysis when he was in his mid-thirties. His father had died when the boy was in the middle of his Oedipal struggle. He had childhood memories of lying next to his father, who was in an alcoholic stupor and had saliva dripping from his mouth. The child wished for his father to be dead, and his father actually died after one of his drinking binges. For a year after his father's death, William slept with his mother. His Oedipal fantasies were actualized: he had killed his father and possessed his mother. When his mother married suddenly a year after her first husband's death, William had to move to his stepfather's house. Literally overnight, he was separated from his mother, who now slept on the first floor with her new husband. The children of William's new stepfather slept on the second floor of the house, and William was "exiled" into a dark and scary attic. William went from feeling like a prince to feeling like a slave; he was consumed with rage, but had to develop surface masochistic tendencies in order to survive in the new environment. The new home was on a farm. As an adolescent, William shot and killed some puppies and chickens representing his stepsiblings. These actions further crystallized his unconscious fantasy that he was his father's "killer" and that one can actually kill other competitors for a mother's love. William became an adult with extreme inhibitions. His analysis was successful. As the termination phase neared, he developed a dramatic "story" in action about dangers to the analyst's life. The patient checked the tires of the analyst's car parked in front of his office, declared that the tires were worn, and warned the analyst that he may have a fatal accident. Since "killing" the analyst had become a very familiar story by this point, and since the analyst and the

patient both knew what it meant, the analyst remained silent. By the next session, the patient had checked the electrical wires in the analyst's building with the same idea: that the analyst may meet his death in an accident, this time in a fire. The patient's telling a story through his actions of how the analyst will die went on for several weeks. Finally, one session, the analysand suddenly began to laugh with relief: "you know," he said, "I have been trying to kill you. I knew all along what I have been doing. But you are still alive! I now surely know that I did not kill my father. Now I feel free of guilt." There was nothing for the analyst to interpret; he offered only his affirmative "Hm! Hm!" and soon the patient entered the termination phase of his analysis.

The second type: This type of therapeutic play appears in a neurotic individual as he or she is in the middle of assimilating interpretations of an actualized unconscious fantasy. The action is necessary for the assimilation of the interpretation.

Like William, Roger—who was also in his thirties when he started analysis—had many inhibitions and suffered from an obsessional neurosis. He was obsessed with conscious fantasies (daydreams) of inventing something that would bring sunlight to the earth's dark side during the night. His fantasies included thoughts of a spaceship with a vast mirror that would reflect to the dark side of the world the sunlight from its bright side. As his analysis progressed, the meaning of Roger's daydreams were understood. As an only child born to parents in their early forties, Roger lived in an apartment so small that all the family slept in the same room. Roger was exposed to multiple primal scene activities. One night when he was 12 years old, Roger was lying in his bed, which was alongside his parents' bed, his father unexpectedly turned on the light and Roger caught a glimpse of his mother preparing for intercourse by putting Vaseline in her vagina. The light was quickly extinguished. But this event became a symbol of his previously actualized unconscious fantasy in that witnessing a primal scene would blind him, as the light turned on quickly (temporarily) would blind him. The unconscious fantasy also included his "belief" that his mother had a vagina with teeth, *vagina dentata*. He wanted to see it so that he could master his fear of it, but the light necessary for seeing his mother's vagina also would blind him (castrate him). His conscious daydreams about

bringing light to the darker side of the earth reflected the globalization of his actualized unconscious fantasy.

As a neurotic individual, Roger was able to develop a workable transference neurosis. He understood interpretations, including the interpretation of his actualized unconscious fantasy when they were reflected in his transference neurosis. He had many dreams concerning his actualized unconscious fantasy and they were also interpreted. Yet, Roger could not fully work through the influence of his previously unconscious actual fantasy. At this point, he became involved in a “therapeutic play.” He began speaking of his preoccupation with an inanimate object, an adult toy. He had answered an advertisement in a magazine offering material for a Viking ship model. He was like a child whose eye had been caught by a toy in a shop window. Should he buy a kit, or shouldn’t he? He kept asking me, but I gave no answer. At times, I felt as though he were asking me to buy it for him. After a month or so, he came to a decision, and sent for the kit, which was expensive. When it arrived, he was like a child playing with building blocks. He filled his hours with me with accounts of his work on the model. I felt like a spectator as he planned aloud each successive step of its construction, pondering over it without letting me become at all involved in his “play.” I did observe that he was launching forth into some original “creativity” beyond what was indicated in the instructions; he wanted to add a lantern that would blink and quickly alternate light with darkness. The original model called for one unisex head, but he wanted to add a head suitable for a woman to use.

I then came to understand what his “toy” and his activities and “creativity” pertaining to it meant to him. In his analysis, he had gone over the ramifications of the event that had taken place when he was 12. He had repeated it “out there” in action, in transference, in dreams, in order to authenticate the existence of his incestuous desires, his fear of castration (going blind) at the hand of his father, his fear of female genitalia, and the reasons for his symptoms and behavior patterns. My interpretations now provided the authenticity he sought—and the capacity for related affect. Old desires and old fears had lost their ferocity; the old dreams about vaginas that bite and about Oedipus had lost their frightening force. I came to see his new play with the Viking ship as something like seeing a frightening film for the second time and no longer being terrified by the

monsters in it, instead, being amused by the monsters' actions and being able to enjoy the film light-heartedly. The making of the symbolic toy was an activity in the service of gaining comfortable immunity from being sucked into neurotic seductions. The play with the ship had positive qualities because of the following: the ship had a feminine shape, and his measuring and remeasuring its narrow length led me to understand that it represented his mother's vagina. The dragon's head he used for the figurehead on the prow was the Oedipal father getting ready to possess the mother and lead her away from her boy child. The blinking lantern (which he had added) recalled the bedroom disclosure when he was 12, as did the head designed for a woman. He was concerned over where to put this convenience on a show so narrow; the manufacturer's plans made allowance for only one common toilet. By trying to add a head for women only, he was trying to gratify his wish to separate the father's penis from the mother's vagina. He was concerned that it be so situated in the ship that no one would see a woman urinating in it; his desire and dread about seeing the mother's vagina was being repeated in this. Also, his serious attention to the details of the ship's interior reflected his old fear of vagina dentata.

I must emphasize that his "play" with the ship model came after he had worked through in transference the repetition of the bedroom episode—or, at least, was in the process of doing so. When I made some efforts to show him that his work on the ship model also reflected like phenomena, he seemed simply a child absorbed in serious play, unaware of his surroundings. I gave up trying to interpret, and contented myself with being a "spectator." But when his ship model was completed within some months, he was able to listen to my interpretations and to join me in describing what he had accomplished psychologically by taking the action he had. He felt different, and turned to a new chapter in his analysis once his "play" was over. The Viking ship was no longer important; he had worked through the influence of his previously actualized conscious fantasies and had crystallized the working-through of his Oedipal conflict with his "good" actions.

During the next phase of his analysis, there was exaggerated identification with my analytic attitude, like a child's identification with the father in order to consolidate superego development and to rearrange the internal psychic organization in general.

The third type: The third type of therapeutic play, while descriptively similar, is very *different* from the first two types as far as its function is concerned, and refers directly to this chapter's theme: patients who possess psychotic, borderline, or narcissistic personality organizations or have structural defects do not hear interpretations in the classical sense. Some other therapeutic maneuver, such as Tähkä's "emphatic descriptions," needs to take place before they move toward a neurotic level.

Among these therapeutic maneuvers, there is one that is initiated by the patient him or herself: initiating a therapeutic play. As stated earlier, the analyst does not offer them such activity. Obviously, this play occurs as part of patient telling his or her internal story and object-relations conflicts, defects, wishes, and defenses through action. In such cases, the therapeutic play *precedes* utilization of interpretations and empathic descriptions and appears almost necessary in order for therapeutic progress to take place. None of these patients have cohesive self-representations; they cannot use repression effectively. In fact, their unconscious fantasies are not fully repressed and symbolized as much as a neurotic person's are. They are constantly under the influence of this actualized unconscious fantasy in a rather obvious way. While they can do routine things like going to the store, buying bread, or keeping a job, the other part of them that is under the influence of the actual unconscious fantasy is constantly expressed.

Sepp underwent circumcision at age five and again at age eleven. Both were surgeries to correct his phimosis and both were extremely traumatic. In his unconscious fantasy, he "believed" that he was a castrated individual.

Sepp grew up on a farm and had a rather bad mothering. His early recollections of his mother was her coming after him and forcing him to eat, and in his adult mind, he had symbolized this interaction of his mother's offerings of food to Chinese water torture, where one drop of water is followed by another, and then another, until the person is driven crazy. Everybody told him that in his early childhood, he was a crybaby, most likely representing disturbances of the infant-mother interactions. In turn, Sepp idealized his father and tried to be close to him, but this came to an abrupt end when he went for his first surgery. The day after the surgery, his father came to visit to him and said to him in front of everybody, "what a pity; you no longer have anything to play with." Sepp believed that his father thought that he no longer was "a man" and that his penis was

damaged. He regressed a great deal and began going to sleep by putting his arms around his body and rocking himself, sometimes for hours.

Medical procedures continued after the first circumcision, supporting the actualization of his unconscious fantasy that he had lost his penis. For example, one procedure involved fitting a plastic ring around the glans penis and then pulling up the skin covering the glans penis and tying a string around it. Part of the skin was then tightly squeezed between the string and the ring, stopping the blood flow to the top part of the skin. Within three or four days, the skin above the squeezed area turned blue and was destroyed. Eventually, the dead skin was pulled off. Apparently, the surgeons who took care of him preferred this method of curing phimosis to the actual cutting off of the skin; they considered this type of procedure to be less susceptible to infection. It was, in actuality, a painful procedure, and mentally created a psychic reality that his penis was being constantly cut off, so that the fantasy of being castrated and actuality merged.

There are many stories to indicate how the Oedipal issues were kept alive with young Sepp's interaction with his father. For example, six months after his first surgery, Sepp was playing with a female cousin in a silo. Both had taken their clothes off and were exploring each other's bodies. They were discovered by Sepp's father, who became angry when he observed the children's sex play. In an attempt to quickly dress and come out of the silo, Sepp lost one of his socks. Since the silo had an unpleasant odor that infused Sepp's body and clothes, he was not allowed to enter the farmhouse. He stayed out of the house for hours, feeling humiliated, before the odor dissipated and he was allowed to enter the house. From that day on, his father would aggressively joke with him and continue humiliating him by asking "Sepp, have you found your sock yet?" and then laughing. The loss of the sock also represented the loss of his penis. One solution concerning his Oedipal issues was to crystallize his unconscious fantasy about being castrated so that he, in turn, would not have "power" to "kill" his father.

When Sepp was 10 years old, his phimosis reappeared. One day while in a bathtub, he pulled the skin covering his glans penis back. This resulted in the skin squeezing his penis. In pain, Sepp showed his penis to his mother. Thinking that there was a possibility of acute necrosis, she took Sepp to the hospital, where, without anesthesia, four hospital attendants pinned him down on the operating table while a

physician pulled up his penis in order to make the penis “thinner” This maneuver enabled the physician to pull up the skin that was squeezing Sepp’s penis. During this humiliating and very painful experience, Sepp had a thought that the doctor pulling his penis might tear it off. After the danger of necrosis had passed, Sepp, this time under anesthesia, went through a second circumcision. The second circumcision further crystallized his fantasy that he was castrated.

It is beyond the scope of this chapter to give details of Sepp’s analytic work. His analyst, Dr. Gabriele Ast, who began to see Sepp when he was in his mid-thirties and who consulted with me about Sepp’s treatment, had a feeling that her patient was “untouchable.” He was behaving as if he was maintaining his posture in order to avoid damage, or recastration, by her. Sepp was not ready to develop a therapeutic alliance that would allow him to hear interpretations, clarification, explanations, and so on. But deep down, he was so dependent that he kept coming to his analytic hours.

During the first three years of analysis, obviously the analyst learned a great deal about Sepp’s internal world. Sepp had conscious daydreams about his first surgery. For example, in one of them, his penis was being peeled like the skin of a banana is peeled. Sometimes, he would daydream about the “skin” of a carrot being shaved. Carrots and bananas were symbols, but they were so common that he knew what they meant. At other times, he daydreamed about a symbolized penis, such as a mountaintop set ablaze. The fire would burn the brush and the trees and destroy the land.

Not only had he had conscious fantasies rather directly reflecting his unconscious fantasies, but most of his night dreams also centered on his childhood trauma. For example, he would dream about holding a large water hose and watering a green area, and then fearing that he would be found and punished as if he had done something wrong. Then he would go into hiding. Since he did not have much repression, he could easily translate his dream and talk about an event before his first circumcision. After he was put on the operating table, he had to urinate, and was allowed to go to the bathroom and urinate. But unfortunately, he had to come back to the operating table and undergo the operation. In the dream, there was a wish that he could hide and not return to the operating table. Other dreams included operating room lights, catheters, plastic tubes

used to dilate his urethra (he had edema after the second circumcision), and a mountaintop (glans penis) that would be bruised and damaged.

The analyst joining the patient in exploring the “meanings” of these verbal productions in the sessions and sometimes their hit-and-run type transference reflections would go nowhere. In real life, too, Sepp was living “in hiding.” In spite of his intelligence, he worked in a psychiatric hospital where the patients represented himself, and he could not leave his job.

In the third year of his treatment, Sepp acquired a “uniform” that included a helmet with a dark visor. The helmet had a red picture of a biker. He also bought shoes with high heels to make him appear taller and began coming to his sessions as such. He reported that he had bought a motorbike that was absolutely in ruins, and that he would repair it. The analyst sensed that the broken-down motorbike represented Sepp’s castrated penis and that Sepp was entering into a therapeutic play. For six months, mainly what Sepp reported was repairing this almost-unrepairable motorbike.

After six months, Sepp called his father and asked the older man’s help in transporting the motorbike, now not working at all, to a dealer’s store. Sepp’s father arrived with a truck from the farm. The father and the son put the nonfunctioning motorbike in the truck and took it to the dealer, where Sepp exchanged the vehicle for a brand-new, powerful, and big motorbike. Interestingly, he had asked his father to buy a big, strong motorbike too. The father did not buy one, and Sepp felt very disappointed. (I think that the wish that the father also had a strong motorbike (penis) would make his image as a strong Oedipal father with whom Sepp could identify.) Nevertheless, Sepp drove the new motorbike back to his apartment and became involved with a woman whose first name is identical with Sepp’s analyst and had intercourse with this woman (Sepp’s previous sexual relations were full of object relations conflicts and unsatisfactory and fear of castrations, the details of which I need not report here). Since his father would not buy a strong motorcycle, and Sepp was disappointed with him, in a sense, he was trying to receive approval from his mother/analyst to have a penis.

At times, Dr. Ast would try to give interpretations and/or empathic descriptions of what Sepp was going through, but she had the impression that such verbal communications to Sepp about what he was doing would go in one ear and out the other.

It soon became clear that what Sepp had done by buying this “superbike” was going from having a nonfunctional penis to a “superpenis.” And obviously, the opposites are the same. He received an anti-anxiety drug from another physician who did not know Sepp’s psychology, and began taking these drugs and driving his motorbike recklessly. Despite the fact that Dr. Ast knew that Sepp could not hear interpretation, she still “interpreted” Sepp’s searching and creation of a penis, searching for a strong father to model himself after, his disappointment of not finding such a father, trying to receive approval from a mother. By doing so, Dr. Ast tried to convey to Sepp that she was understanding his dilemma and that she could put his frantic activities into a storyline. When Sepp’s reckless driving became very dangerous, the analyst told Sepp that she had a responsibility to stop him from driving recklessly. She explained that the activity with the superpenis could be done at a slower pace. She told him that if he were injured badly or killed, she would not be able to continue his analysis and that she was a protector of the analytic process. Thus, the analyst acted as a strong parent figure, putting realistic boundaries for Sepp’s expensive and dangerous “celebration” of finding a superpenis, to have a superpenis was not an adaptive solution for Sepp’s internal problems.

Soon after this, a drastic change in Sepp’s real life situation was initiated. Identifying with Dr. Ast, he wanted the motorbike to be “safe.” Thus, he left his work at the psychiatric hospital, where the motorbike could be stolen or damaged, and moved into a new apartment where there was a safe parking lot. Eventually, he began “sublimating” his activity. He found a job transporting small packages or mail using his bike. His new boss, in fact, had many motorbikes and he was a man with good humor and Sepp was hired by this man to be a courier. For Sepp, this meant the systematic study of a map of the city and memorizing streets. In a sense, he had to learn new ego functions to move out from his restricted external and internal world. When Sepp accepted the job, he made sure he could keep his psychoanalytic appointments and he made arrangements accordingly. One day, Sepp came to his appointments wearing the uniform of the courier company and reported that the superbike was now gone because it was not practical to use. He felt sad giving up his superbike, but he now knew that it was not an item that he wanted to keep. He said that he appreciated his analyst’s interest in him in that she was trying to stop him from damaging his body. Instead, he bought a smaller, more realistic

motorbike that could go through the city streets safely. Now in his sessions, he reflected the idea that “a bike is a bike” and not a penis. The symbolic representation of the bike was enhanced and Sepp’s further ability for repression began to take place.

### **Concluding Remarks**

Working through structural conflicts and even remnants of some object relations conflicts to a great extent *precedes* the appearance of a therapeutic play among neurotic individuals in treatment, whereas gaining insights into and beginning to work through object relations conflicts and ego deficiencies typically *follows* the completion of therapeutic play with people who are not on the neurotic level. I consider a therapeutic play of a person who does not yet possess a cohesive self-representation and effective repressive ability to serve the following aims:

- 1) Differentiating actual experience from the mental images of traumatic events associated with an actualized unconscious fantasy
- 2) Evolving protosymbols into symbols
- 3) Increasing capacity for mourning (for “losing” previous self and object representations)
- 4) Developing the ability to tame and tolerate aggressive drive derivatives
- 5) Learning to experience and master painful reality
- 6) Building ego identifications with the analyst as a “new object”
- 7) Achieving cohesiveness of self-representation
- 8) Becoming capable of the creative living associated with societal and cultural adaptations.

To accomplish these objectives, the “play” should take place in the therapeutic space between the analyst and the patient—a space into which the analyst must not intrude on countertransference impulses.

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