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Clinical Relevance of Social Character and Social Unconscious

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My thinking today relies on some of Fromm’s views. I will talk about my clinical experiences with Fromm when I was a candidate at White. Oral history is always relevant. In the case of Fromm, it is particularly valuable since he did not write at length about his clinical work, although he was known to be an outstanding clinician¹. I will discuss Fromm’s clinical thinking on social character and the social unconscious, and its relevance to present-day clinical work. Then, I will present my work with a patient which addresses certain of today’s clinical views that resonate with Fromm’s ideas.

Fromm was an active presence at White during the early part of my candidacy. I found myself in awe of him. He was known worldwide as a thinker and writer in social psychology and psychoanalysis, and an outstanding clinician with a private practice. He would often spontaneously enlarge upon his views on psychoana-

lytic theory and on the clinical work with ideas taken from Freud, Biblical scholars, Rabbis, philosophers, Marx or Marxian thinkers. He could be critical of European trained psychoanalysts, except Ferenczi, Horney and Fromm-Reichmann who had moved to a cultural view of man. He did, however, explain his agreements and disagreement with his peers. Fromm spoke with great authority and conviction. I did not critically question his thinking nor memory, even when he was discussing my clinical work or the work of my classmates. It is significant that I never asked him for supervision nor personal analysis. I was supervised, however, for two years by Anna Gourevich and one year by Ed Tauber. Each were mentored by Fromm, and consistently referred to his clinical views in their supervisory work with me. Anna Gourevich, for example, in my first supervisory session with her, asked me to present a case. After presenting for some time, I stopped. She then posed this question. “Well now, Dr. Ortmeier, whatever leads you to think you can be a psychoanalyst?” She listened in silence to my halting explanation. Thus ended our first supervisory session. I left, anxious and confused, but challenged to learn from her. Indeed, I did.

I was surprised when Fromm was appreciative of my clinical work as I presented my ongoing treatment with patients in two of his case conferences. My idealization of him lessened as I

¹ I am still most appreciative that Michael Maccoby, Marianne Eckardt and Bernard Landis, among others, spoke at length of their recollections of their experiences of Fromm, when I chaired a panel on Erich Fromm, entitled: Personal Reminiscences, at the Historical Weekend Program of the Fiftieth Anniversary of the White Institute in 1993. I also recall the reminiscences of Ed Tauber and Anna Gourevich who were among those who spoke about Fromm at the Memorial Service at White that I chaired in 1980 shortly after Fromm’s death.



realized that he demanded I think and express myself about my clinical work and my views on theory, regardless of whether he agreed with me or not. He was never one to give unqualified support. He demanded a dialogue, sometimes a debate, always a thoughtful interchange of views.

Fromm was creative with patients. He said each patient should be approached with an open mind, not stereotyped nor labeled nor diagnosed in conventional categories. He kept insisting the analyst was responsible for aliveness in each session. Boredom had no place in the experience of the analyst nor the analytic work. When asked about patients being boring, he said, of course, that often occurs. It did not mean that the analyst needed to be bored. He was clearly aware of the vulnerability of the analyst to “enactment”. Boredom, for Fromm, may well have been similar to “low grade depression” to some other clinicians. Boredom, implied the possibility of relief and hope of change. It is an experience we all have and can connect to. His language invited connection more than concepts like low-grade depression, which are more remote and cerebral. Those not appreciative of his thoughtful use of language could call him superficial.

Fromm could be warm and caring; he could also be stern and demanding. As a listener, he insisted that the analyst keep his mind active about the patient. He did not subscribe to Freud’s notion of “evenly hovering attention”; but then, neither did Freud. He maintained that the challenge for change and growth of patients had to do with confronting of rigid social character patterns, i.e. fixed interpersonal patterns of relatedness. Patients typically felt better, less anxious, if they understood their ways of relating to others, both internally and externally. He treated many patients who were successful in their work, business or professional lives; but who were deeply troubled in their intimate and personal lives. He talked about patients needing to relate authentically, not only presenting a cover story for social approval. Patients needed to be in the room with their total being, not only their social character. He was dedicated to a humanistic orientation that could be loving, giving and socially pro-active. He was in no way

indifferent to life, nor to the emotional life of others, nor the social and political culture in his patients lives and values.

Fromm was aware that characteristic interpersonal views of self and significant others, and the accompanying linguistic-emotional style are the warp and woof of the social character (1, 2), the internalized patterns commonly held in the culture, not idiosyncratic to the individual.

Conceptually, one can differentiate social character as only a part of the overall character of a patient. In the clinical work with a patient, however, separation is impossible unless the patient sees the difference as important to him/her. Enduring (structural) social character is consistently changing as long as interpersonal relatedness is a reality in the patient’s life and internal self-other patterns are not inflexibly maintained to ward off “high anxiety”. We have all seen how much adults or children can change with some significant people or rigidify and resist change with others. These external interpersonal experiences do modify internal self-other experience. In his views on the “development” of social character, Fromm did not pursue the significance of others who are siblings, peers (3), teachers, religious leaders, or neighbors. Neither did he emphasize that social character can be significantly influenced by TV, the movies, or the internet. My view is that the roles and images of significant others can be world-wide, are as real as photographs or as fanciful as Darth Vader with human attributes. I think such imagery input has great significance for some in the development of their social character, and can lead to constructive or destructive experience (4). Perhaps, Fromm’s being an only child; and not growing up in the heyday of TV family sitcoms, he did not focus on the importance of peers, TV or movies as vital for the development of social character.

The acquiring of social character seems almost completely out of awareness of any conscious learning process. There is a social unconscious. It is that which is most commonly repressed by members of a society (2). Elsewhere, I have discussed his debate with Marcuse on the topic of the social unconscious; I will not pursue



it here². Fromm cited the following clinical example of the social unconscious, in a case seminar at White. He said few people have any awareness of the multi-determined experience, use and misuse of monies in the course of family living. He would say that marketing, competitive, power-driven aspects of social character spin (today's word) around money and are as difficult to bring into awareness and to change as are sexual fantasies and practices. We try to present ourselves to others with a cover story; a positive view that seeks approval from others, even though we may know we are "gilding the lily". We are most resistant to becoming aware of that part of our social character that is duplicitous, conflicted, has negative emotions, and accompanying negative behavior. While awareness is crucial, it may or may not result in change, and change may precede awareness. Uncertainty and ambiguity, as Witenberg (8) says, are ever-present in the reality of living. To what extent change occurs through conscious deliberation in the analytic work is ever open to question. Enactment, transference, intuition, non-verbal communication are vital in the analytic work and an ever-ongoing part of it. Awareness and deliberation are much more focused and not as consistently present. Winnicott, by the 1960's, was questioning the value of 'interpretation' in his analytic work.

Ferenczi and Michael Balint, earlier, in the 1930's, posed that relationship is an essential analytic issue for patients who have a developmental deficit, a basic fault. Fromm was clear that awareness was not enough; and that relationship was a vital humanistic concern. Otherwise, why his considerable emphasis on the analyst's authenticity, or on his teaching of love, humanism, and efforts to encourage patients to try to change in the direction of a loving attachment with others? He never spelled out, however, the art of developing these humanistic cares in the analytic work. My experience is that with some patients, there can be effective psychoanalysis in many respects, but the art of imparting humanistic concern that becomes inter-

nalized, seemingly occurs little, if at all. I will come back to this issue in my clinical presentation.

I would like to comment on comparing analysis today and in Fromm's time, particularly in terms of the current stress on gender issues. I have selected a current psychoanalyst, Lynne Layton, (9) of Harvard medical school and Women's Studies as one representative of current psychoanalytic relational thinking, who also writes on feminist values and on gender. In her paper, "The Doer Behind the Deed" (10:152), she says succinctly: "Only a therapy mindful of intrapsychic dynamics, family dynamics, and the way these link up to cultural norms can contribute to creating post-conventional subjects." Was not Fromm committed to trying to help patients become post-conventional? See his "pathology of normalcy" (2) where patients may be successful in the culture but alienated in their intimate relatedness. A major difference with Fromm is that Layton comes from a feminist background. She frames her views with an eye to gender in the culture. Fromm came from a complex analytical and philosophical background, a mix of Judaic study, Freud, Marx, European philosophers, and had escaped from the political arena of Hitler's rise in Germany (11, 12, 13). These experiences undoubtedly influenced his views on politics and society, and their internalization in the individual. These two differing backgrounds, to some extent, reflect the change in our culture in the 1950's and in the 1990's.

I experience similarities between Layton's description of patient's of today and Fromm's comments about patients of the 1950's-1960's, although Layton makes no written reference to Fromm. (In a personal communication with Layton, she was sympathetic to Fromm's ideas even though she does not refer to him in her written work.) Layton is working primarily with women patients and generalizing to males; perhaps the reverse of Fromm's clinical experience. Layton said that many of her patients have low grade depression and are very negative and conservative in their ways of viewing the self and others. They are resistant to change and hold onto the cultural status quo of workaholism, isolation, oppression. Fromm might have agreed, particularly in the framing of his marketing per-

² McLaughlin (5, 6, 7) has much to say about Fromm, critical theory and the Frankfurt School. For those interested, I recommend reading him.



sonality, where the emphasis is on “what will you do for me” rather than “how can I give to you”. Layton continues that patients have complicated relational patterns that keep them tied to significant others, and they deny these patterns by their criticism and attack of themselves and/or others. Fromm might have included, similar to Ferenczi and Balint, that some have never developed other ways of relating. Layton goes on to say that such patients do not tolerate diversity, change and uncertainty. Confronting such patients with their self-defeating patterns of relatedness was a hallmark of Fromm’s approach, which he coupled with suggesting the hopeful possibility that other, more flexible patterns can be learned. He agreed, in part, with Sullivan’s “interpersonal styles”, but his concept was “ways of relating”. Fromm’s “ways of relating” certainly emphasized need and desire, areas that Sullivan did not significantly focus upon.

Fromm’s social character descriptions also had a social-political flavor. As I asked before, how is the social character of today different than that of the 1950’s, given the changes in the culture? Maccoby in his paper on The Social Character of the 20th Century, given at the International Federation of Psychoanalytic Societies Conference in Brooklyn, in May 2000, discussed his current social character description as that of an Interactive Character. His description resonated with Erikson’s stages of development but with different content.

Clinical Vignette

I will now describe my treatment of a 37-year old woman patient I saw for approximately two years. She was a striking woman with stylish attire, a friendly presence, very attractive appearance with her black shock of hair, parted, her subtle perfume, her short, stylish skirt and sheer hose. A woman of commanding intellectual and sensual confidence. She traveled world-wide in a prestigious firm with important assignments in mergers and acquisitions. She was successful, liked the competitive, high-powered environment and the knowledge that her salary and bonuses depended upon her entrepreneurial initiative and successful administering of a staff that

brought in prestige and millions of dollars to the firm. She began an affair, earlier in her work life, with her boss in another company. She married him as he left his wife and children. When I began seeing her, she had been with her current firm for about two years. With much crying and apparent guilt, she was in the process of leaving her husband. She was having an affair with her present boss. In time, she told me of continuing affairs with, in her words, “playboys who lived in cities around the world who were great lovers and fun to be with but who disappeared as readily as appeared”. I think she was what Fromm would have called a “marketing personality”, a personality that Fromm saw in male patients in the 1950’s and 1960’s, when I was in training at White. As I recall, he was most reluctant to discuss such patients he was seeing, citing confidentiality as his reason. I think his views on the character structure of the marketing personality, however, and his confronting style of treating such patients, evolved in his treating the kind of patient I am discussing. Fromm’s views resonated with W. Reich’s (14) earlier approach to “piercing the character armor” of patients. Would such a marketing personality patient have been a woman in the 1950’s and 1960’s in New York? What do you think?

My patient had no interest in changing her style of living; but was afraid her “cover story” could fall apart if her secret affair was found out in her conservative firm or in her current boss’s “happy” family life. I might add that she was very good friends with her boss’s wife and children, spent time with them being helpful and generous, closely monitoring if there was any change in his wife’s friendship with her. She carefully observed if others she worked with in the firm implied a “coupling” of her boss and herself. She also let me know that she openly discussed with her boss the possibility of being “discovered”, then the necessity of mutual denial and “a parting of the ways”. This was pre-Monica, by the way. Both my patient and her boss were “high profile” in their firm.

In my consulting room we sat face to face. She was frequently late, always apologized with a valid-sounding reason. Because of her frequent world-wide trips, the next session was agreed upon at each current session with occasional



double sessions. Her initial transference to me was erotic and intense. I did not analyze her lateness nor her erotic presence. I had just begun to see her. We were both aware, however, that she was sensually exciting. She, e.g. could play with the hem of her short skirt, let it ride up and then pull it down with a slight smile on her face, watching closely if my eyes drifted from her eyes to her legs. Such non-verbal communication was in awareness, and served to intensify the ongoing dialogue. She, I think, was closely observing if I had the same subtle ability that she had of control over desire and erotic feelings, and could proceed with the task at hand. We quickly engaged in her problematic issues with her family of origin. Her transference changed, in the first few months, to a “crying girl” who desperately needed to separate from and stand up to her critical, abandoning family. Her family consisted of a non-present father, CEO of a small but important corporation. He briefly attended to her only if she was ill. Otherwise, he was busy or absent. She was seldom ill. She had a depressed, alcoholic mother who gave up a promising career to devote her life to the business world of her husband. Her mother was clinging and emotionally dependent on her children—my patient and her younger brother. My patient had anorexia in adolescence. At that time, she said she was helped by a female therapist recommended by her father. I suggested that, back then, she gained a “new family” with her therapist “mother” and “fantasy good father”. She agreed. Surrogate parent(s) can be profoundly important in life. Witness psychoanalysis. Howard Gardner (3) makes a similar point about Erik Erikson, in his review of Lawrence Friedman’s (15) biography of Erikson. Gardner says (3:51): “...he (Erikson) was eventually to encounter the parents he desired in Sigmund Freud, his intellectual father, and Anna Freud who became his teacher and his personal psychoanalyst.”

My patient had a younger brother whom she took care of in their younger years. She was a surrogate mother for him. Unfortunately, now he is severely drug-addicted without work or completed college education. She was particularly guilt-ridden about abandoning him; fearful of what he might do if she confronted him and

set limits with him. She had secured work for him in her first corporate job. He had not done the work, was fired, and she almost lost her job as well. In letting him live with her, in her home, she became aware of the extent of his addiction. We established her enabling co-dependency. Unable to insist that he get intensive help or leave, she felt suffocated. I helped her understand his addiction and his unwillingness, unlike her, to give up the addiction. She, therefore, needed to set limits on her enabling of him. She became furious at him in sessions with me, but highly controlled in her feelings when with him. As she set limits with him, he left. Her anger quickly lessened turning into intense sadness that she had lost her brother. Our shared belief became that she had bonded primarily with her brother in her family. He had been vital to her own development, and now she required independence from him to ensure her own continued growth and success. Siblings, as the Adlerians have correctly maintained throughout the last century, are often central to each others’ development. I helped her confront, set limits, and disengage from her emotionally abandoning family. In turn, she became more of an independent and concerned adult with them.

We talked from time to time about her discussing her dreams. She never reported a dream, saying she could not remember any. Her ability to have intense control over her inner life was undoubtedly true; and may have had much to do with her never reporting dreams. This also indicates that she was highly controlled in her relationship to me; and was also highly controlling of the therapeutic work. We discussed her early-on, erotic approach to me and to significant other men in her life. She agreed, and commented that she usually both gave and got satisfaction. I pointed out that it helped her rapidly succeed in business life as well. She quipped: “Not only in business”. When I asked her to explain, she quickly replied: “When I first saw you, you had your chance to have a sexual relationship with me”. I suggested that would have been “monkey business”. We both laughed. She was adept in therapy at not analyzing her power-driven and controlling traits.

Over time, she found a man her age, a suc-



successful professional who was in long-term therapy in a city of another country. He could set limits with her; and was as insistent as she in discussing the nuances of their relationship, including the many difficulties they had with each other. This included a language barrier, much e-mail relatedness, a power struggle for control, and infrequent but intense loving, caring and sensual-sexual presence with each other. She gave up her affair with her boss, remaining distantly friendly in the business relationship. She, at least temporarily, let go of her “playboy lovers”. She became a friendly peer in the transference with me. This was growth for her. She had become more caring, more direct, loving of self, of boy friend, of family.

This patient fits the adult life stage of women that Stewart (16) describes in her research with adult women. Stewart is professor of psychology and director of the Institute for Research on Women and Gender at the University of Michigan, and is the co-author of several books on women’s lives. She states that her research indicates that: (17:3):

...women in their late thirties have a sense of alternatives—I could get a divorce, I could change my career, I could have that baby, I could do something drastic. And some of them do. Then, when in their fifties, others say, well, you know I am not going to do that, that isn’t going to happen. And it’s okay.

My patient definitely had a sense of alternatives which overrode regret and which fueled her ambition. She was also aware that these alternatives were time-limited in her life.

Near the end of the two years of treatment, she achieved an even more consuming advancement in her firm which absolutely delighted her; and raised serious reservations on the part of her boy friend. At that point, she saw no need to continue treatment. She had achieved monogamy with a boyfriend she “loved”. She had not jeopardized her career. On the contrary, she found increasingly great success in her work. She wanted no part of further questioning of her power-driven relatedness in her firm, nor how she “used” people to gain success. We parted on friendly terms.

My impression is that if Fromm were commenting on this case, he would be positive as to the progress that was made in resolving some issues of her cover story. He would approve of the aliveness in the therapy—no boredom here. He would like the innovative use of the psychoanalytic process. He would agree that it was growth for the patient to become independent of her family. At the same time, he would be quite critical of her continued marketing orientation of seeking unlimited prestige, money and power. Fromm might have said to me something like: Well now, Dr. Ortmeyer, you might say that the patient prospered, but her concern for others remained dead. Her rhetoric of persuasion continues to over-ride her search for truth. (She shares a position of social constructionists of today and Sophists of yesterday. The rhetoric of persuasion over-rides the search for truth. I am referring to Ian Hocking’s (18), “The Social Construction of What?”, and Barry Allen’s (19) review of Hocking’s book.) I would ask you what you think? Was there a change in her marketing personality? How do women differ from men in their marketing orientation? Certainly, this patient was not sexually repressed nor abusive. She was not controlling of others through angry intimidation nor authoritarian demand. She was quite caring of those who worked under her, and they were very loyal to her. Was she detached emotionally; or was she able to process emotions very rapidly? She thought the latter was true for her. Would you have treated her quite differently than I described?

I hope I have stimulated your thinking and questions regarding the clinical Fromm, my views of him, his clinical relevance for today, and my work with the patient I described.

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