failure in the adolescent process cannot be stated in sharply defined, absolute terms, because we observe individually a great variance due to its particular contextual embedment in a developmental medley of preoedipal and oedipal trends, both being simultaneously and antithetically in motion.

Two facts which derived from developmental infant research should be mentioned here. It has been noted that the male toddler turns away from the mother and toward the father earlier than the girl. Furthermore, dyadic father deprivation exerts a far more injurious influence on the boy's subsequent adaptive faculties than is the case with the girl. These findings, borne out in the analysis of adult male patients, often beg the question whether their adaptive failures are due to a basic conflictual constellation and subsequent regression or to a developmental delay or arrest. In a considerable number of my adult analytic male patients, ranging in age from their twenties to their late fifties, the isogender ("negative") complex—in its two-tiered entanglement—appears surprisingly often as the rock bottom of their neurotic disturbance.

I remind the reader here of Freud's 1931 paper on female sexuality, to which I have referred earlier. There he calls attention to some of his women patients' all-encompassing fixation on the early mother which lies at the root of their neurotic illness. One cannot help but wonder why the male's isogender ("negative") complex, being of equal neurosogenic valence, has never received an equal measure of attention. This neglectfulness persisted despite the fact that Freud—as quoted by Ruth Mack Brunswick (1940) in her classic paper (written in collaboration with Freud) on the "preoedipal phase"—had commented at the time, ". . . on the basis of this new concept of early female sexuality, the preoedipal phase of the boy should be thoroughly investigated" (p. 266). This admonition was never fully heeded, unless we declare the preoedipal phase of the boy simply identical with a bisexual phase—a position which is hardly tenable. Clinical observation leaves no doubt that a universal constituent of normal psychosexual development, namely, a homosexual propensity, does not follow the same course or development in men as it does in women. Without doubt, its repression in men is by comparison far more profound than it is in women. Change of object, gender morphology, and cultural imprinting are in all likelihood accountable for this divergence.

The residues of the dyadic, i.e., preoedipal, attachment of son to father, lie, to a large extent, buried under a forceful repression once adolescence is passed. The profundity of this infantile experience, when roused into emotional reanimation during analysis, remains usually inaccessible in its latent intensity by verbalization alone. It finds expression via affecto-motor channels, such as uncontrollable weeping and sobbing, when the patient is tormented by overwhelming feelings of love and loss in relation

to the dyadic father. One man in his fifties exclaimed at such a moment, choked by tears, "Why did I love my father so much? After all, I had a mother." In contrast to these affects of passion, the manifest and remembered son-father relationship had usually been distant or hateful, admiring or submissive, governed by a fear of rejection or grudgeful with a sense of gnawing disappointment. This latter sensation follows the boy's alert and sensitive registration of the father's shortcomings which disqualify him as the son's hero or worthy opponent. To these configurations has to be added the little boy's yielding or opposing posture toward the father's unchecked need for libidinal gratification which he seeks in the closeness to his son. In either of the little boy's extreme reactions to paternal seductiveness—surrender or flight—the son remains eternally remorseful over having failed to evoke his due measure of the father's approval, pleasure, and loving support in growing up and becoming his "big boy." Thus is the bewildering paradox of the father complex which I have described. Over time this early experience lays the foundation for a self-image of depressing inadequacy or aggressive self-sufficiency; both coalesce in adolescence into pathological forms of adaptation which become elaborated throughout adult life.

The clinical references in this essay were taken from my analytic work with male patients of various ages. Within the dyadic and triadic father transference, once manifested in treatment, it was possible to work out or resolve enough of their father complex to render their lives reasonably mature, productive, and rewarding. Pertaining to the dyadic father fixation of the male patient, it seems that an isogender transference is of special significance in his treatment because preoedipal memory traces do not readily appear in word representations, but—as already alluded to in my clinical illustrations—require affecto-motor expressions before the symbolic process via verbal communication can serve the work of insight and reconstruction.

A question to be asked here concerns the dyadic father transference when the analyst is a woman. In the literature on this subject, which is extraordinarily scant, our interest is aroused by Laila Karme's paper (1979), which raises relevant questions of clinical importance in this area of unsettled observation as well as conception. The opinion taken as axiomatic for a long time states that "the repetition of the complete Oedipus complex is an essential part of all analyses"* (Glover, 1955). It was, therefore, taken for granted that transference repetitions are not limited by the sex of the analyst. This assumption, which is presently challenged, predates the growing conviction that the dyadic father complex of the male

* The term "complete Oedipus complex" came into use in the psychoanalytic literature in order to extend the definition of the original Oedipus complex to include the dyadic phase (preoedipal), once its importance in neurosogenesis was recognized in its universal, often dominating, role.