Psychoanalytic Practice: Clinical Studies

Interpretation of Dreams

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Introduction

Readers of this book will frequently encounter the interpretation of dreams as being the *via regia* to the unconscious and, at least as dreamers, they will also have taken this royal path. A dream cannot be equated with the unconscious but it is, in Freud's words, the *via regia* to it, getting lost somewhere in the depths of the unconscious. Dream interpretation enables analysts to get close to unconscious fantasies. The interpretations lead to the latent, i.e., the unconscious meaning of the dream. To be precise, then, the interpretation and not the dream itself is the *via regia* to the unconscious.

The series of dreams described in this chapter were embedded in a course of treatment that formed a significant phase in the life history of a patient and in the course of his illness. In order to be able to follow dream interpretations critically, it is essential to be aware of the patient's biographical background, his illness, and the implications of his illness for his self-esteem. Information and discussion of these points serve several purposes. For example, a patient's dreams are influenced by his neurotic and somatic illness. It therefore seems logical to take this case as a starting point for discussing general problems of psychoanalysis and psychosomatic medicine that go far beyond dream interpretation.

In 1924 Rank published a monograph entitled *Eine Neurosenanalyse in Träumen* , in which he described a therapy that took the form of a pure dream analysis. In interpreting a large number of dreams during a 150 session therapy, which was successful, he did not distinguish between abstract interpretations and individual therapeutic ones. We mention this typical publication from the 1920s because the contrast between it and the present day demonstrates the progress that has been made in analytic technique. We believe it is essential to make the reader aware of the individual steps in an analyst's interpretative work in his dialogue with a patient.

5.1 Self-Representation in Dreams

In Vol.1 (Sect. 5.2) we drew attention to the intricate relationship between word and image in

Freud's theory. This relationship is characterized by several transformations that on the one hand led Freud to distinguish between the latent and the manifest contents of dreams and, on the other, are related to the therapeutic task of translating images into words and thoughts. The plastic portrayal of the manifest content of a dream becomes a relatively superficial event of the dream genesis only if the latent *dream thoughts* forming the basis of dream work are taken to constitute the essential content of the dream. Freud spoke, in this sense, of the manifest dream element as being a "concrete portrayal . . . taking its *start* from the *wording*." At the same time, Freud also wrote, in this contradictory context, that "we have long since forgotten from what concrete *image* the word originated and consequently fail to recognize it when it is replaced by the image" (Freud 1916/17, p. 121, emphasis added). Bucci (1985) has since replaced Freud's inconsistent "zigzag theory" of the relationship between word and image, which depended heavily on his untenable economic principle (see Vol.1, Sect. 1.3), with the dual code theory (Paivio 1971). As a result, the distinction between the manifest dream image and the latent dream thoughts in the *dream genesis* is shifted in favor of stages of *dream interpretation* . The significance that images always had in Freud's theory as *symbols* is also reestablished. Erikson (1954), in his configuration analysis of dreams, initiated an interpretative technique that in large measure corresponds to the primacy of plastic portrayal.

These introductory comments are meant to prepare the reader for the fact that the self-representations contained in the following series of dreams are variations of the important subject of *body image* (see Sect. 9.2.1). The images that we have of ourselves and that others have of us are not only related to personal characteristics and manners of behavior, but are always also related to our physical existence. The images that we and others have of ourselves comprise both personal identity and body image, whose numerous and discordant layers are important determinants of an individual's sense of self-security. In addition to these general points, the fact that body image plays a special role in specific interpretations in the series of dreams reported here resulted from the nature of the patient's symptoms.

Freud's advice for therapy was to look for the dreamer's ego in the person who succumbs to an affect in the dream. In patients whose conscious experiencing is affected by imagined physical defects, the defects will probably be presented in a scene and possibly be expressed by different individuals. Yet before we, with the help of dreams, start down the royal road to the unconscious in order to reach the dreaming ego's enactments and answers, let us turn to the general and specific problems posed by a

typical case.

5.1.1 Dysmorphophobia and Spasmodic Torticollis

Erich Y suffered from a dysmorphophobia since adolescence, i.e., for about 25 years. He was also afflicted by spasmodic torticollis, which first appeared about three years prior to the beginning of treatment. The patient's *wryneck* made him feel so insecure that it precipitated episodes of depression.

Dysmorphophobia is defined as:

> the unfounded fear of a circumscribed physical deformity. The phobic ideas refer to body parts assigned a special aesthetic or communicative function . . . . The fears of an unaesthetic, ugly, or repulsive appearance are almost exclusively focused on circumscribed body parts and only in exceptional cases on a person's overall appearance. The most frequent objects are facial and sex-specific features. (Strian 1983, pp. 197, 198)

Küchenhoff (1984) has described the history of this concept and assigned the fear of deformity a position of its own in psychiatric terminology and nosology, locating it between hypochondriac syndromes and the delusion of reference. From Küchenhoff's review of the literature it can be seen that early psychoanalytic case reports describe dysmorphophobic patients without designating them as such (e. g., Freud's Wolf Man).

In the psychoanalytic literature the predominant view about the relationship between the psychodynamics of body image and psychosexual development is much too one-sided to do justice to the genesis and therapy of the rich diversity of imagined defects or deformities. The earlier tendency to reduce everything to the castration complex has been succeeded by the emphasis placed on narcissism. Finally, the symptoms are often considered to fulfill the function of protecting against psychotic disintegration, similar to the situation in chronic hypochondria (Philippopoulos 1979; Rosenfeld 1981). We believe that an interpersonal approach can clarify many of the puzzles surrounding the genesis of such body images.

According to our experience, dysmorphophobia is gaining in significance because many of those turning to plastic surgeons for, for instance, mammoplasty or rhinoplasty imagine they have a deformity. Yet an operation can hardly alter the attitude of these individuals toward their presumed unaesthetic appearance (Mester 1982).

With the passing of time the anxiety component of the belief that one has a partial deformity often recedes behind a less anxious hypochondriac or obsessive preoccupation with the deformity and its correction. Since the belated recognition of the significance of Schilder's works (1933, 1935) by Fisher and Cleveland (1968), the theory of body image has been profitably applied to the analytic understanding and therapy of dysmorphophobia. Of course, Erikson's and Kohut's theories of identity and self have contributed to our improved understanding of this form of insecurity, which is central for these patients and for many others (Cheshire and Thomä 1987). The body, however, is not the focus of these theories, in contrast to the theory of body image, whose interactional development was excellently described by Schilder (1933) (see Sect. 9.2.1).

Erich Y suffered since puberty from a severe case of dysmorphophobia, i.e., from the unfounded idea, which was more hypochondriac than phobic, that he had a receding chin, a crooked nose, and a deformed head. He attempted to balance these presumed deformities by, for example, compulsively taking care of his hair and pushing his chin forward. His self-security was further limited by his belief that his penis was too small, with the logical consequences that this had on his capacity for making contacts. The only reason this belief is mentioned here as the last in this series of symptoms is that this patient, like most of those with similar symptoms, did not mention it at first. The hesitancy to mention it is not only the result of a displacement to other parts of the body, as is typical for phobias; the shame anxiety of these patients is so strong that they do not discover the preconscious starting point of their presumed defects until later in analysis.

It was natural that Erich Y's unstable self-feeling was badly shaken when he acquired a symptom that was definitely more than just imagined, namely a typical case of torticollis with his head turned to the right. According to his recollection, it had first appeared during a meditation exercise, i.e., in a situation in which he was trying to find relaxation. He had immediately given it a meaning, seeing a connection to a crisis in his marriage. He observed, above all, that the automatic twisting movement of his head occurred or became more pronounced especially when he felt observed or was supposed to present himself in some way. The shame affect that was already present became very substantial, making his suffering become quite severe. His suffering increased as a result of his depressive reaction to the symptom, i.e., from the way in which he coped with it.

Approximately two years after the successful conclusion of psychoanalytic treatment the patient became impotent during another marital crisis. In this connection he had a recurrence of his torticollis symptoms, which led him to resume his therapy. He overcame his impotence, and his neck condition improved significantly. We will now give a brief description of his case to demonstrate that the causes of the torticollis and the dysmorphophobia were at different levels.

Torticollis is an abnormal twisting or inclination of the head that cannot be willfully suppressed, is frequently accompanied by tremor, and is caused by continuing contractions of the head and neck musculature that are primarily unilateral and spontaneous. The increase in tone of the individual muscles that slowly sets in and does not relax until many seconds later, the hesitant movements, and the stereotypic features of its course and localization must be viewed as dystonic hyperkinesia in conjunction with an extrapyramidal illness. These movements are neither a reflex precipitated by passive expansion nor an increased muscle tone such as in a spasm during a central motor disturbance.

The dystonic movement in torticollis cannot be suppressed by voluntary tensing of antagonistic muscles or by pressure applied externally. It decreases during sleep and under anesthesia, and increases primarily as a result of intentions to move as well as from *affective arousal*, focusing *attention* on it, and *exposure* in public. By using certain grips, which themselves do not require any force, for example placing a finger tip lightly on the contralateral cheek or side of the face, it is possible to reduce or suppress the abnormal movement.

Clinical observations have demonstrated that the momentary manifestation of the symptoms is dependent on situational factors, which have been very impressively described by Bräutigam (1956). Many patients are free of symptoms in the solitude of nature. The involuntary twisting of the head occurs especially when disconcerting eye contact is made.

What is important now is the significance attributed to these precipitating factors, whereby it is important to distinguish between the patient's view and the interpretation the expert makes on the basis of various diagnostic findings. It has been proven that persons suffering from such conspicuous symptoms become insecure and that, when they feel they are being observed, they twist their head all the more and with extreme force; a slight tremor can also occur. Anxieties initiate the manifestation of the

symptoms. There are different ways this partial cause can be interpreted. In our opinion, the grave misunderstandings of the psychogenic and somatogenic factors arose because the environmental dependence of this and other somatic illnesses led doctors to misdiagnose torticollis as "hysterical." This fact was emphasized by Bräutigam (1956, p. 97): "The dependence on situational conditions is surely one of the important reasons that extrapyramidal symptoms were long misinterpreted as hysterical."

It was incorrect from the very beginning for the psychogenic element in the genesis of symptoms and the course of an illness to be restricted to the model of the genesis of *hysterical* symptoms. To determine the psychogenic element in extrapyramidal movement disturbances in which the brain is the organic cause, it is necessary to start by establishing correlations, just as in any physical illness (Alexander 1935; Fahrenberg 1979; Meyer 1987). It can be said in summary that the occurrence of wryneck in conjunction with stress does not justify the conclusion that the former is expressive movement, whether in the sense of an emotion or of a unconscious action.

Hypotheses about the psychogenic element in etiology must be compatible with the physical findings in order to escape the either-or dichotomy of somatic-psychogenic. We believe it is then possible for the neurologist to give appropriate consideration to the importance of the emotional disposition of the patient reacting to environmental factors (i.e., precipitating factors).

The analyst can employ his therapeutic means everywhere that certain forms of latent dispositions are activated and reinforced by a *circulus vitiosus* , as in an exaggerated shame anxiety. In such cases there is a chance to achieve change as far as reactions have not become completely determined by somatic causes. Much depends on whether the analyst successfully manages in the first diagnostic interviews to discover together with the patient that the latter's experiencing has influenced the course of his symptoms, as indicated above, and to make the patient's observations the starting point of their joint reflections. One could make the somewhat daring statement that the Oedipus complex never entirely disappears in any man, it just "wanes" and "repeatedly requires . . . some forms of mastery, in the course of life" (Loewald 1980a, p. 371). Many clinical and experimental data, as reviewed by Greenberg and Fisher (1983), suggest that men are more insecure than women with regard to their physical integrity. Previous anxieties and mastered insecurities may be revived when a patient encounters new burdens, and they may be strengthened by realistic fears during physical illnesses, making it more difficult for the

patient to cope with his illness. These general points apply to both men and women regardless of the differences in body-related anxieties between the two sexes. It is obvious, however, that the unjustified fear of having a physical deformity has a different conscious and unconscious background for women than for men. The genesis of imagined defects in one's self-image (in the comprehensive sense of the term) follows the typology of phases of psychosocial development. All the factors causing insecurity toward one's sense of identity can also have an impact on body image. Why specific deficits are limited in one case to the level of self-consciousness and in another are related to physical appearance is a difficult question that we will not go into here.

5.2 A Dream Sequence

Self-representations in dreams open up a hidden dimension because of the scenic character of "dream language." Deformities of the body image then occur in an interactional context. In comparison with dream language and in contrast to the vividness of hypochondriac complaints, the descriptions of imagined deformities are one dimensional. Patients describe the ways they experience their bodies to be defective—such as a small chin, crooked nose, deformed back of the head, overly narrow vagina, and an injured heart—and how this diminishes their self-esteem without the patients themselves being able to understand or to experience the processes in which their frequently abstruse ideas about their body images develop. Self-representations in dreams, in contrast, exhibit latent dimensions lost to conscious experiencing and absent in descriptions of symptoms except for the fixed imagined final product. The scenic context of the dream thus makes it possible for the analyst to have insights into the genesis and meaning of disturbances that in conscious experiencing take the form of psychopathological phenomena, that is of a "damaged body image" to use a brief but appropriate expression.

The following dream sequence provides an insight into the analyst's interpretations. The analyst added the notes about his feelings and thoughts either immediately after the session or soon thereafter upon reading the transcript.

5.2.1 Dream About an Injection

At the beginning of the 37th session Erich Y delightedly told me about his discovery of things that he had in common with his boss. He used to have many disputes with his boss; both had been "blinded by our ambition." Spontaneously and without any apparent

transition the patient started telling me about a dream he had had the previous night. "I saw a younger doctor in a hospital. I told him about my illness, and he gave me some hope. He claimed he knew something that would help. He experimented by giving me injections in my back, and while he was giving me a shot—it took a long time—I pulled away because it hurt."

He then came to speak in a vague manner of agreeable experiences, ones he might have had together with his wife. The day before, for instance, he had experienced something good at home. It had become clear to him how important mutual confirmation is. Following his longer statement there was a pause, which I interrupted by pointing out that the patient had received something good in the dream but that it had also caused pain. The topic shifted to the patient's ambivalence to therapy. A few sessions earlier the patient had been at a loss as to what he could answer curious questioners who wanted to know what he got from analysis. The experience that he frequently had not received any concrete support from me could have led the patient in his dream to turn to a young doctor who—as I interjected—knew of a particularly good form of medication.

P: Yes, it took a long time.

A: You mean, the injection.

P: Yes, and I got uneasy. I wanted to get it over with.

A: Hum.

P: It took too long. And then I had to think again about whether it was already working.

A: Yes.

P: While he was still giving me the injection, I tried to move my head again.

A: Hum.

P: Well, it worked right away.

A: Yes, and that is where the treatment situation comes into play, with the worrisome expectation: Yes, does it help? It's taking a long time.

Consideration. The patient's expectation of getting rapid help was disappointed. Although he tried not to become impatient, he looked for concrete help directly related to his symptom.

P: Hum.

A: I'm sitting behind you. In your dream something is happening to you from behind, isn't that right? Behind.

P: Hum. [Long pause]

The patient formed the image of a piece of granite that he himself or someone else was chiseling at. He also had, in contrast, weak impressions that he lost without being able to describe them. To me, the patient seemed a little unhappy, which he confirmed. I viewed the patient's statement that he could not hold on to anything and that he had the impression he were on a turntable as a sign of resistance. At this point the patient mentioned his dream again, including a few key words such as the sudden stop and the departure, which he then summarized.

P: There are so many things going through my mind again today. Lots of weak impressions.

A: You sound a little unhappy, as if you would change your mind too much. Or? Some place you had the feeling that you would not have liked to think it through or fantasize any further, for example as I referred to my view that you're looking for more. In the dream you're given an especially good drug. This went on for a long time, and you had the feeling that you don't want to be concerned about it any more.

P: I just had the thought, again in connection with my impatience and possibly with the dream: stay involved for long enough, don't give up early, so that there's nothing left that's only half done.

Consideration. The disappointment triggered dissatisfaction, which was suppressed. This topic was picked up in the next interpretations.

A: Hum. Yes, that's the one side, the disappointment, but your wish is still there. The wish behind it is, well, to get as much as fast as possible, isn't it?

P: Yes, yes, yes, yes.

A: This is presumably one of the wishes you had in your dream.

P: Right.

A: And as much as possible as fast as possible, and something really special . . . .

P: Hum.

A: . . . being able to get something really special.

P: Effectively. [Short pause]

A: It's a younger doctor who gives you something, younger than I am.

P: Yes, that seems to be the case.

A: Hum.

Commentary. The patient did not grasp at the offer, which was relevant to transference. The analyst realized this without commenting on it.

P: This impatience, it's true that I get impatient. Something has to happen fast. There has to be something effective, something I can grasp. Yes, and if this isn't the case, then I get impatient and would like to forget the whole thing. If I conclude everything correctly, then I have a lot more from it.

A: And then you almost force yourself by being patient, don't you? You suppress your natural striving and make an effort not to become impatient.

Commentary. By emphasizing that impatience is something natural, the analyst encouraged him to experience the aggression contained in his impatience.

P: Yes, yes, yes. I don't want to know about it.

A: Hum, hum, hum.

P: Well, when I think of it, then I have the feeling . . .

A: Hum.

P: . . . that I hope you don't drop me.

A: Hum. Yes, perhaps you're making a big effort not to be impatient because of this concern, as if you would be dropped if you got impatient once.

Commentary. This was a typical kind of a statement offering indirect encouragement: You will not be dropped if you get impatient. It was only the later and unmistakable assurance that made it possible for the patient to open himself more. As-if formulations frequently do not provide sufficient security. This type of interpretation is based on the assumption that the patient really knows that his anxiety is unfounded. On the one hand this grammatical form creates openness, which stimulates reflection, yet on the other the patient is left in the dark. Reassurances cannot cancel unconscious expectations. As accurate as these observations may be, it should not be overlooked that stereotype as-if interpretations can undermine self-security. We have the impression that such stereotype interpretations can frequently be

found in unsuccessful treatments.

P: I've often had the thought that this might be my last chance, and that I probably won't have another one in my life, to see something like that. And afterwards I have the feeling of being able to make even more out of it, to take . . .

A: Hum.

P: . . . even more out of it and to be creative.

A: Hum. Yes, and perhaps the dream is related to the fact that just today you would like to take as much as you can, because there's going to be an break in treatment.

Commentary. This established the connection to the situative factors possibly precipitating the dream: the break and the distance.

P: Hum, yes, it could be.

A: To get as much as possible.

P: Hum.

A: The subject of distance is still there too, in view of today's session, because of the break.

P: Hum.

A: However, you're the one moving away, away from the injection.

P: Hum.

A: Perhaps symbolically there is a little pain portrayed, yes, somewhere it hurts that there is going to be a break, a distance. [Short pause]

P: Yes, I just had a thought. My wife has asked me a couple of times: "What are you going to do when you can't go to your doctor any more, when you're on your own again?"

Consideration. A confirmation of the assumptions contained in the interpretations?

A: Hum, hum.

P: [Taking in a deep breath] And I said I hadn't actually thought about it and don't want to either.

A: Yes, for now you're still here, and I am too.

P: Yes.

A: Yes, hum, hum. [Longer pause]

P: Somehow I suddenly feel so protected and have to think of puppets who get to walk around but who are really on strings, I mean who aren't free. Well, I have some room to move but there is somebody there who's leading me.

Consideration. My pacifying comment that "for now you're still here, and I am too" enabled the patient to have an insightful fantasy and initiated a regression. Maybe the point is not for some substance (which?) to be injected but for the patient's father or mother to take him by the hand.

P: I'm just asking myself, well, room to move, to move, and—without being arrogant—say to myself that I can really try everything, can do everything, because I know that someone is there. [Very long pause] I have to think of this dream from last night over and over again. The doctor is standing there, and I move.

A: Hum, hum.

P: I'm in a certain place and feel my way around.

A: Hum, hum.

P: And this and that come by.

A: Hum.

P: And he stands there watching, watching me. [Breathes very deeply]

A: A while ago you thought about puppets who move, who are led by someone's hand and moved, in other words who aren't merely observed.

P: Hum.

A: That you can feel and can move and turn and move around, can't you?

P: Yes, yes.

A: Hum, yes.

P: Suddenly I have some help. I have somebody who is there. Because of my insecurity I didn't even know whether I was right or wrong.

[Long pause]

A: Yes, I have to stop for today. We'll continue on Monday, the 25th.

P: Doctor, I hope you have a good time.

A: Thank you, I hope you do too. Good-bye.

P: Good-bye.

In Retrospect. [Dictated by the analyst immediately after the last session] It's difficult for me to summarize the main topics of this session, which was crammed full of information. At the end there was a sentimental separation. For my part, I too sense a particularly close relationship to the patient in response to efforts to find harmony. I think of the puppet theater, which always impressed me very much, Kleist's puppet theater, then of a mother who takes her child by the hand. In the last few minutes I made an interpretation to decrease the distance the patient referred to and to balance his feeling that was left all alone and being observed from outside. This feeling has to be seen in connection with the dream that was the center of interest in this session and that the patient mentioned toward the beginning. I have the impression that he encountered resistance to continuing where he wanted more from me. He said he would start too many different things, and I agree (because of resistance to passive, receptive, homosexual transference wishes?). Important is his concern that he will be rejected when he demands something impatiently, which is the reason that he forces himself to be patient. I think of his oral and other wishes to get as much as possible as quickly as possible, and then of his anxiety that he would not get enough because he's presumably been rejected frequently when he has raised such demands. I formulated his anxiety. The third topic was the break in treatment. And in reaction to my suggestion that he wanted to take as much as possible from the last session, he actually mentioned comments by his wife, asking what he is going to do when he can't go to the doctor any more. I confirmed the continuity by assuring him that he would not be turned away if he gets impatient.

5.2.2 Dream About the Crane

Erich Y opened the 85th session by telling me about a dream that apparently had made a special impression on him. He only interrupted his comments to make several short pauses.

In the dream a neighbor, whose relationship to the patient was not free of conflict and who talked a lot, was involved in putting a crane together. The patient immediately added that he did not want to disparage the neighbor, but he then had a slip of the tongue, referring to a struggle instead of a dream. In the dream Erich Y was an interested onlooker without any immediate function. An important part of the crane, the boom, was missing.

P: I was completely absorbed in the dream. What could the boom look like? How did it fit? I couldn't tear my thoughts away from this missing part—what kind of a structure was it? What was it like? It seemed to me as if it lasted the entire night. All my thoughts were concentrated on finding the crane's missing part. This morning I don't know what meaning it might have; I don't think it has any special meaning.

The patient did not have any associations. To stimulate the interpretive work I reminded him—thinking of the castration complex—that he had desperately looked for the missing part. The patient repeated that it had tortured him until morning: "What's missing, and why?" In the following description of his mood he mentioned a word that was a first reference to his memories of his traumatic experiences at the end of the war, which he mentioned later.

P: The bad part is that I was as absorbed as if I were involved, as if I were captive. I couldn't get out; there was no way around it. But as an engineer I ought to be able to solve the problem. I ought to have the ability to solve it.

In response to my questions about the missing part the patient described the exact form and function of the crane's boom. The boom, he said, was an important connecting piece, and without it the whole thing would not work. He was outraged by the indifference of the construction crew; at the same time it irritated him that he was upset even though he was only an onlooker. He got more and more involved while the crew responsible for it was indifferent.

Consideration. His affect is a clear sign that he was by no means only an onlooker but that he was very much involved, just like I was. His story reminded me of my own desperate searching for misplaced objects and of exaggerated anxieties about having lost something.

A: You are not merely an onlooker. You are obviously so affected by it because you might be missing something. That would make your intense attempt to use all your means to find the missing part comprehensible.

P: But then I'm not uninvolved.

Consideration. He had formed an ideal of being uninvolved. I therefore pointed to the connection between being affected and disquieted, on the one hand, and distancing as a reaction formation on the other.

Once again Erich Y emphasized how upsetting it was not to get away from the narrow confines of this spot, with no chance of getting out of the way. After a short pause he mentioned that he sometimes felt good, but saying this did not help him any further.

He then surprised me by recalling childhood memories, of events when he was 3 or 4 years old. "Prisoners were driven through the village, first Russians by the Germans, then Germans by the Russians. He recalled feeling miserable and helpless. Memories of attacks by dive bombers entered his consciousness. Without being afraid, merely curious at first, the children had left their place of safety in a basement. When shots were fired, panic erupted, and farm animals broke lose and were wounded.

I picked out "injury" and "loss" as important themes, intentionally emphasizing at first his successful life-long effort to overcome the loss of all his belongings. This confirmation of his successful reacquisition of property would alleviate the trauma when he reexperienced it and would facilitate his efforts to cope with it.

The patient then described scenes in which he had felt fear, fear of the Russians and fear for his mother. He established a relationship to his later conflict in the triangle formed by his mother, his wife, and himself.

P: I can't make a decision in favor of my wife the way she wants. I can't swear at my mother; there simply is the fact that we belong together.

He told me that his wife's mother had died while his wife was a small child. Maybe that was the reason she expected him to belong entirely to her. He then complained about how he missed his father.

P: Why was he the one who had to die; if he had still been alive we would have had more security.

His grandfather graciously stepped in, and his values were a major factor that contributed to forming the patient's superego.

At my initiative we then considered what functions his father, who could have made the connection with the outer world easier, had for him. I stayed at the general significance of the loss and attempted to make his self-representation in the dream more accessible to him by describing the fact that "the crane towered over the region" as standing for his wish to compensate for the numerous deprivations he had had to endure while fleeing to the West together with his mother and brothers and sisters. These experiences of suffering were the subject of the rest of his associations. "We were treated like the plague." He traced his feeling of inferiority and his striving to make something of himself back to these humiliating experiences as a refugee.

The impression I had from his further associations strengthened my assumption that the defects in his body image had to be seen as derivatives of his castration complex.

I then made a summarizing interpretation, intentionally employing a *dreamlike language of images* to revive his physical sensations.

A: You would like to hold your head up higher and move the crane and its boom around, high above everything else. But then along comes this despairing feeling of insecurity; all kinds of things are missing. It's not just the symptom as such that's obstructing you. You cannot show what you actually are. In such moments you recall all kinds of losses. What is visible are your injuries and the effects of injuries. And today you recalled threats and being shot at. When you stick your head out, then somebody lets you

have it.

The patient then complained once more about his lack of security and that he always took two steps backwards after he had taken one forwards. He said that if he is attacked or simply even challenged in a discussion and doesn't react optimally, then he simply thinks he is a "loser."

The patient's reaction made it clear once again that the reference to traumatic events can only be a preliminary step to coping with them, which is the way to rediscover security.

From today's point of view I can note self-critically that in my enthusiasm for the psychodynamic connections I overlooked the situative damage caused by the overly talkative neighbor (the analyst) and in doing so possibly missed an opportunity to make transference interpretations starting from the here and now.

I prepared the following psychodynamic summary in order to demonstrate the reader the theoretical background that apparently somehow, has more or less consciously, influenced me. The patient's wishes to stick his head far out and be big and strong are defeated by his unconsciously precipitated anxiety of only being able to show himself as someone who is defect. His neurotic defects, such as the idea that his penis was too small, his chin too short, and his nose unsightly, were reinforced by his neurologic symptom of wryneck. A real defect was there for everyone to see. This was a vicious circle in which traumas from his distant past became linked with the way other people looked at him as a "cripple" and made him feel ashamed. The defect he had previously only imagined had become reality, first because a physical illness occurred, and second because the disturbance of his body image appeared realistic within the group of events described above.

I connected his castration complex with a deficit and a defective self-representation. This statement contains numerous intermediate inferences. There was no description of a human torso lacking a phallus, just of a crane without a boom. A metaphor was used that was based on the primacy of anthropomorphic perception and thought. Man-made machines were extensions of the patient's own body and were guided by him in his dreams as in animistic thought. The crane is a means serving the patient's self-representation, which we arrived at via the interpretative step of identification. Numerous questions had to be solved in this way. Why did the patient not portray himself as a human torso without a phallus? And when he used the crane, why did he not append an enormous boom to it instead of desperately searching for a missing part? At least at this point an omnipotent phallus wish did not manifest itself distinctly. He described a deficit and sought a substitute. In the dream the trauma seems to have really occurred; he sought help. I needed the hypothesis that the pain of separation from a vital and pleasurable body part was so excessive that the dreamer resorted to an indirect portrayal, one which was compatible with the possibility that he himself may still be "whole." In this way the patient gained some room to maneuver so that he might still overcome and make good the feared trauma which had already appeared as an impressive defect. There was thus an analogy between dream representation and dysmorphophobia. I emphasize once more that the etiology of his wryneck is at a different level.

From this description we can deduce how it is possible to interrupt the circle of events therapeutically and thus to keep the situative precipitating factors (e. g., being stared at) from attaining any significance

for the manifestation of such a disturbance of movement that is primarily neurologic in origin. The point is to transform the clinically well founded theory of situative precipitation and the connections described above into therapeutic steps.

5.2.3 Dream About Automobile Repairs

In the accompanying commentary I have included thoughts that ground my interpretations. My considerations are based on the feelings precipitated in me by the topics that were discussed.

The first part of the 153rd session was concerned with a fight the patient had had with his wife. He concluded this part of the session by deciding to find a constructive solution.

P: I tried to talk to her. "Tell me what's wrong. Let's talk about it." I can tell when she can talk about it in a way that makes her aggressions go away. I have to become more resolute toward myself and try not to always feel attacked, but try to see what she wants to shift off onto me because she thinks that I'm responsible for the fact that she has become the way she is.

The fact that he had become better able to respond to his wife was one positive result of his therapy.

After a pause the patient talked about a dream he found peculiar.

P: Last night I had another dream that was very peculiar. I was in a garage again because I was having problems with the car exhaust. It was broken. They were having difficulties because new ones didn't fit right. Then they started to make a new exhaust. The problem was the muffler, and more and more people got involved in making the muffler. At the end everybody at the garage was busy working on the exhaust. And suddenly it was finished. My car was ready, and I could hardly believe that so many people had been involved in helping me. Then I was supposed to pay for it, and I said of course I would.

Consideration. This dream made me assume that there was an anal source for his hypochondriac disturbance of his body image.

The patient commented about the many helping hands.

P: While praying this morning I thought about it. I suddenly had the idea that it was my brethren who had given me so much when I couldn't find any help anywhere else. They still accepted me. And you were one of them too. The last time I wanted to say that the more I am freed of my troubles, the more devout I become, and find so much . . . so much security.

A: Yes, in the dream things are recreated; things that were broken become whole again.

Consideration. At first I was irritated by being included among the group of bigoted brethren with

whom he was linked in a sect. Then I felt that the patient apparently needed this harmony and had to include me to reinforce his feeling of security. I was enthusiastic about his dream and its anal symbolism. It was the first dream on such a topic in the entire analysis. I thought about the fact that some extrapyramidal disturbances are accompanied by coprolalia. Such patients have the compulsion to say obscene words, especially those related to feces.

I referred to his self-representation in the dream and to the latent anal significance that I assumed the dream to have, and specifically mentioned anal references—letting air, fizzling, having fun, giving gas, and stinking. I also mentioned the words "fart" and "shit," and used the word "pot" literally. I assumed that he would reject this anal aspect and that his longing to be loved, even as a stinker, was large.

P: Funny, but I just had the thought that there was also a single woman in the garage. I was a bachelor and was immediately fascinated by her. This doesn't go together at all with the exhaust.

Consideration. This addition was presumably triggered by my interpretation of his longing to be loved anyway. The woman did not fit into the anal world of men and boys.

The patient made longer statements about sexual games he had played in childhood, which provided some new details.

A: You feel secure when you pray together with your brethren. Then you're not a bad guy or a stinker or a fart.

P: I have a different attitude toward sexual things, but my wife still condemns me when I massage her, pet her on her buttocks, her breasts, and her genitals.

A: What I said about exhaust, bowel movement, and stinking seems to be foreign to you; I have the impression that you weren't convinced.

P: Not entirely.

Consideration. My forced attempts to make interpretations went too far. The patient did not respond to them. I therefore attempted to build a bridge for him by returning to it again and doubting my own assertiveness. Although I was sure of my assumption about the unconscious meaning, I had doubts about the timing of my intensive allusions. I therefore attempted to remind the patient of observations he had made at home on the farm. The patient responded by remembering many details.

P: And there was a village bull, and the cows were led to him to be covered. And now I recall something, an experience, while I was an apprentice. A journeyman asked me to undress and to play around with my genitals on his behind.

I was surprised that this forgotten experience, which was very explicit thematically, became conscious again. The patient did not clarify how far the seduction went, and I did not want to be intrusive. The patient talked about this experience until the end of the session, and about his fears about getting caught and punished, about his subordinating himself to somebody else, about his fear that something might be damaged, and also about his pleasure and curiosity.

5.2.4 Dream About an Agent

Before relating the following dream in the 216th session, Erich Y said that it was "typical," meaning that it fit well into the framework of his problems.

P: They were looking for an agent, and I was their suspect. To avoid being discovered, I had to move around as if I were a cripple.

The patient continued and enriched this simple description of his dream. He was being followed by someone hot on his heals, followed wherever he went, whether on trips, at the train station, or to the toilette.

P: I had to use force on myself, because I couldn't stretch out or stand up straight in order not to be recognized and discovered.

It remained unclear why he was being followed in the dream and what he was accused of having done. He was simply being sought as an agent, and hiding was at the focus of his experiencing.

His vivid description of his hunched posture and the way he anxiously avoided stretching himself, because he would have been recognized and taken into custody, led me to allude to the way in which he choked off his gestures. I pointed out that many of his actions were linked with feelings of guilt. As an agent, he did things secretly and in a concealed manner.

By referring to the ambiguity he attributed to my role, I cautiously prepared the way for a transference interpretation: For his conscious experiencing I was the one who offered him help; unconsciously, however, he was afraid of what might be discovered and come to light.

A: That is something that always worries you. How can you keep your aggressive fantasies and fantasies about being an agent a secret? How can you hide them? You're not supposed to get mad or let anyone know who you really are.

P: That's right. There are a lot of things I have to keep in mind just so that I don't give them a reason to suspect me.

A: So you stay hunched over where it's not at all necessary, like here with me.

Commentary. Since the patient knew that the analyst was neither a policeman, secret agent, nor state's attorney, readers may be amazed that the analyst acted so cautiously. It was nevertheless clarifying to refer to discordant ambiguities by name. Many analysts do not bother to do so because they assume that

such simple clarifications of what the patient very well knows are superfluous or can be made when the situation demands. We believe that the reference to the double function in this specific transference interpretation is reassuring, but that in precisely this way it is possible to unravel the entire extent of the unconscious secret actions.

I concluded my interpretation by suggesting that the patient put himself into his favorite roles when watching movies about detectives and agents, in order to learn more about himself.

The patient then looked for the reasons that he "increasingly adopted the bent over and hunched posture to keep from being recognized." He accused himself of being a coward, and out of the blue he suddenly said: "Becoming a father isn't hard, being one is." We were both surprised by this sudden thought, and without beating around the bush I referred to the patient's association in an interpretation: "You can become a father fast if you don't hide your tail between your legs. You always had to hide your tail so that nothing would happen."

The patient responded to the metaphoric nature of this colloquial manner of speaking and mentioned numerous examples. He was still afraid I would throw him out if he succumbed to his aggressive fantasies. He described himself as a captive bird that would like to escape or, having learned to fly, left the nest only to immediately succumb to his anxieties about being punished and causing damage. "Yes, they took my wings away from me."

I now made an interpretation offering several possible reasons for this behavior, which the patient had previously helplessly sought. To indicate the spectrum of reasons and open the perspective as wide as possible, I spoke in general about his desire to be active. I described hands—agent's hands—that were not permitted to reach here and there. The dialogue also contained the direct statement: "You are an agent. You see a lot more, even here in my office, when you look around. But even then you think you're doing something illicit."

Encouraged by my direct allusion, the patient then made the helpful discovery that he himself bound his wings, although he had previously always assumed that others had imposed this restriction on him.

Consideration. This discovery cannot change the fact that—in accordance with Freud's theory of anxiety—Erich Y had been exposed to real dangers and had not escaped them unscathed. Yet what remained was the therapeutically important question as to why the patient still behaved like a coward and ducked his head.

P: I keep myself in this position. I tie my wings.

A: Your fear of punishment is revived over and over; you're afraid that even more will be clipped off if you don't tie yourself down.

P: Hum.

A: How was it in the other dream when you underwent an operation?

P: Yes, hum, on my head; my brain was cut open.

A: You protect yourself in the dream to keep even more from happening, to avoid even more injuries.

P: Yes, the peculiar thing is that I let my body and everything available to me, that I let myself be pushed so far that I walk around crooked and like a cripple, that I don't fight against it. Why?

The subject at the end of the session was the relationship between persecutor and persecuted. The patient turned to these ideas by listing what it would be like if he were to turn the tables and pay back all the humiliation and shame he had suffered. This reversal appeared in drastic form in the following dream about an amputation.

5.2.5 Dream About an Amputation

In the last third of the 223rd session Erich Y happened to mention a very drastic dream. In a certain context the word "foot" had reminded him of having had a very gruesome dream.

The dream was preceded by a subject that was on the patient's mind a lot and that was active as a day residue. He was worried about the future willingness of his insurance company to pay for his treatment, and he therefore wanted to reduce the frequency of the sessions. The patient paid a small portion of the expenses himself, about DM10 per session. Since he was a voluntary member of a public insurance fund, he was treated as a private patient. This precipitating factor, i.e., his concern, has to be mentioned at the beginning because the patient was strongly affected by it, showing again that minor causes can have large effects. Unconsciously he experienced this fee to be a significant loss of bodily substance.

At first we discussed the matters of financing treatment, saving, and stinginess. He and his wife had differences because of their differing attitudes to money. Erich Y was extremely upset by minor debts he had after buying a house. After considering the rational and irrational sides of this issue for a long time the word "foot" happened to be mentioned and it reminded him of a dream.

P: I want to be free, on my own feet again. The word "foot" reminds me of a gruesome dream I had last night. I was here, with you and you were limping. After you had sat down, I asked "What's wrong?" "It's my other foot, they've amputated my other leg." "What do you mean, your other foot?" "Well, one of my legs is already made of wood, and now I've lost the other one, too." I just couldn't believe it at all. I hadn't even noticed that you already had a wooden leg, and now the other one. You were pretty composed. I just couldn't get over it. It's very peculiar which mental combinations take place and appear in a dream.

A: Yes, you would like me to stay in one piece and not get injured, and be sure that nothing happens to me. That means that you have to pay attention here and be careful not to offend me. Well, in the last session we talked about persecution and being a victim, injure

versus attack.

The associations and interpretations proceeded from the day residue. The patient had viewed my request that he personally contribute to the fee as a threat to his bodily existence. He was amazed and even shocked by the highly emotional consequences that my expectation provoked.

I focused my interpretations on the fact that the patient attempted to secure his peace and harmony through subordination and that he at the same time felt he was the victim. By stingily holding on to and keeping what he owned, he had established a balance and overcome the damages he had suffered.

A: My request is an intrusion on your substance. Eye for an eye, tooth for a tooth. As you do to me, so I do to you.

P: I can really imagine that if I had to pay all the expenses for these sessions here, then so much pressure would develop that I could progress as much as possible and as quickly as possible in order to get out of here again and to get some relief.

Commentary. The patient's unconscious wishes and expectations would have found some other plausible linkage to a realistic perception if the question of the patient contributing to the fee—a slight increase in the total fee from about DM 80 to DM 90 per session, which was of course also a welcome increase to the analyst—had not arisen. Asking the patient to contribute was not a means the analyst had intentionally introduced to guide transference in a particular direction. It is not necessary to artificially create plausible and realistic perceptions that can turn out to be offensive. The utility of the small private fee in this case is demonstrated by the patient's further thoughts.

A: Yes, you'll be under so much pressure and it would be easier for you to be angry, because I would be the one who's reaching deep into your wallet and taking the leg you're standing on. If you had to pay everything yourself, that would really be a tremendous burden. And you feel it when it's only 10 marks. Of course, you can always minimize its significance, that it isn't so bad after all even though you experience it to be very bad now. The dream shows it, too. My request is an attack on you. An eye for an eye, tooth for a tooth. It's fortunate that you remembered it and that you were able to dream about it at all, and that you told me about it. You suddenly thought about the dream.

P: Hum, yes, I thought of the dream a couple of times over the weekend. And I asked myself, "Why?"

Commentary. As a matter of principle, and not only because of the disturbing strength of the unconscious dynamics, it is advisable to focus interpretations on the issue of security and to begin from the longing for wholeness, the reaction formations, and the efforts to overcome deficits. The analyst followed this rule in this treatment. He proceeded from the assumption that the patient would like him to remain uninjured and had the wish that nothing should happen to the analyst and that any injuries be

overcome. Otherwise he himself, a cripple, would not have a chance either.

This transference dream provides an insight into the genesis of defects in body image because in it the injury was translated back into the context of its interactional genesis.

This topic was continued in the decapitation dream described below.

5.2.6 Decapitation Dream

Erich Y opened the 230th session by mentioning the worsening of his symptoms in connection with a family quarrel. According to my impression, the patient occasionally reacted to his wife's pedantic behavior by trying to do everything right—which was of course beyond his ability. In view of these marital problems I was also helpless because his wife's behavior influenced his psychic life by reinforcing his superego. Yet she had refused to attend counseling herself, although she also accused the patient of being the only one who had the opportunity of speaking his mind and finding some relief.

After a short pause the mood changed and the patient, now dismayed, told me about the "gruesome dream" he had had last night.

P: We were in a small company that I wasn't familiar with. Two men were quarreling, but then it got serious and turned into a fight. One man tore the other's head off and threw it around, and the man whose head was torn off was suddenly gone. Although I had been there, I asked where he had gone. He was gone, they had gotten rid of him, without a trace, just like with a girl who had also been missing for some time. She disappeared just the same way. Not that she had lost her head, but she was simply gone. [Short pause] Peculiar, such a gruesome dream.

A: Yes, it's a sequel to your dream about my missing leg. The intensity of the fight, the fighting, the struggling to have your way is clearer now.

Consideration. This was meant to emphasize the continuity of the castration theme in transference.

P: In the dream I helped to destroy all the signs of the fight, to make an investigation impossible. There was an oven and what do I know what else, and the contents were destroyed and removed, so that nobody would could find anything, even though I had only been an onlooker of what happened. [Long pause]

A: You always had to appease people or conceal and hide things, hide yourself, and not be aggressive or competitive or fight a duel to the bitter end. Partly because you were afraid. Then you were the loser, the little boy, the refugee, who had to hide his tail, who watched two men fighting for their lives. Although you were just an onlooker in the dream, you participated actively in covering things up.

Consideration. I viewed the fatal and gruesome duel both as a symbol of transference and as multiple

self-representations of the patient, who—as a result of working through the consequences of earlier duels at the unconscious level—thought that he was the one walking around with a deformed head. Yet he had also distanced himself, or split himself off, if you will, so that he was only an innocent bystander. The defensive aspect of the dream was most important to me at first.

P: But it was so gruesome.

A: It was no coincidence that a head was involved. A head is involved in a lot of things. Your idea of being small is partly a result of thinking that something is missing there, although it's obvious that nothing was ever missing. But at the level of images, fantasies, and the unconscious, wishes are transformed into actions, for example when people say that someone is risking their neck.

P: Hum.

A: Hum. You also asked yourself why you pictured me as being injured.

Consideration. I established a connection to the dream in which the patient had visualized me as having an amputated leg, and drew his attention to the fact that there had been a change. At the dream level he was now also a culprit, no longer just a victim. This change from passive suffering to active participation is important not only for general therapeutic reasons. I repeatedly had the idea that action potentials could assert themselves in the automatized sequence of movements in the way Lorenz described vacuum activities (Lorenz and Leyhausen 1968).

P: Hum.

A: For a long time you portrayed yourself as being the one who was injured, as the victim.

P: Hum.

A: Because you are very afraid of yourself, you were the victim, not the culprit. And otherwise you also try to cover up all your tracks, so that nobody notices anything and nobody knows that are involved in this and that. Just like everyone else, you are a person who competes, who is involved in violent disputes and rivalries, even in murder and manslaughter, no, not in reality, you have such impulses at the fantasy level.

By making the generalization that the patient is human just like everyone else, I attempted to weaken his anxiety about fatal aggressive actions so far that he could give more room to these unconscious aspects. For the same reason, I emphasized the fantasy level, after I had gone a little too far by using the words "murder" and "manslaughter," which had shocked the patient. While reading the

transcript I thought about how the patient had had reservations that I could somehow use his thoughts, possibly not in his best interest.

P: This sensitivity, that's it. Yesterday at work. Right now there's a man in the office who's supposed to make a career for himself in a subsidiary. He's collecting information from us and being trained, and he came to me and asked me about this and that. I gave him the information, documentation, and a copy of the monthly report so that he knows what to report to the management. Afterwards a colleague said that he's being supplied and armed with the best materials. He meant that we shouldn't help the new man to get off to such a good start.

Consideration. There was another, insincere side to the patient's extreme willingness to help. Rivalry and competition entered into it at the level of the day residue, as competition between ideas. As the following associations demonstrated, the patient had had a good idea that someone else had snatched away. The issue is that something that originated in his head was taken away from him.

The patient had had a very good idea to significantly improve the routine at work. In embittered silence he had accepted the fact that his department head had taken credit for it and acted as if it had been his idea.

P: It hurt me very much, but I accepted it.

A: See, he took what was in your head. He took your head away, in the language of the dream. There is a little rivalry in the situation. You hid your tail, well . . . .

My interpretation corresponded to my theoretical reflections. The day residue is a minor cause with a large effect.

P: Hum.

A: You can see that the others are fairly envious or don't try to control their envy.

P: But when I put myself in the limelight [the patient sighed], I feel as if I'm showing off.

A: Yes.

P: It still hurts. I actually ought to be satisfied that I had the idea and that it was successful. Yes, alright, there would be advantages if the boss at the top knew that everything was my idea or somebody else's.

A: You see how much rivalry is involved. You have your duels. When you touch your head, then apparently the duel you are fighting in your head becomes one between your head and your hand.

In this interpretation I attempted to focus on the internalization of a duel. Erich Y was always dismayed at how he used his hand to struggle against the involuntary twisting of his neck. The angrier he got and the more force his hand applied, the stronger the

counterforces twisting his head to the right. His observations were noteworthy. In addition to the duel described above, other types of contact such as shaving or touching his cheek caused his head to turn. My interpretation was based on the assumption that at, the unconscious level of this symptom there was an internal duel, and in my interpretations I attempted to shift the conflict back to the level of interpersonal relationship, including the *transference* .

A: Your hand is your own. It belongs to you just like your head, but when you touch yourself, touch your head, then your hand apparently turns into a foreign object . . . .

P: Hum, hum.

A: . . . into something attacking you.

P: Hum. [Long pause]

A: When I ask for money, even if it's a small sum, it seems like a substantial amount. As if it cost a piece of yourself. It unconsciously touches on an immense feeling of losing something, triggering rage, which in turn leads you to chop off my leg.

It was important for me to refer to this conflict in transference at a level that was concrete for the patient. That is where the affects reside.

P: That this feeling, this tension as it's expressed in the dream, is so immense, in other words, right to the end, like in the dream, head off . . . .

A: Yes, yes. [Long pause]

P: . . . as if there weren't any alternatives.

A: Hum. Yes, it's not for nothing that there are headhunters.

P: Hum.

A: Besides, a head is something magical. Having a head means having strength. Just like cutting off genitals and drawing strength from them; it's at the same level. [Long pause] Cannibals consume human flesh to incorporate their foe's strength in themselves.

In these interpretations I attempted to revive the magical components at different levels, in order to make the patient more receptive for his own unconscious motives. I immediately had the feeling that I had gone too far, and therefore in my next comments returned to the level of symptoms and the associated envy for the healthy heads of the people around him.

P: Hum.

A: A lot of things are precipitated by your complaints. "If I could only have another head, if I could only have his head." And now personally, "You could have my head." Remember, I copied the circuitry in your head, stealing your ideas just like your supervisor did.

Consideration. I recalled one of the patient's earlier dreams, which I referred to now to make it even clearer to him why he attempted in his dream language to get my head, too, and to appropriate the substance of my ideas.

P: Yeh, yeh, yes, yeh, yeh. But those are ideas—stone age, that's how far back they go.

The patient had become extremely animated. While showing his confirmation by repeating the yeses, his voice was full of enthusiasm, which was followed by the slight restriction about the primitiveness of his thoughts.

A: Yes, they are in each of us.

P: Of course everyone carries them around in their unconscious, like in a backpack, but that I can't control them, and when I control them, then there are these repressions. But this desire to possess and this force, that can't come to the surface, it can't be done. If everyone were to act according to this principle, then there would only be murder and manslaughter. [Long pause] Now I'm thinking about human relations and about complaints. Sometimes you notice how the customer tries to find out what's really happened. The way I see it, he doesn't have control of himself, overshoots his goals, and things are no longer in proper perspective. People who act this way, even in daily life, are repulsive.

Consideration. It was logical that the patient tried to direct the intensity of the competition and rivalry into reasonably acceptable forms, as all the other day residues indicate. It was important to me to further clarify the transference components, specifically in connection with his personal contribution of DM10 to my fee, which he experienced to be a loss of substance.

P: There are definitely capabilities, possibilities, and thoughts that can be awakened without becoming brutal. Yes, what good is it for me when I tell my colleague, "Do you think it was right to take my idea like that?" What good is it for me now? He knows that it wasn't right. I ought to have enough control of myself that I don't have to give him a piece of my mind to be satisfied. Hum. Yes, naturally, I would also like to do good compared to the others.

The rest of the session was concerned with this topic and competition.

P: Naturally it's an important point, feeling hurt, the feeling you've been passed by. As you say, something is taken away from me, and it means I get shorter, am constrained, yet to me that's a petty way of thinking.

A: Yes, I think it only looks that way. It's not petty, because of the immense consequences we experience. It's really almost the opposite of

petty something important, because the consequences that we experience are immense and because it conceals how much it affects you. Yet you experience it as something petty because consciously it really isn't so terrible.

P: Hum.

A: On the one hand it's a ridiculous event, yet on the other it's an enormous experience.

P: Yes, emotionally.

A: When I take DM10 from you, then I'm attacking your substance, to be or not to be.

P: Yes.

A: Or when I have your circuits in my head, then you want to have my head and wear it prominently, not hunched over like the agent. You would like to get into my head, yes, to have everything that's inside, what do I know. Then you would have everything yourself. It's human. Then you would be free and . . . .

P: Hum.

A: . . . and would be strong and potent and whatever else you attribute to my head. As if I had a superbrain or were a bigshot.

P: Hum.

A: The bigshots are the ones who have lots, lots of money, who are rich, and have the power, the powerful fathers, like the one you especially longed for after losing your own so early and being on the run and abandoning house and home.[Pause]

P: Maybe I'm deceiving myself when I think that the other person, the big shot who has everything under control, can immediately tell that I want to use it.

A: Hum. But covering up isn't the best solution either, is it? We have to stop now.

The patient said good-bye, also wishing me a nice weekend, and I did the same.

Commentary. The way in which sessions are ended and which words are used to announce the end is more than incidental. Both participants are subject to time, even if in different ways. The "we" form emphasizes the shared element, which analysts should not routinely suggest because the patient is only entitled to 45 or 50 minutes. It is the analyst who must end the session if he is to adhere to his schedule. To remind the patient of this, we recommend that the analyst use the "I" form in announcing the end, switching to the "we" form when the mood makes it seem advisable.

5.3 Dream About the Symptom

It is not unusual for symptoms to appear in dreams. According to wish theory, it should even be a frequent occurrence that individuals overcome their symptoms in their dreams and portray themselves as being healthy. In the following dream, described in the 268th session, Erich Y suffered from wryneck. This fact would not deserve special comment except for the context that the patient and I gave the event. The patient's associations and my interpretations show that the twisting of his head in his dream represented searching movements that could be analogous to those of an infant at its mother's breast.

Erich Y said that in the dream he was wandering around aimlessly and anxiously. The company he worked for was spread over a large grounds. The canteen was separate, with the plant set back in the countryside.

P: I had the feeling I was small and lost. Then I met a secretary and an assistant, who were talking. It seemed to me that I was standing off to the side. Then we walked some distance and my head turned to the side. I couldn't get it under control; no matter how much force I used, I couldn't do anything. My head twisted to one side just the moment it was important to be in the middle.

Consideration. The patient's feeling in the dream of being lost and his great insecurity made me think of childhood situations in which helplessness and lack of motor coordination are especially conspicuous.

A: Yes, and what can you recall about your mood in the dream? Could it be that you portrayed something in the dream? Out in the big wide world you're very exposed.

The patient expressly denied that he felt observed, and then continued:

P: I wasn't feeling well. I was standing all by myself and didn't have contact to anyone. The company directors were discussing something. I felt left out. For me it was like being in a different world, something . . . . [Long pause] It has something to do with "child," but I can't really say, it's so far away.

A: In a large room, at their mercy and exposed to everyone, without support and without a hand to hold on to.

P: Yes, I was superfluous, maybe because I walked along without saying a word, or that I didn't have contact because of my appearance or reserved behavior. Maybe I wanted to go along and take part, but that wasn't at all possible because of my attitude and behavior. People can somehow tell that I cannot let others get close to me, even though I would sometimes like them to. It's very funny that I have to think of a woman's breast now.

A: How? Think of it right now?

P: In my thoughts, like a child looking for its mother's breast, to gain strength—not at all ironically.

A: Yes, yes. You were worried that I would react *ironically* .

P: But I didn't have any sexual feelings.

Consideration. The idea of deducing the patient's searching and rediscovery of the primary object from sexual desire in a narrow sense was so distant to me that I could not take the patient's concern personally that his pregenital sensuality might provoke ironic ridicule from me. For a long time I had been aware of not blurring the qualitative differences of pleasure within the libido theory.

A: Yes, as if I would only think that you are following sexual desire, and not another one. Even children turn their heads.

P: At the moment I can't get it out of my mind.

A: Yes, but why should you get it out of your mind or turn away from it? That's what you mean, isn't it?

P: Hum.

A: Just while you're in the process of looking for it in the dream, in the large room.

P: It's the anxiety again about turning to the breast and taking something from it, because someone else might misinterpret it, think that I am doing something wrong, always when I'm expressing my feelings—the inhibitions—the others. [Pause] In my imagination it's always the same, just like in this dream. The secretary and the assistant seemed so large to me because I magnify them.

A: Yes, but, just like the breast also somehow probably seems very large, in comparison to a mouth. The mouth grasping for it, or the eye when it's close to the breast, then the breast is very large. If only a part is visible, then it seems very large.

P: And then I have the feeling as if I have many more sensations toward my mother than I want to believe and than I show, and that I was always looking for love and affection even as a child, but that even as a child I was very reserved and didn't say anything about my feelings. And then at times I act a little like a child to my wife when we snuggle, when I embrace her, hold her, and touch her, she says, "Hey, what's going on. This isn't normal, you're exaggerating so." And there's a parallel to now; it's always been this way. I sought it in love too. Love, love, affection.

Erich Y was referring in this passage to a comprehensive sense of love, and mentally protected himself against his wife, who misinterpreted his gentle sensuous feelings because their ultimate goal was sexual in nature and complained even after "harmless" contacts. In this way she extinguished his independent searching for nearness and tenderness from the very beginning. The relationship between tenderness and sexuality in the each of the sexes frequently leads to serious misunderstandings in relationships between men and women. Thus it is no coincidence that Freud developed two theories of tenderness,

which Balint (1935) in particular studied extensively.

5.4 Thoughts About Psychogenesis

The restrictions on Erich Y's self-feeling that resulted from his imagined physical defects were at the focus of therapy from the very beginning. As early as in the fifth session the patient had described a dream in which he had been injured in a traffic accident. In the 35th session, in the context of controlling movements and actions, he discussed the puppet theme for the first time, and later it appeared in numerous variations. Defects were a frequent part of the patient's self-representations, both in the dialogue between him and the psychoanalyst as well as in his dreams. The dreams we have selected mark points at which themes come to a climax that exhibit a tendency of a shift in the objects chosen for his self-representation, from inanimate objects to persons. This shift was no simple linear progression. The questions as to which modifications can be demonstrated by studying a series of dreams and which diagnostic and prognostic conclusions can be drawn from the initial dream have been discussed in earlier publications by close associates (Geist and Kächele 1979; Schultz 1973). Here we employ a dream series to demonstrate problems that have been worked through since we consider the treatment process to be an ongoing form of focal therapy with a changing focus (see Vol.1, Chap. 9). We have tried to center attention on self-defects in dreams and consequently have neglected the other dimensions of the therapeutic process that are relevant for a synopsis.

We believe that consideration of this dream series contributed substantially to clarifying the genesis of the dysmorphophobia. This symptom is at the same level as the dream if we assume that the compromises are similar in structure. According to the psychoanalytic psychopathology of the conflict, the symptom and the dream are linked together by the idea of compromises between the repressing and repressed forces and ideas (Freud 1896b, p. 170). We apply the idea of compromise to the genesis of symptoms just as much as to dream interpretation and the entirety of items produced by the unconscious. Freud emphasized

> that neurotic symptoms are the outcome of a conflict . . . . The two forces which have fallen out meet once again in the symptom and are reconciled, as it were, by the compromise of the symptom that has been constructed. It is for that reason, too, that the symptom is so resistant: it is supported from both sides. (Freud 1916/17, pp. 358-359)

Yet what is the case with Erich Y's *wryneck* ? According to the distinctions made in the initial diagnosis, it was a neurologic illness that was precipitated by psychic conflicts and whose course was codetermined by them. In the therapeutic interviews the differences between the purely *neurotic* symptoms of dysmorphophobia and the *physiological nature* of neck twisting were occasionally blurred. The neurologic disturbance of movement was placed in the context of expressive and emotional movement in the dream about the agent and in the patient's image of the movement as the search for the mother's breast. One consequence of the fact that human experiencing is *holistic* is that patients often do not distinguish between whether the source of their physical limitations is psychic or physical. An analyst's task in this regard is complex, including examining the reasons for a patient's ideas about his illness. A patient's explanations for his physical ailments, which he often experiences, for example, to be a form of punishment, are an important aspect. Even a scientifically incorrect subjective theory of the genesis of an illness is a part of how an individual copes with his illness. A patient's observations and conjectures about his illness often constitute an access to psychic factors that may have been involved in its genesis and course. The analyst has the task of making diagnostic distinctions and clarifying the respective roles that the physical and psychic components played in the origin and development of the illness. On the other hand, it is important for the analyst to take the patient's personal theory of his illness seriously because the two parties otherwise talk at different wavelengths.

Erich Y's condition was strongly dependent on whether he could stand up straight or whether, because of his social and superego anxieties, he had to sneak around like a cowering coward to keep from being recognized or—as in the dream about the agent—being caught. The conspicuous twisting movement of his neck, which was beyond his conscious control, increased his feeling of insecurity, creating a typical vicious circle in which the physical ailment reinforces the psychic disturbance and vice versa. Erich Y's neurotic ideas about his disfigured head and other constrictions that Reich might have referred to as character armor (see Chap. 4) had for decades even made him incapable of moving around freely and without inhibitions. Conflict had characterized much of his marriage and was one reason that his self-security was very weak. Important in this connection is the existential significance of upright posture and standing straight for an individual's self-feeling and self-confidence, because the ability to stand up and stay erect belongs to man's fundamental experiences and has been the source of a wealth of metaphors. In the last few decades systematic studies of the development of infants' ability to walk

upright (Mahler et al. 1975; Amsterdam and Levitt 1980) have supplemented earlier phenomenological and psychoanalytic studies (Freud 1930a; Erikson 1950; Straus 1952). It seems obvious that a physical disturbance that appears to the subject to be an incapacity to control or coordinate movements revives latent insecurities rooted deep in his past. In this particular case a very large role was played by the conditions under which the patient's loss of autonomy was accompanied by a feeling of shame and his self-confidence was transformed into bashfulness, and by the way in which this change could be reversed. Neurotic symptoms of this kind are conducive to change.

Erich Y experienced his physical symptom (his wryneck) to be related to guilt, anxiety, and shame. The analyst pursued the patient's personal theories in order to eliminate secondary neurotizations. It was plausible to assume that freeing the patient from his neurotic suffering could also have an affect on his physical symptom because it would reduce his anxious expectations and the accompanying increases in both general and specific excitatory potential.

Since we have discussed the general principles of examining hypotheses in therapy research in Chap. 1, we will limit ourselves here to considering the analogy between the searching movement for the maternal breast and the (pathological) twisting of the patient's head. We recall that one of Erich Y's associations to one of his dreams was about a woman's breast, which turned into that of a nursing mother. In transference the patient feared being rejected, and consequently tried to find reassurance by emphasizing that he had not sought anything sexual. The momentary cause for his anxiety that the analyst too might misunderstand his longing for nearness and tenderness was the fact that his wife had frequently rejected him. This scene was definitely very important therapeutically. Yet what does this mean for the suggested analogy between the searching movement and the pathological twisting? Is it possible that the torticollis, i.e., the twisting of his head, was an expression of an unconscious reflex of searching for the oral object?

These issues are related to the question as to the degree that psychogenic factors were involved in the development of this patient's illness. Knowledge of the course of this treatment supports the view we presented in the introduction, namely that psychic factors contribute to the manifestation and exacerbation of a symptom. Of interest here is whether the observations made in this individual case throw some light on how the psychic precipitants and psychogenic conditions functioned as contributory

causes as Freud suggested with his term "complemental series."

To help readers keep their orientation, we will reveal the outcome of the following discussion by weighting the various factors in the complemental series according to the theory that we adhere to, namely the nonspecific nature of the pathogenesis of psychosomatic illnesses. Physical disposition in the most general sense of the term determines which illness occurs. The individual symptoms thus follow biologically given patterns that are rooted in the patient's physical constitution, as described by Freud's notion of complemental series, and that are referred to as "organ vulnerability" in Alexander's schema (see Sect. 9.7). Incidental items that can be found in the different psychological dimensions are factors contributing to the modification of physical reactions. With regard to the speculations raised below, right at the outset we can pose the critical question of why an early disturbance presumed to constitute the psychic prerequisite of an illness does not become manifest until so late in life.

Melitta Mitscherlich (1983) applied this general assumption of an early disturbance to the genesis of wryneck. In earlier studies she had described, in spite of the problems that had become manifest during Abraham's (1921) and Ferenczi's (1921) discussion of tics, torticollis as being (preoedipal) conversion hysteria, and in her 1983 study she argued that torticollis represents a *preverbal symbol* . According to her, such patients regress so deeply that they become incapable of using linguistic symbols to express their affects. In such a condition of deep regression such patients resort back to motor forms of expression whose counterparts are in the infant's pre-ego stage, because no other means of expression are available. The motor patterns used in such cases correspond, according to her, to rooting, the infant's schema for controlling sucking and touching movements that Spitz described. Starting from Ferenczi's (1913) omnipotence of gestures, M. Mitscherlich spoke of the magic belief of the torticollis patient in the "omnipotence of movement." Motor activity itself contains the profound ambivalence of turning toward, as by a hungry infant, and of turning away, as by an infant whose hunger has been satisfied.

An infant's rooting and the analogous searching movements in a regressive state are one thing, and the extrapyramidal head movement in wryneck is another. We have to emphasize that the twisting in torticollis must be considered in light of the results of neurophysiological studies, and cannot be considered to parallel any natural schema of infantile motor movement. The muscle activities or hyperkinesia demonstrated on an electromyogram can be interpreted neurologically as disintegration

taking place within the extrapyramidal programs of motion schema, which leads to a false activation of the relevant muscles by the central nervous system. The coenervation of the antagonistic muscles that are already tensed in the relaxed state which occurs in voluntary turning of the head is, according to Fasshauer (1983, p. 538), "another argument, in addition to already very substantial complexity of this movement anomaly, against a psychogenic cause of spasmodic torticollis." In other words, the anomalous movement in torticollis is not an isolated psychogenic symptom in the sense of a regressively deformed searching movement. In order to prove such a theory it would be necessary to test and verify many hypotheses, for example which cognitive affective processes in the adult precipitate infantile searching movements and, more importantly, how these searching movements can be transformed into the motion in torticollis through regression. The concept "presymbol" is no more a substitute for plausible hypotheses and their examination than the assumption of a preoedipal conversion. The concept "presymbol" contains, just like all other speculation about the alleged early genesis of physical ailments, highly speculative assumptions about splitting processes. In order not to be misunderstood, we would like to expressly emphasize that Freud and Breuer's discovery of the consequences of inhibited affects and the significance of abreactions and catharsis in therapy belong to the fundamentals of clinical psychoanalysis. Yet if this twisting movement were based on a splitting off of circumscribed instinctual or affective oral object relations, then it would have to be possible to discover them in the cathartic primal scream or in some physical therapy, and no such discovery has been made. It also cannot be expected that an abreaction can be therapeutically effective in cases of torticollis or of similar physical ailments because these symptoms do not originate from a split off quantity of affect.

Although these critical comments about the psychogenesis of somatic illnesses and of torticollis in particular limit the range of psychoanalytic therapy, they also give it a solid scientific foundation. Proceeding from those factors that maintain a set of symptoms, one encounters the typical basic anxieties that are precipitated and reinforced by the illness and occur in a form corresponding to the patient's personal psychodynamics. The result is a group of special targets for the therapeutic technique. In accordance with the Ulm process model outlined in Vol.1 (Sect. 9.4), we have described several issues from the psychoanalysis of Erich Y as thematic foci. In the theory of the genesis of psychosomatic illnesses that we have adhered to for many years, these foci are in a nonspecific relationship with the torticollis. We thus share Bräutigam and Christian's view "that in most psychosomatic illnesses *the formative*

elements, i.e., those that are specific to the illness are already present in the *physical disposition* " (1986, p. 21). Our experience also indicates that the manifestation and course of the illness depend on both psychic and social factors.

The variety and diversity of psychic problems mean that it is in principle improbable that specific correlations of wryneck—or of other somatic illnesses—with specific conflicts can be found. Nonetheless, the impression of many doctors that, for example, patients with wryneck somehow differ from others is probably not only based on an uncritical generalization of individual observations. The observed or presumed similarities result from the fact that the same illness provokes similar psychosocial problems, which in turn influence the further course of the illness and reactivate typical anxieties and feelings of insecurity. This is also the basis of the approach that psychoanalysis can follow to favorably influence the course of the illness as well as to reduce subjective suffering. Thus it would be a mistake to conclude from the nonspecificity of the pathogenesis that psychic factors play a minor role in the manifestation and course of the illness. If the analyst makes his psychodynamic diagnosis from the perspective of therapy, i.e., by determining thematic foci, then he and the patient will proceed in a manner that makes it possible to achieve changes. Conducting a group comparison is something else. The question of the typology to which an individual case is assigned depends on the perspective of the person conducting the examination. Because of the lack of prospective studies and of knowledge about the consequences of the illness on the patient's subjective condition, it is impossible to generalize from the results we have collected. The fact, which is beyond all doubt, that a *secondary neurotization* frequently or regularly takes place must be considered especially important and, in our opinion, sufficient for a psychoanalytic therapy to be indicated.

It is especially burdensome for patients who are already neurotic to experience their helplessness toward a socially conspicuous chronic illness. Existing social and superego anxieties frequently reinforce each other when there are conspicuous physical symptoms, leading patients into isolation in order to avoid being exposed to the humiliating glances of others. The resulting insecurity leads to increased self-observation. The patient's own eyes, in addition to those of others, are now directed at himself, creating the millipede phenomenon, i.e., causing him to stumble over his own feet because of his increasing self-consciousness. The therapeutic liberation from self-observation takes place hand in hand with the liberation from being the object of observation by others, enabling the patient to have exemplary

experiences in his relationship to the analyst.

From this perspective it is simple to explain the dependence of the symptoms' manifestations on the situation, mood, and the spatial situation (described by Bräutigam 1956), such as the automatic reinforcement of symptoms that results from the individual worrying about being seen. Christian (1986) followed a similar approach in explaining writer's cramp, which he considered a result of the excessive burden of simultaneously processing affective and cognitive demands. Fluent actions are disturbed because the simultaneous processing of conflicting affective and cognitive demands exceeds a patient's capacity to coordinate them. Agonists and antagonists literally work against each other instead of cooperating harmoniously. Writer's cramp is purposeful behavior and obviously has an instrumental side, while the pathological twisting in wryneck has none. Writer's cramp is precipitated by touching a writing implement or by the act of writing itself. The critical glances of others frequently function as factors reinforcing the symptoms. Often writer's cramp occurs only in specific situations or after specific actions, such as writing one's signature for a bank teller. This makes it clear that writer's cramp, just like other cramps and unsuccessful actions—e. g., while playing a musical instrument—and other tics, must be viewed *primarily* in a context of unconscious meaning; this context is missing for torticollis.

In light of the results of research on affects we believe that these processes are subliminal for long stretches, i.e., they are not conscious. Since, for example, the cognition of danger is simultaneously accompanied by anxiety and the latter triggers the motoric disposition to move (away from the object), it is quite likely in subliminal anxious tension of unconscious origin for muscles to be enervated and hyperkinetic activity to be precipitated by the automatic elaboration of possible movement by the extrapyramidal motor system. This state of affairs might apply to all habitual "tensions" that are manifest as personal dispositions to react. Psychoanalytic therapy proceeds from them and from their relationship to neurotic or somatic symptoms.