Psychoanalytic Practice: Clinical Studies

Means, Ways, and Goals

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Means, Ways, and Goals

Introduction

We discuss the important issues of scheduling, remembering and retaining and of anniversary reactions from the perspective of time and place in Sect. 8.1. Due to the importance of the reconstruction of the historical and political factors that exert an influence on an individual's life history, we dedicate an entire section to this issue (Sect. 8.2). This is followed by an study of interpretations, a subject which has been a focus of our interest for a long time; here we refer to a treatment that took place many years ago (Sect. 8.3).

A discussion of acting out (in Sect. 8.4) leads over to the topic of working through (Sect. 8.5). The first of the five examples of this issue that we discuss (Sects. 8.5.1-8.5.5) is a detailed description of a case in which traumatic experiences were repeated in transference and of how they were mastered.

Interruptions of treatment are accompanied by particular problems up until the final separation (Sect. 8.6; we discuss the significance of the latter issue in connection with termination in Chap. 9). It is impossible to restrict psychoanalytic heuristics to one section of text in this volume on the practice of psychoanalysis, in contrast to first volume on the principles of therapy (see Sect. 8.2 in Vol.1). Each chapter of this book illustrates the specific and nonspecific means the patient and analyst use to make their way.

8.1 Time and Place

8.1.1 Scheduling

The most convenient arrangement for the analyst is to schedule his appointments so that the

majority of his patients regularly come and go at set times. Such inflexibility, of course, restricts an analyst to accepting those patients whose personal situation makes it possible for them to keep appointments several times a week and to pay for hours they miss. To avoid such a restriction, many analysts are willing today to plan free time into their schedules in order to accommodate rescheduling and to have time for emergencies (see Wurmser 1987).

Whatever solution is chosen has its own advantages and disadvantages, which can be different for each of the two parties. All other considerations become superfluous if the analyst cannot create the preconditions under which a patient can come to treatment frequently and over a sufficiently long period of time without being forced to accept substantial restrictions or deprivations in his private or professional sphere. We are therefore in favor of a certain degree of flexibility, which of course is associated with problems all its own. For example, according to our experience it is primarily in the flexible part of the analyst's schedule that he is prone to make mistakes or overlook items, such as forgetting an appointment or scheduling two appointments for the same time.

Because of his limited amount of time and the need to be punctual, the psychoanalyst is under increased pressure; the consequence can be a form of countertransference that is specific to the profession and directed in particular at patients who are tardy. On the one hand, we must remember that the patient is free to dispose of the time he or his health insurance company is paying for; on the other hand, tardiness and missing sessions mean that valuable time is lost. Any financial compensation does not change the fact that in such a case the analyst can only think about the patient, not do anything for him. If the patient continues to disregard his appointments, the analyst has practically no chance to exert any influence. And having become powerless, all that remains is for the analyst to reflect about the absent patient's motives and about what he himself may have contributed to the situation.

The commitments that each of the two parties makes are supposed to *lead to* something by

creating an atmosphere of freedom. If the patient and analyst do not lose sight of the goals of psychoanalysis, there is less danger that the discussion of appointments, missed sessions, or rescheduling appointments will degenerate into haggling.

The following example illustrates the issues of *punctuality* and *perfectionism* .

Arthur Y entered my office out of breath.

P: I'm late, I messed up.

A: A minute, isn't it?

P: Yes, but your clock is a minute fast.

A: Really?

P: I think so.

A: But then you're on time.

P: One minute late. But that puts us right back in the middle of our topic.

A: Yes, you can want to be emperor, not just king.

P: Yes, or the pope.

A: [Laughed] Yes, the one at the very top.

P: There's a nice fairy tale called "The Fisherman and his Wife." In essence it says that the fisherman caught a fish, and the fish said, "Let me go and I'll make a wish come true." The fisherman's wish was to have a normal house instead of his old hut, and when he came home and told his wife the story, she scolded him: "You could have wished a lot more." The next day he caught the same fish again, and well it happened over and over again. His wishes got bigger and bigger, until finally he was the pope. But then he wanted to be

the Lord God himself, and then he was sitting in his old hut again.

A: Oh, yes.

P: Yes, I once wrote down the word "perfectionism," in order to think about it. When I'm in a race with time, like now, I get afraid and act irrationally. I drive much too fast, a lot faster than you're supposed to. And when I think about it, it's completely out of proportion to the minute or two here. [The patient's comments are only interrupted by an encouraging "hum" or "yes" by the analyst.] If I get caught in a radar trap, then it might get tricky.

A: And there's more and more inner tension, paralyzing you and blocking everything so that you can't think about anything else. The fairy tale gives a deeper meaning to perfectionism.

P: Yes?

A: Namely of being the best with regard to punctuality, but it's linked to your concern that the punishment will come some time. It's very pronounced in your case, the idea of being punished. The extreme was to want to be God, and if that is what you want to be, the biggest of all, then the arrogance preceding the ruin is complete.

Arthur Y then mentioned a problem with one of our next appointments. I made several suggestions, saying that I preferred 7:00 p.m. The patient agreed and added:

P: Then you'll have a long working day, although it's none of . . . . Yes, yes, I'm being impudent again.

A: Hum.

P: It's really none of my business.

A: But it's very much your business. Yes, for example, after a long day at work, "Can he still manage at 7 p.m.?"

P: Hum, yes, that's precisely what I was thinking.

A: Yes, it's very much your business.

P: Well, we were talking about the fairy tale "The Fisherman and his Wife." I love this fairy tale because it's so profound, it contains so much practical wisdom, about being satisfied with something. Perfectionism is something that professionally has always been on my mind. I enjoy it, I like being the biggest, and I am in one region. But I let my perfectionism maneuver me into a deadend . . . . I should be able to take it easy some time and say, "So what, then I'll be two minutes late." The worst thing that can happen to me is that the two minutes are gone. That makes three marks, and they're not going to break me. But that's not really the issue. I mean, you stand here, look at your watch, knit your brow, just like I might, and get more and more upset and angry, simply because it is 9:09 or 8:08, and there's no quibbling about it. Perfectionism, not liberal but stubborn.

Commentary. The patient's comment about the profundity and practical wisdom of the fairy tale was a reference to the different ways it could be interpreted. The topic of perfectionism was, in contrast, limited.

A: Perfectionism is the pearl. And why is it then so terrible . . . .

P: . . . for the pearl to fall out of the crown.

A: A pearl so precious that your own esteem depends on it.

P: Yes, yes.

A: So it's not just stubbornness, and you even claim that I make it the most valuable item and raise my brow over it.

P: Yes, I transferred it to my own situation, and I think that if I'm this way, then the others are too.

A: I have to be this way, because if I weren't, it wouldn't matter to me if you came or not. If that were part of it, wouldn't it matter to me then?

P: I really don't think so. At least I wasn't thinking of it.

A: But why it is that way? Why does it become so awfully valuable?

P: Well, because it's the opposite of what caused me problems when I was a child. For example, if I'm on time, to the very minute, or if I double my turnover, or if the superiority of my company gives me power over the competition and it's really enough power to drive my competitors, the smaller businesses, to the verge of bankruptcy, then first of all I'm punctual, second the best, and third the most powerful. In other words, it's exactly the opposite of what I used to be.

A: It's wonderful that you can be exactly the opposite of what you used to be. And if you can get me to consider punctuality to be the most important value, then we have the proof that you're different than you used to be.

P: Yes, it's clear to me too from what I said that I have to be the exact opposite of what I used to be.

A: And that's why the fairy tale is so fascinating, because the old fisherman did change.

P: Yes, but then there was the other turn around, and I'm afraid that everything is going to break down and I'll end up in an institution or prison after all. [This was one of the numerous compulsive thoughts and anxieties that afflicted the patient.]

A: And if you come a minute too late, then I'm completely dissatisfied with you and lose all interest.

P: Yes, it's peculiar that this one minute is decisive for my esteem.

Commentary. The dialogue was focused on the struggle for survival and success, on the transformation from pope into devil, and vice versa, and on polarizations and antipodes, being the best in both good and bad. The analyst gave the patient support by referring to the unconscious aspects of his struggle for survival. If someone is the most powerful of all, then

nothing can happen to him.

P: Yes, I understood what you meant. What I've achieved here—yes, just saying this causes me problems because the thought spontaneously crosses my mind that you might object to the word "I" when I say "what I've achieved." That you might reprimand me, "At the very least you should say `we.'"

There was a momentary interruption of this line of thought.

P: I know that it's not true. Well, good, whatever the situation. Gone, shame, it's gone, what I wanted to say.

Arthur Y lost his train of thought.

A: Maybe you were blocked by the idea that you should at least say "we." But presumably you didn't like the fact that you deprecated your own importance.

P: Yes, maybe I can pick up my train of thought again. I started from the idea that I have achieved something here.

A: Then your train of thought was interrupted. When you say "I," then you get punished.

P: Hum.

A: Then the "I" is gone. And then you're small until you've recovered from the punishment.

Commentary. This "momentary forgetting," this interruption of the patient's train of thought and his rediscovery of it, deserves special attention. It belongs to a large group of phenomena that offer us insight into unconscious defense processes. If a parapraxis or a psychic or psychosomatic symptom appears during a session, it is often possible to clarify its immediate source. Very instructive is also what the analyst contributed to the weakening of the repression and the rediscovery of the line of thought, i.e., to the disappearance of the microsymptom. Luborsky (1967) discovered that momentary forgetting while associating can serve as a

prototype for research to validate hypotheses.

P: Yes, yes, now I've got it. It's the independence, the freedom, I demonstrated today by not waiting in the waiting room until you came. But where's the limit? One minute, or two or five or even ten minutes? Maybe some day I'll say to myself, "Ha, I'm not going at all today!"

Arthur Y then related a story about how he had had his way. He made it clear that if someone were late for an appointment with him, he would choose a friendly but reproachful statement like "It's not so bad. The next time you're sure to be on time again."

P: And I felt so terribly liberal when I said it.

At another point Arthur Y asked anxiously whether he talked too much about himself, implying that it might become too much for me.

A: You would be getting too personal if you said that I had a long day. Why are you worried about it? Maybe one reason is the question of whether I can still offer you proper treatment after a long day, whether I still have something to offer.

P: One thing was primary for me, namely transgressing some border by making a personal comment.

Commentary. The patient's anxiety about committing some transgression was, as can be concluded from a more thorough knowledge of his psychodynamics and symptoms, motivated in part by unconscious anal sadistic impulses, which were contained in his masochism. At the same time the patient identified with the victim, i.e., the analyst who was exhausted in the evening. This was presumably also the mode of his empathy, which the analyst pointed out to him. Finally, the analyst drew the patient's attention to the fact that he had expressly said that the suggestion of a session in the evening was especially good. This made it all the more probable that the unconscious source of his concern was irrational.

8.1.2 Remembering and Retaining

We chose this heading to draw attention to a significant topic, namely the problem of establishing a connection to the preceding session and remembering what happened. Who remembers what the patient and analyst felt, thought, and said, and how and where is this knowledge retained? What about forgetting? In psychoanalytic theory the development of object constancy is tied to the continuity of a stable interpersonal relationship. Whose responsibility is it to ensure that this continuity is maintained despite the unavoidable interruptions in life and in therapy, and what can the patient and analyst do to ensure that it survives the inevitable crises and is strengthened? Such questions surface when the patient cannot recall his line of thought and wants the analyst to tell him what the contents of the preceding session were. Proceeding from the word "contents" we could have decided on a heading for this section that we intentionally did not chose, namely the word "container," a metaphor that Bion introduced to refer to the reproduction of a comprehensive theory of communication and interaction expressed in terms of specific variables and constants. This metaphor stands for a specific theory and, accordingly, has to struggle with its connotations and implications. Although it is obvious that Balint's two-person psychology does not exist in a realm free of theory, it is important to us to achieve as much frankness as possible toward the phenomena discussed below. This is the reason we have chosen a heading that is colloquial.

After remaining silent for several minutes, Clara X began with the words:

P: I've tried to think of what happened in the last session. I can't remember. Can you remember anything?

A: Yes, I can recall a few things, but I assume that a few points will still cross your mind.

P: I can only recall that I cried. Maybe you can give me a hint.

A: [After a longer period of silence] It's possible that you need a hint from me, yet I still hesitate

because it's also possible that it would be better to wait until you yourself come up with something. You can surely remember something; it must be stored somewhere. But perhaps you can't remember anything because what's most important is whether I've bridged the gap to the last session and whether I've kept mind on you, so that you can forget it. If you or something of yours is safe with me, then you don't have to remember it.

P: Yes, that would be a wonderful feeling.

A: Yes, it would be terrible if I couldn't recall anything. As a matter of fact, this was even one of the topics in the last session. We talked about the session we missed. I had left it up to you to schedule an additional hour. The topic at the beginning of the last session was whether your reason for running away was your deep disappointment in me. I hadn't understood how important it was whether I thought about you or not or whether I missed you.

P: But I still don't know why I cried so much.

There followed a period of silence that lasted several minutes, which I interrupted:

A: Have I passed the test? No, I haven't said anything about your tears and why you cried. So I haven't passed the test yet, inasmuch as I can pass it at all.

Commentary. It is possible to feel how the analyst struggled to make the best of the patient's forgetting, but he was uncertain about what to do. He even doubted whether he could pass the test at all, yet it was not clear what the reasons might be. His admission of his helplessness took on a therapeutic function by relating the problem to their relationship.

P: Yes, I think that's an important point for me, I mean how it affects you, whether it repels you, whether you think it's impertinent, whether you're offended, whether you would like to ignore it or—as in behavior therapy—to erase it by disregarding it. Of course, it could also cause just the opposite to occur, all the more so. Or whether you would have liked to say, just like my earlier therapist, "Don't scream like that" and screaming referred to talking loudly or crying. Well, you've survived it, so it won't have been so terrible.

A: A number of things were terrible. There wasn't anything left. You've forgotten it. You gave it to me for safe keeping. You didn't think about the session or me.

P: I did think about you, but not in connection with the last session. If I can't get control of my eating binges, then I'll kill myself. I wanted to kill myself close to your office and leave my diary addressed to you. A pretty spiteful idea, to make you feel guilty, give you a bad conscience, for something that's not your doing. "Let him see how he handles the trash that's left over." Yet I can't relate this thought to the last session, only to my continued helplessness toward myself.

A: You experience this helplessness during the binges you have at night.

P: Yes, everything's part of a circle that I can't break out of. After eating I have such strong stomach cramps. It's the same thing every night. As far as my body is concerned, I couldn't get through the night without binging. It's a true compulsive act, a real parapraxis. It makes me sick.

A: Yes, at night it catches up with you. It's gotten to be a habit that you can't overcome, it's a nuisance and repulsive because you've got a full stomach, but you've transferred everything that wants to come out to your stomach, while you're dozing and without you're feeling ashamed. Then it comes out that you have needs you're dependent on. You can't suppress your longing any more. During the day you hardly experience it anymore, you've got yourself under such complete control. I think your feeling of shame has to do with this dependence. Your thoughts about committing suicide express the idea that I haven't helped you and you haven't been able to accept the fact that you are just as dependent as someone who can fast.

P: I would be glad if I were still someone who could fast. Good, that was my best time. But I'm on the verge of thinking that I could always eat a horse. I'm more afraid of binging than anorexia.

A: Yes, in anorexia you were independent. Had no reason to be ashamed. It's possible that you

were excessive for a while, but that would took care of itself.

The patient mentioned her anxiety about becoming addicted.

P: I'm desperately looking for security, for an identity of my own. Otherwise I have the feeling I'm melting away or of adjusting and having to do everything just right so that I can survive. At the same time I have the feeling I'm nothing, an nonentity like a jellyfish that's spread out in the sand. Everybody can step on me and shape me the way they want. So it's still better, even if you don't like it, to be Death. That's me, I admit it. That's my feeling of identity.

Commentary. Just because two people may make the same statement does not necessarily mean that they mean the same thing. Although Clara X referred to herself as an anorexic and Death, as embodied by a skeleton (and contained in the German word *Knochenmann*), and thus disparaged herself by, in a certain sense, identifying with the aggressor, it made a difference if she referred to herself in this way, or if somebody else did, in which case the words had a very disparaging effect.

A: Excuse me for interrupting you at this spot. It seems clear to me that this is how you protect yourself. Otherwise I would walk all over you and you couldn't take the pressure any more. And what affects you from the outside is probably connected with it; it's your own activity and spontaneity that you attribute to people around you who influence you, who want to give you something. That's why you cling so tightly to your present identity; you use it to protect yourself against yourself.

P: I can't accept this in this form even if—to you—all of it seems clear and natural.

The patient complained about the gap between us.

P: An immense gap, a huge difference that makes my blood boil. [She became more enraged.] It's clear, obvious, natural, everything was clear and natural to my father too. He didn't have any emotional understanding.

Consideration. It's quite obvious that I let my countertransference maneuver me into a duel, so

I made the issue into a mutual problem by admitting my helplessness.

A: Yes, I've exaggerated quite a bit, probably because your position is so strong. I took a position that was just as stubborn as yours, and you have good reason for criticizing me. There's no sign of compromising or listening to the other's needs even though this is your deepest wish. Something like this has happened here, with one rigid position confronting another.

The patient asked me which compromise I had to offer.

A: Yes, I'm also asking myself what I can do to make everything more appealing to you, instead of being so rigorous and reinforcing your position.

P: You could avoid the word "clear." When I mention something I've realized and you use the word "clear," then I can feel it. I feel like I'm a little sausage and the contrariness in me gets stronger.

I shared her opinion, and told her she was right.

The following session began with the patient telling me about her idea that she could lay down under the couch.

P: Once when my daughter was small I had the idea of crawling under her bed and not coming out any more.

A: And in the last session you talked about what I contribute to your hiding and not coming out any more. And that you don't have enough leeway. That I inhibited you by overusing the word "clear." My comments reinforced your opposition.

P: I think we just managed to straighten things out by the end of the session.

A: Yes, we were able to reach agreement. It ended on a good note after all, without an explosion. I really believe that you want me and your husband to see you in a different

way. You don't want to be offended by being called an anorexic or Death.

Alluding to Rosetti's painting "The Annunciation" [as mentioned in Chaps.2 and 4], which Clara X had copied, I said:

A: I used all my powers of speech to describe the changes your body has undergone.

P: Yes, and I still prefer to be Death; it's my identity, externally to be a normal wife and innerly one making sacrifices.

A: The good wife who innerly makes sacrifices?

P: If I adhered to my husband's ideas about a woman's role, then I would have to sacrifice almost everything. Emotionally I would go to the dumps, even if I were completely normal. My husband wouldn't give me any encouragement to take a step toward being independent and having a life of my own. He sometimes accepts something, but sooner or later he rejects it and rides roughshod over me.

A: Yes, these are experiences you've had. Your husband doesn't make it easy for you to change the situation. You haven't tried much to see what would happen if you did do something differently here or there, if you were different. Perhaps you wouldn't still be living with your husband, perhaps you would have found a friend or your life would be different in some other way. Yes, I believe that most people see you just the way you described yourself—as Death. And although you've accepted it, comments about it still offend you and reinforce your attitude. In this way your environment and I contribute to maintaining your situation, for example when I say "It's clear, isn't it," when I trample you and strengthen the force that's already powerful in you, namely stubbornness. Your special form of self-assertion, your special form of finding triumph in all the humiliation and insults that you have to bear. It must be horrible for you to sense that in several important points you don't please most people even though you have so much charm and a natural sense of humor.

P: What are the several important points?

A: Well, I'd like to leave it up to you to decide.

P: The question is really whether I still want to.

A: Nothing happens against your will, nothing, you can choose the dose. I can't do anything. Maybe you don't even know how powerful you are. Perhaps you feel threatened and disturbed by me and the therapy.

P: I feel inhibited and reprimanded. But I still haven't found out how I'm supposed to be different.

A: You sense serious danger when I try to make something appealing to you.

P: Why don't you ever say "It's good the way it is"?

A: Well, it is good the way it is. Yet I can imagine that it could be even better, that you could be more beautiful than you are, I can't hide it even though it is good the way it is. I can also imagine that you would feel better if you didn't have to hide yourself. You're hiding yourself regardless of whether you're on the couch or under it; you have a lot hidden in you, things that you still have to live out. In this regard I'd be sad if you left here, but it's good the way it is, relatively speaking. [Longer pause] You've reached the best possible solutions to a lot of the difficulties you used to have or have now. It isn't easy to find solutions that would offer you more pleasure and happiness. Once you asked me how I would feel if you stopped.

P: Yes, and?

A: I think you asked me if I would be sad or distressed.

P: Yes, and why do you mention it now?

A: Well, the core of the matter is satisfaction. Whether when you go away one day you'll go away feeling satisfied and leave me here feeling satisfied. To the question of whether I

would miss you, I just had a peculiar thought. I would miss you more if you left with a big deficit, or in other words, if I had the feeling that there was a lot that was still unresolved where I could have provided you some help.

There was a pause that lasted several minutes, during which deep sighs could be heard—an eloquent silence. I added a "humm."

Commentary. The silence was a quiet continuation of this dialogue. How deep does the agreement and feeling of identity have to be to give the patient more security—that is the question that cannot be solved by contrasting verbal and nonverbal dialogue.

P: Just as I turned to one side I had the thought that we aren't getting beyond a certain point with words. This back and forth is like ruminating. Deep down inside there's something that looks an awfully lot like desperation. Death, pleasing or not pleasing, feeling well or not, it misses the point.

A: Yes, you despair about yourself and about me, and desperation has something to do with doubt about how you are and what you are. To avoid being torn back and forth, you cling to what you have, as the only certainty there is. [Renewed silence and sighs] Words aren't enough, nonetheless at the end I would like to ask whether there is anything you wanted to add.

The patient expressed the wish to shift the next session to the morning because she wanted to leave for the weekend. I was able to arrange it.

8.1.3 Anniversary Reactions

The doubts and criticism that depressive individuals have toward themselves are a sign of their being dominated by the past. Their lived time seems to stand still. The more the depressive person is overcome by the past and his feelings of guilt, the more the future is closed to him. The phenomenology and psychopathology of experiencing time, which we have discussed in Vol.1 (Sect. 8.1), makes it possible to determine the severity of depression. The more severe the

affective disturbance, the grayer the future appears to the patient. The restrictions put on activity in psychotic depression takes the form of inhibitions of vital functions. From a psychoanalytic perspective the question is the extent to which the affective disturbance is caused by unconscious *psychic processes* that also manifest themselves in the symptom of a loss of a positive feeling for time. In depressive patients we can assume that the disturbed experiencing of time that was described by von Gebsattel (1954, p. 141) is a disturbance of vital fundamental activity that psychoanalytically can be explained by unconscious defense processes. There is no doubt that our experiencing of time is closely linked with the rhythm of instinctual gratifications. The lack of such gratifications therefore has to lead to a loss that takes the form of hopelessness and of there being no future. Thomä (1961) has described these problems for chronic anorexia nervosa patients.

In the interaction between analyst and patient the internalized time structure is transformed into the current, flowing, and experienced time (see Vol.1, Sect. 8.1). When Kafka (1977, p. 152) referred to the analyst as a "`condenser' and `dilator' of time," he had the linkage between temporally very divergent statements and their possible meaningful connections in mind. The following example is intended to demonstrate how unconscious time markers can take the form of anniversary reactions.

Ursula X, who was approximately 40 years old, came to psychoanalysis because of a chronic depressive neurosis. The patient's depressive complaints had begun 12 years before, after her younger brother had committed suicide. He had been the first son in the family after three daughters and was admired and given preferential treatment by everyone in the family, but especially by their mother. By coincidence the first session of analysis happened to fall on the anniversary of the day he died, a fact the patient did not mention at first. In the course of therapy, however, it became apparent that the patient's depressive symptoms worsened on her brother's birthday and on the anniversary of his death, so that it was justified to speak of an anniversary reaction. The conflicts, which had remained unconscious, seemed to be labeled by a time marker, which made it possible for me to pay special consideration to the relations

between the patient and her brother and between the patient and me in transference.

In the first year of analysis the close childhood relationship that had existed between the two of them—and that the patient had maintained—became clear. In her brother she sought the warmth and protection that she had not received from her mother. At the same time, she felt a special sense of responsibility for him and bound, as the oldest daughter, to fulfill their parent's will. The patient's inner conflict was shown particularly clearly on the thirteenth anniversary of her brother's death, i.e., after one year of analysis. In her severe depressive self-doubts and self-accusations she attempted to imagine what was going on in her brother before he was run over by the train. Her intensive desire to think herself into his situation and to understand him demonstrated her own struggle with her thoughts about death and her desires to die. For her, being dead meant being together with her brother and achieving her long-sought unity with him. The anniversary of her brother's death also marked the beginning of the second year of analysis, which the patient had undertaken in order to make a new beginning. The analysis documented that she wanted to live, and to the very day when she should have had to mourn her brother's death. Every step she took toward independence and out of her depressive withdrawal was associated with severe feelings of guilt about leaving her brother behind, dead.

In the second year of analysis an unconscious transference fantasy developed between the patient and me in which I assumed the role of her brother, which fit as far as our ages were concerned. As analyst, in the fantasized exclusiveness of our relationship I satisfied her longing for protection and warmth; at the same time she admired me. The manifestations of her feelings of envy became stronger.

In the last session before a vacation break (the 250th session) the patient was overcome by doubts about whether she should actually go on the trip she had booked with an airline. It would be the first trip she had gone on all by herself, and she said: "I've got pangs of conscience because I have to leave my daughter and parents behind, not to mention you." Then she made the serious suggestion that I should go on the trip instead. She had already gone through the conditions and told me everything she would do to make it possible for me to

go. I said, "Okay, we can play through the idea of what it would mean if I were to take your place." Noticeably disappointed, she told me how she had imagined that I could tell her about the trip upon my return. She knew that in a certain sense she was taking the easy way out. She would not have to leave her daughter, parents, or me and afterwards could still take part in my pleasure.

After a long period of silence she recalled that it was her brother's birthday. She had not thought of it until then. Her associations indicated that her brother had often gone on trips, taking her place and that of their mother, and was able to give vivid descriptions of what he had experienced. This was one reason she felt closely tied to him. She had the feeling of having gone on a trip with him, so that despite the external separation from him she still felt innerly united with him. After briefly thinking that she would therefore probably feel much worse for a few days, I offered the interpretation, "If I were to go on the trip for you, then mentally you would be linked to me although we were really separated. Yet if you were separated from me by the trip, then you wouldn't be sure if you would stay linked with me." She then recalled that she had always asked her brother to only tell only her about his trip upon his return. She felt ashamed about how she had kept him for herself. She also felt ashamed now about wanting to keep me for herself when I returned from the trip. I said, "Then I would go on the trip for you, you would be linked with me in your thoughts, but you would also bind me." Her response was to have stronger doubts about herself, but she had a better understanding that she wanted to avoid the separation from me in order to avoid having to assume responsibility and to retain her longing for unification. After a pause she had the association that a part of her inappropriate feelings of guilt for her brother's suicide might have resulted from her having sent him out into the world in her place. By doing so she did not have to give up her place next to her mother and was still able, by identifying with her brother, to hold on to him and to their mother. At the end of the session she sighed and was sad; "I would really have liked it if you were to fly in my place." Because of her ambivalence it was hard for her to enjoy her very own personal pleasures without the detour via altruistic transfer.

In the course of the analytic process the focus was on working through her separation traumas and their repetition in the analytic situation; one consequence was that the patient,

during her fourth year of analysis, forgot her brother's birthday for the first time.

Commentary. Freud's original description (1895d, p. 162) of this phenomenon had been long forgotten when Hilgard (1960) and Hilgard et al. (1960) coined the term "anniversary reaction" to describe it and identified in empirical studies the psychic preconditions for its manifestation. They proved that anniversary reactions are significantly associated with traumatic losses in early childhood and that they lead to serious separation difficulties in later life. Mintz (1971) distinguished clinically between two types of anniversary reactions, depending on whether an event or specific date is conscious or unconscious. In the former, a date that the patient is aware of, such as a birthday or the first day of vacation, can provoke a current conflict that is associated with an earlier one and reinforced by it. The anniversary reaction occurs as a result of a specific response to this unresolved conflict. Characteristic is the annually recurring reaction to the conflict on a date that the patient consciously experiences. In the latter case, the time marker that is associated with a psychic conflict is unconscious. The date of a divorce and the birthday/deathday of a close member of the family are engrams that remain unconscious. They lead the person affected to suffer from puzzling emotional fluctuations or from a worsening of symptoms because on such days unresolved earlier conflicts regain importance without, however, reentering consciousness.

Mintz emphasized, similar to Pollock (1971), the connection between unconscious time markers and psychic conflicts related to death. Engel (1975) has reported numerous dream examples of this second type of anniversary reaction in his self-analysis; in them it is possible to recognize time markers that remained unconscious, for example, the anniversary of his twin brother's death.

Our example belongs rather to the first category. The precipitating factor is preconscious and easily accessible to the patient. The nature of her anniversary reaction—her stronger feeling of depression—illustrated her inner conflict. Her increased longing for union on the dates of her brother's birth and death led to a significant reinforcement of her own anxieties about death. The

connection between the anniversary reaction and her pathological mourning, a feature that has recently been described by Charlier (1987), is impressive. Since the anniversary of her brother's death coincided with the "birthday" of analysis, unconscious feelings of guilt were activated. For the patient to have led a life of her own would have meant a complete separation from her brother. This conflict makes comprehensible the idea of a disturbance of one's experience of time.

The patient resolved her ambivalence toward her brother, whom she both loved and envied, with the aid of identification, which made it possible for her to maintain the relationship with the lost object and to control her strong feelings in connection with the separation. Thus anniversary phenomena are "manifestations and reactions that are related to time, age, and dates, and identifications and introjections that are complex and ambivalent" (Haesler 1985, p. 221).

We believe that this patient's anniversary reaction belonged to the context of ambivalent identifications. As long as she was able to act out the related conflicts with her husband, she was free of symptoms. It was only after her divorce that a reactive depression was precipitated because the patient did not feel permitted to feel free. Her partner fulfilled an important function as an object of displacement. The patient had unconsciously linked him with her brother. After the couple's separation this unconscious linkage revived old feelings of guilt, so that her reactive depression became chronic.

8.2 Life, Illness, and Time: Reconstructing Three Histories

This heading refers to the interconnections and complications that characterize these three topics. Our age is dominated by ideologies (Bracher 1982). Narcissism has become a collective metaphor (Lasch 1979). Considered from a psychoanalytic perspective, ideologies and narcissism have common roots. According to the definition given by Grunberger and Chasseguet-Smirgel (1979, p. 9), one inherent characteristic of ideologies is that they are all-encompassing systems of ideas and political movements whose goal is to make their illusions become reality. As we have explained in Vol.1 (Sect. 4.4.2), man is susceptible to ideologies

because of his capacity to utilize symbols, which is also linked to his capacity to be aggressive. Such ideologies can take on the character of delusions.

It must be emphasized that according to psychoanalytic criteria the contents a growing child attributes to his own fantasies are linked to the history of the time, particularly via the influence exerted by his family. The ideologically based, intolerant division of the world into good and bad individuals and the development of a system of values featuring mutually exclusive qualities are facilitated first by the family and later in school. Many people suffer psychic traumas but are able to liberate themselves from the unfortunate consequences, which sometimes seems to be a wonder. Others adopt the views that prevailed in their families, maintaining the unconsciously grounded prejudices of their parents. Others, finally, become ill from the incompatibility of opposing factors (Eckstaedt 1986; Eickhoff 1986). For example, such polarities are contained in the symptoms of compulsion neurosis, which is characterized by an alternation between extremes and the associated incapacity to be tolerant to one's self and to people with different opinions. The psychopathological *contents* of the compulsion change through history and from one civilization to another, yet the *forms* remain the same. This fact relativizes the causal role assigned to specific psychosocial factors in the origin of psychic and psychosomatic disorders.

8.2.1 Example

There was no doubt that the Nazi ideology exerted a significant influence on Arthur Y in his childhood and adolescence and on his entire life history and that of his illness. Yet it would be nonetheless misleading to overlook the decisive difference between the Jews who were the personal victims of the racist ideology, the individual who actively participated in the persecutions, and the compulsive neurotic. In this particular case, the patient's conscious and unconscious identifications with the Jewish victim and the SS officer who performed the execution paralyzed each other and protected the patient and those around him from the

possibility that either tendency might manifest itself in reality. In this regard Arthur Y exhibited a structure similar to that of the Rat Man or the Wolf Man, Freud's paradigms for the unconscious mechanisms of compulsive neurosis. This phenomenon must be taken into consideration when discussing the question of how ideologies are handed down from one generation to the next. It is important to clarify which group the father or parents belonged to—the persecutors, the active adherents, the fellow travelers, the silent majority that adapts to the given political situation, or the victims.

The therapeutic work on several of the topics outlined in the following case study can be found under the appropriate patient code. The detailed presentation of this case history is intended to serve as a basis to help the reader understand the many vignettes of therapy.

This analysis concentrated on disentangling the extremely disastrous complications that consisted of personal, familial, and historical elements. As always, it is futile to ask whether the patient would have become ill if this or that had not happened, e. g., if he had not had numerous traumatic experiences before and after adolescence.

Arthur Y had suffered from the disorder for nearly 30 years when he decided to make a fourth attempt at therapy, which proved to be successful.

As the analyst providing treatment in this case, I was more than just a close contemporary of the patient. In this therapy I was able to reconstruct some of the history of the psychoanalytic technique, as it was reflected in this patient's experiences. To renounce the anonymity that I neither can nor wish to maintain in this case, in hindsight I can state that I rediscovered some of my own development in the therapeutic technique of well-known colleagues who were involved in the previous therapies.

More important was the fact that many of the stories the patient told me made me recall the experiences I had had when I was young. Many of my own experiences and events in my childhood were reanimated in this therapy. There are many faces to the relationship between agent and victim.

Familial Background

Many typical Nazi ideas were handed down in the patient's family just as they were in many others between 1933 and 1945. The racist division of people into Aryan and non-Aryan and into Germans and Jews was the foundation on which the idealizations and prejudices—which were linked with the drama of family life in a unique way, reaching down to the individual member of the family and into life in the small village—were erected.

Both of the patient's parents were enthusiastic supporters of Hitler, who was also the patient's ideal until late in his adolescence, i.e., until early in the 1950s. The patient's father was a prosperous mill owner and the second person, coming only after the major local landowner, in a small village in southern Germany that did not have any Jewish inhabitants. He served in the army from 1939 on until he was reported missing in action. He was declared dead many years later. The patient's mother, who bore four children for "the Führer and the volk," held particularly high expectations for her eldest son, the patient. After the war she was insecure and not up to the demanding work of running the mill. She was a chronic depressive, ultimately committing suicide. The patient had three siblings, a brother born in 1939 and two sisters, born in 1940 and 1942.

The familial background affected the formation of the patient's ego ideal, as a consequence of which the first-born son did not fulfill the expectations his parents had placed in him. According to the patient, it was rather inconceivable for his mother to have been proud of her oldest son. His memories did not take him far enough back for them to give him a feeling of happiness at having once been the object of admiration. His development did not at all correspond to the ideal for a German boy in the 1930s. Until far into the analysis the patient viewed himself and the world through his mother's eyes, as he described it. After the birth of his brother, his mother had treated him like a cry baby, and everyday in kindergarten he acted correspondingly—his reaction to his brother's birth was to dirty his pants every day. Since he was not allowed to stay home, walking to kindergarten and especially back home again became a source of torment and humiliation for him. He would be hosed off in the room where the wash was done and where butchering was also done. The totality of his traumatic experiences erased

any positive feelings toward life that the patient might have had, since it is, after all, hard to believe that his mother's eye never shined when she looked at her oldest son, to use Kohut's metaphor.

The repeated traumatic experiences the patient had from dirtying his pants included the disparagement of being called a weakling and everything else other than being "tough as leather, hard as Krupp steel, and fast as a greyhound," to use a popular phrase of the time. He was not one of the boys who were big, strong, and good looking—the type he was afraid of in kindergarten as well as later on.

His annihilation anxieties, which he retained throughout his life, were so extreme that it took a long time before the patient was even in a position to consider the possibility that he might have aggressions of his own and that he might project them onto others. He was free of anxiety, however, regarding the idea that a fast, painless death might rescue him from life.

The patient, who was raised an atheist, drew the religious contents of his compulsive thoughts from the years he spent in a boarding school. There his idea of God was also shaped by a sadistic teacher and a homosexual one; the latter looked after the sick children in particular. Although the patient did not submit to either of them, and was not used and abused "to the end," whatever that meant, his feeling of distress increased because of his longing for a father. The mixture of homosexuality and sadomasochism was so virulent that he had his first compulsive idea after reading a detective story, namely of committing the crime in the story himself—by killing the sadistic teacher with poison. In his panic he threw the book into the toilet. By getting rid of the corpus delicti that had given him the idea, the anxiety disappeared.

The patient's mother brought him home from the boarding school to become an apprentice in the family mill. An uncle had filled in as miller while the family waited for the missing father to return. The family did not believe that he was dead, and the mother and grandmother lived in the illusion and hope that they could keep the mill running until he returned, even though the mill did not produce a profit. The uncle, who had an affair with the patient's mother, and a business manager pocketed money from the mill, and after they left the

patient attempted to keep it running, until he closed it down shortly before it would have gone bankrupt; this left him with substantial debts, which he was able to pay off by selling property. Since then Arthur Y worked in a related field as a salesman, where he worked his way up through hard work. Yet the success he had in his career increased his self-esteem just as little as the fact that he had established a family of his own and could have been proud of the fact that he had managed to find a—both attractive and intelligent—wife he had liked especially well ever since they had first met, and to have three teenage children who were developing well.

The Symptoms

Throughout his life the patient had tried desperately to overcome the irreconcilable contradictions inside him. Yet despite his strong anxieties of possibly committing a murder and defense rites that took the form of compulsive thoughts and acts, he was successful in his profession. He just managed to keep his dependence on alcohol under control; every day he lived for the soothing effect it had on him in the evening.

One far-reaching therapeutic insight must still be mentioned. He asked if fulfilling all the commands, in whichever form, that might come from an absolute ruler and whose common denominator for the patient was the fact that they were directed against pleasure and sexuality would lead to him being and staying the only and beloved son. These projections of power and impotence and his use of simultaneous and rapidly changing identifications to participate in them went far back, leading beyond the pathological resolution of oedipal conflicts.

It is known that such idealizations and prejudices can be linked with different meanings. Since masochistic self-denigration, e. g., "I am a pile of shit," are constantly linked with more or less unconscious anal-sadistic ideas of grandeur, diagnostically the one is implied by the other. Compulsive rites that lead to a temporary soothing of anxiety can take on numerous forms.

In object relations theories, i.e., from the perspective of the interdependence of inner and outer, the contents of value systems and the absolute division into good and evil are given the significance that Freud (1923b) attributed to the ego's object identifications:

> If they [these identifications] obtain the upper hand and become too numerous, unduly powerful and incompatible with one another, a pathological outcome will not be far off. It may come to a disruption of the ego in consequence of the different identifications becoming cut off from one another by resistances; perhaps the secret of the cases of what is described as `multiple personality' is that the different identifications seize hold of consciousness in turn. Even when things do not go so far as this, there remains the question of conflicts between the various identifications into which the ego comes apart . . . . (Freud 1923b, pp. 30-31).

Psychogenesis

The focus of the *reconstruction* of the different psychogenetic factors behind the patient's symptoms must be on the mutually incompatible identifications. They are related, to give an abridged explanation, to attitudes of his parents that he internalized; yet viewing this issue in greater detail it is necessary, following Loewald (1980, p. 69), to assume that the contents and ideas of identifications mean that interactions are also internalized. For example, when the patient's mother believed—even before her illness, i.e., during the patient's childhood—that the mentally retarded should be killed—"wack off their heads"—then the object (the mentally retarded and his head) are internalized in this behavioral context. If the incompatibility of various identifications is taken as the common denominator, then it is not difficult to form a sequence that ranges from early ambivalences to the later splittings. Thus, the process that isolates individual identifications from each other may result in a self-reinforcing vicious circle existing throughout one's life. This patient, for example, suffered the misfortune that the manner in which he was raised underwent a radical change when he was 10 and after the death of his admired ideal (Adolf Hitler). Initially he was raised as an atheist, deifying the Führer and condemning the Jews; later he was submitted to an upbringing that confronted him with a punishing God, whose earthly representatives reinforced the patient's conflicts.

I will now reconstruct this process on the basis of knowledge gained during the psychoanalysis. In doing so I will follow the categories Freud set out in the passage quoted above. Involved is (a) a splitting of the ego into different identifications that alternate between grabbing power and isolating themselves from each other, so that (b) the later identifications refer back to the earliest ones. Especially important is the fact that Freud, in a footnote to the

text referred to above, traced the origin of the ego ideal to the individual's "first and most important identification," that with his *parents* .

It is surprising that Arthur Y was able to hide his condition from those around him and that not even his closest relatives knew that he suffered from an abundance of anxieties and compulsive ideas. He feared that he might end the way his mother did and felt responsible for her suicide because he had no longer been able to take her complaining and had flown into a fit of rage the day before her death. He thought that by committing suicide he would keep much worse events from happening, such as being isolated in a prison or an insane asylum after a sex crime. Such compulsive ideas first surfaced when he was 20 years old, when he became optimistic that his later wife might return his affection. At that time Arthur Y secretly submitted to inpatient psychiatric treatment, which did not bring any improvement. Later, in the course of two long analytic psychotherapies, he gained some insights; these were then deepened during a classical psychoanalysis that lasted nearly 600 hours.

Although the patient suffered from strong fluctuations of the symptoms of his anxiety and compulsions, he was able to continue to work without therapy. His expertise in his field and his excellent ability to empathize with his customers enabled him to be fit and alert at the right moment even though he was rarely free of compulsive thoughts. Simply the sight of something red, a sishing noise, or the sound of certain vowels could precipitate severe anxieties and the compulsion to avoid them.

The fatal illness of his younger brother led to a worsening of his symptoms and to his decision to consult me. He had visited me once before, long ago. All that he could recall from the first consultation in the mid-1960s was my accent. At that time I had referred him to a colleague for the psychoanalysis mentioned above, since I had anticipated moving to another city. The patient, after completing his therapy, had happened to accept an offer for a good position in the same area I had moved to, so that it seemed logical for him to consult me again some 20 years later.

Arthur Y's professional success and the stability of his family did not diminish his feeling of

negative self-esteem and submission toward the compulsion that overpowered him. It was only in abstract terms that he imagined he had retained some of his own will and skills. Yet when I asked him toward the beginning of the analysis what it would be like to be free of all anxiety, he promptly answered, "Then I would be intolerably arrogant." By means of his ego splitting he had retained more than just his unconscious arrogance. Existing side by side in him were incompatible identifications with victims and with henchmen. In the course of the years the contents of these identifications—the objects in Freud's "object identification"—grew and grew. As a victim he identified with the Jews who had been the object of scorn and destined for annihilation, and sadistically he identified unconsciously with heroes and their medals. Freud owed his discovery of the *omnipotence* of ideas to a compulsive neurotic patient. Arthur Y put the incredible into the sphere of *arbitrariness* . Establishing a connection between the victim and the henchman, or finding the connecting link, was almost like trying to square the circle. Fortunately, the patient precisely did *not* want to be both, yet in his later life he continued to experience repetitions of such thoughts whenever he was in the appropriate mood and it was possible to detect something horrible or incredible in something he heard or saw.

For theoretical and therapeutic reasons associated with Freud's alternative hypothesis on repetition compulsion, I viewed these repetitions as the patient's attempts to solve his problem that were destined to fail because the unconscious identifications were split off and juxtaposed. In explaining repetitive anxiety dreams, Freud considered their problem-solving function in the sense of retrospectively coping with or mastering traumatic situations. If the ego is assigned a "synthetic function" (Nunberg 1930), it is logical to view repetitions, including those outside anxiety dreams, from the perspective of attempted mastering and problem solving. In other words, it is reasonable to ask why the patient had not managed, even with the help of psychoanalysis, to free himself of the repetitions of his anxieties and compulsions.

It is obviously insufficient simply to ascertain that a patient has incompatible unconscious identifications and that they alternately dominate his thoughts to such an extent that his ego feeling is completely filled by a depressive affect from one minute to the next. The important question is how and why such splitting occurs. The reconstruction of the causes here was facilitated by considering the cumulative traumatic experiences that overtaxed the patient's

capacity for integration in all phases of his life until late adolescence.

The consequences of the patient's experiences in adolescence were more far reaching than to simply determine the contents of his central anxieties and compulsive thoughts. Both the polarization of his inner self that had already been initiated and the splitting in accordance with the ideology instilled in him at home were reinforced at the boarding school by two teachers, who were the exponents of love and hate. These two teachers embodied homosexual and sadomasochistic expectations and fears in a manner that precluded any transformation in him. Just the opposite was the case; there was a stabilization of the existing structures at this time, although there is a high potential for transformation at this age (Freud 1905d).

The patient experienced—in the one teacher's attempts to gain his affections and in his observations of the punishments the other teacher inflicted—his own disturbing desires in the discord between pleasure and unpleasure. One scene from analysis is instructive in this context. It took a long time for the patient to feel comfortable on the couch and secure enough to use the blanket, without automatically becoming homosexual or having the feeling that the rumpled blanket, which he did not fold neatly at the end of sessions, disturbed my orderliness; he initially feared that I would therefore have enough of him and terminate the therapy. It is hardly necessary to mention that the idea of stopping was the patient's attempt to protect each of us from even worse events. Every time the patient reached a new balance, he attempted to assert his identity resistance, to use Erikson's terminology (see Sect. 4.6). Erikson has described identity resistance in the following way:

> Identity resistance is, in its milder and more usual forms, the patient's fear that the analyst, because of his particular personality, background, or philosophy, may carelessly or deliberately destroy the weak core of the patient's identity and impose instead his own. I would not hesitate to say that some the much-discussed unsolved transference neuroses in patients, as well as in candidates in training, is the direct result of the fact that the identity resistance often is, at best, analyzed only quite unsystematically. (Erikson 1968, p. 214)

The patient became more courageous, even though he continued to display the pleasure he found in his power by reverting to masochistic and self-destructive forms and by participating unconsciously in sadistic acts.

The constellation at the outbreak of his illness—at the moment he was loved and had achieved an unimagined success—belongs in a general sense to the typology of those who founder on success (Freud 1916d). Since then the patient's life had been marked by his unrelentless effort to attain narcissistic perfection, whether in business or family matters. His altruistic self-sacrificing behavior was the source of both his happiness and his enormous capacity for feeling offended, which continuously activated unconscious sadomasochistic identifications.

Although the patient had long freed himself of the Nazi ideology, the polarizing system of values that had been instilled in him continued to be decisive for his self-esteem. He had an almost unlimited willingness to be self-sacrificing for his family. When he was offended, he regularly turned his aggression against himself. In business matters he also achieved his successes more as a result of his empathy with the customer or, one might say, his identification with the victim he has to sell his goods.

In conclusion, we would like to emphasize a topic mentioned above, namely the problem of the origin of alternating object identifications and their splitting, to use Freud's language. In a

more general sense the issue is the relationship between *contents* and their psychopathological *forms* . It is obvious that elements other than the influence exerted by the Nazi ideology affected this patient's identificatory processes and that they were largely incompatible. Yet it is just as clear that the primary identifications and the preoedipal and oedipal conflicts played an independent role. Multiple personalities and thoughts about a double and the alter ego were in existence long before this patient sought his ego-ideal in Hitler. We could easily describe the patient's desperate and vain attempts to overcome his psychic conflict between the representatives of his identifications in terms of Stevenson's story about Dr. Jekyll and Mr. Hyde (see Rothstein 1983, p. 45), yet this would underestimate the significance that the *summation* of effects of mutually incompatible contents of identifications have on a pathological outcome, i.e., on pathological forms. On the other hand, taking only the early defense processes such as

projective and introjective identification into consideration would also underestimate their significance because this would disregard the role of the series of traumatic experiences a patient has had for years. This is the reason we pointed out above that the internalization (i.e., the formation of "inner objects") involves *identifications with interactive processes*.

The patient could not say as Faust did that "Two souls live, ach, in my breast," because the one soul—the identification with the aggressor—was deep in his unconscious, and the other one—the identification with the victim—filled him with panic-stricken anxieties. During the analysis Arthur Y managed to integrate the split aspects of his ego, which we have described in the context of the applications for payment by the health insurance organizations (see Sects. 6.4 and 6.5).

Whoever suffers from himself in this manner has empathy and sympathy for other people and is far from committing a crime.

8.3 Interpretations

The following treatment report contains selected interpretations (see Sect. 1.3) from the psychoanalysis of a patient with anxiety hysteria. It is taken from a therapy conducted long ago (Thomä 1967), and not based on verbatim transcripts of sessions. The purpose of such a selection, today as well as at that time, is didactic, namely to describe the resolution of hysterical symptoms in practical clinical terms.

During the therapy of Beatrice X anxieties about pregnancy and giving birth took the place of her previous symptoms of anxiety hysteria, which we describe in Sect. 9.2, where we report on the symptoms and the initial phase of therapy. The patient was unable to fulfill her own and her husband's wishes for children because of her neurotic anxieties of what might happen to her during pregnancy and birth, which compelled them to take rigorous birth control measures. The patient's progressive improvement revived both their wishes for a child and the older, oedipal reasons behind her anxiety.

Yet before we comment on this therapy conducted 25 years ago, we would first like to describe how our perspective has changed as a result of the *revision of the theory of female development* .

In Freud's opinion, the development of girls is complicated by the fact that they redirected their love from their mothers to their fathers. The significance of this change in object was substantially relativized in the 1930s through the work of women psychoanalysts. If we proceed from the assumption that a woman has a primary mother fixation and mother identification—which Freud (1931b, 1933a) incorporated in his theory of the development of the female sex—then all of the complications disappear that are incorrectly attributed to the object change that was initially assumed. If we take the significance that this identification has for a woman's life history seriously, then the unconscious and mimetic acceptance of women's manners of behavior is a means by which children prepare themselves for the mother role playfully, as it were. The normal woman, after all, finds her object relations by means of her identifications with her mother, according to Lampl-de Groot, who however did not publish these ideas until 1953.

Oedipal conflicts can take place without causing any significant insecurity, as a result of the formation of female self-esteem. Thus it is probable, for instance, that the triad of equivalent woman's anxieties described by H. Deutsch (1930), namely castration, rape, and birth, is only manifested in women whose underlying mother identification has been disturbed, as Thomä (1967) pointed out.

The revision of the theory of the development of a woman's identity and her sexual role is probably the most radical revision of the fundamental assumptions of psychoanalysis that has become necessary (Roiphe and Galenson 1981; Bergman 1987). The *psychosocial* source of sexual identity that is anchored deep in the core of an individual's personality in the form of the feeling "I am a woman" or "I am a man" begins immediately after birth. A mother and father indicate how they experience an infant's sex in how they take care of it—their gestures, words,

and the manner in which they handle the baby. We would like to refer especially to the work of Stoller (1976), who introduced the concept of core gender identity and referred to primary femininity. Hand in hand with this radical revision in the significance attributed to a girl's primary identification with her mother, which has been documented in a wealth of publications, there has also been a change in the psychoanalytic understanding of female sexuality in a narrower sense (see Chasseguet-Smirgel 1974). A false understanding of the psychopathology of the female orgasm has for decades been the source of iatrogenic stress on women undergoing therapy. For example, Bertin (1982) has reported that Marie Bonaparte, an aristocratic analysand and later friend of Freud's, underwent plastic surgery of her clitoris to overcome her frigidity. Freud's inaccurate assumptions about the origin of frigidity, which he took to be a disturbance of the transition from clitoral to vaginal orgasm, and other mistaken ideas about the psychopathology of feminine sexuality have obstructed the therapy of frigid woman for many years.

The significance of primary identification for the origin of deviances, in the extreme even including transsexualism, should of course not lead to the incorrect conclusion that femininity or masculinity is fixed in the first year of life. Under favorable circumstances, much can still be made good by friendships made in kindergarten and school, especially during adolescence, and from meeting substitute mothers and teachers. After the oedipal phase has passed, there are still chances to establish new and supplementary identifications reaching deeper than imitations but taking the latter as their starting point. Seeking and finding role models promote the processes of self-cure.

The unconscious defense processes that Freud discovered are often stronger than an individual's innate vitality. Then, as in the case of Beatrice X, hysterical anxieties continue to exist as a result of oedipal conflicts. Regardless of the particular conditions in the life history of an individual patient that initiate the unconscious repressions and other defense mechanisms—indicated by neurotic anxieties about pregnancy and giving birth in the case described below—

there are always oedipal conflicts in addition to the fundamental problems of identification.

In the part of therapy in which we discussed her oedipal conflicts in connection with her anxieties, Beatrice X was able to overcome these conflicts and to make up for emotional ties and identifications with women that she had not experienced earlier. Friendships became more intense, and Beatrice X, giving in to a deep longing, even visited her old nurse, with whom she had spent the long years of the evacuation during the war.

Beatrice X had many homoerotic dreams. In the 258th session she related a dream about my wife. She imagined she was her patient, and immediately reassured me that she was very satisfied with me. She continued to be very worried about losing her father's love in transference if she turned to her mother. It was natural for her to seek information from friends who were pregnant and from young mothers.

Commentary from Today's Point of View. Completely aside from the denial of her oedipal desires in transference, Beatrice X had good reason to be unhappy with her analyst and in her dream to turn to his wife. In a contradictory and conflicting back and forth, the analyst had reneged on his commitment to give her the title of several books on sex education, which in this case did not result in any serious damage. If an analyst refuses to provide information because of the abstinence rule, he misses a chance to strengthen the helping alliance and—in mother transference—to make identifications possible. The rejection of a reasonable request that the expert provide some information prevents a patient from obtaining any indirect oedipal satisfaction, yet it also damages the identification. In this case, the analyst apparently let himself be guided by the idea that every indirect satisfaction would not be in the best interests of the analysis. Today we know that the frustration theory of therapy, which appeared to justify a rigorous application of the rule of abstinence, is misleading. It was poorly grounded from the beginning, and it is not surprising that Weiss and Sampson (1986) refuted it. Their study, just like clinical experience, proves the superiority of Freud's alternative hypothesis, which starts from the assumption that the patient attempts in psychoanalysis, by using the analyst's support, to overcome traumatic experiences and master conflicts that had appeared to defy resolution. In

the present case the rejection of the patient's wish for the analyst to give her the names of sex education books complicated the transference and the helping alliance. It caused the patient to turn away from the analyst and look to women as more suitable role models for the information she desired. If the male analyst had acted differently and made possible a mother transference, in our opinion the patient would have been able to find opportunities to identify with him.

We will now reproduce the notes for several sessions that are instructive with regard to the patient's oedipal anxieties. These notes also provide an example of the protocol scheme mentioned in Sect. 1.3.

261st Session

Beatrice X said that she had looked forward to the session, but that once here she had become uneasy while waiting and had wanted to run away.

She said that she felt very good and was very happy with her husband, but that she was concerned about a planned party to celebrate the completion of a building's shell. She said she naturally wanted to be there, but that her attitude was split into both pleasure and anxiety. She emphasized that she was very happy for her husband, without being envious of his success as an architect.

Dream. She entered a room. A man was setting up spotlights and film equipment and did not have any time for her. She was disappointed.

After describing the dream, the patient repeated her feelings toward attending the building party.

Consideration. The session began five minutes late. I wanted to draw the patient's attention to her—presumed—disappointment and asked her a suggestive question: "The man did not have enough time for you?"

Reaction. The patient did not respond to it, but mentioned her desires instead, saying how nice it

would be to be at the center of things at the party. Then she gave me precise details about her sex life. She said she did not use to have an orgasm because she had restrained herself and had not actively participated when she became more excited. Then somehow she had become anxious that she could be injured if she were very active.

She also said it was not right for her husband to have so little time for her. She added that it was her fault because she would do trivial things in the evening instead of enjoying a quiet evening talking to her husband.

Consideration. Unconsciously the patient wanted to exhibit herself, be at the center of attention, and have a particularly satisfying orgasm. She was anxious about injuring herself. To keep from exhibiting herself, in her dream she pictured the man as not having any time for her. Then it was the man who disappointed her, and she could complain about him. This enabled her to maintain her repression of her sexual desires.

Interpretation. In accordance with my consideration, I referred to an older dream in which she had seen a woman dancing and exhibiting herself, and told the patient that she would like to show herself in a state of sexual excitement but that she reckoned with disappointment because she feared too much intensity. Then she would complain to me about my not having enough time for her.

Reaction. This was 100% right, and there were no *buts* . She added that she thought about a dream and her anxiety about giving birth.

Dream. She saw a pale child, the baby of a girlfriend from school who had always looked bad. (In the dream it was clear that the woman had too often had intercourse during pregnancy, injuring the child.) A man put a small boy on a elephant, between its ears, and she was very afraid that something would happen to him.

Associations. She said she knew that a woman should not have any intercourse the last few weeks before giving birth. The elephant's ears made her think of a woman's labia. There was

something to her anxiety regarding pregnancy and giving birth, namely about losing something.

Consideration. The familiar topic of injury and loss returned again. I thought about the fantasies the patient had had during defloration and about her fear that her vagina would tear further and further open. She did not experience anything new in a child; it did not provide any new experiences. She thought most of all that something fell off (the boy between the ears/the labia). I puzzled about the equating of child and penis. The child does not augment her self-image, but it falls off. Why?

Interpretation. She had the impression that she would be injured while giving birth and would lose something. The small boy was where the elephant's trunk is, i.e., it was as if the boy would lose his trunk/penis. She had the impression that she had lost something compared to her brother, namely a penis, and she feared the injury could increase by giving birth.

Reaction. She could not recall such an idea with regard to her brother, but said that it was clear to her how much she was preoccupied by the thought of being injured while giving birth and of losing something. She was disturbed that she still had such thoughts and dreams despite the fact that she knew better.

Her anxiety about losing something was further clarified in a later session, almost without me making any contribution.

264th Session

Although she had really wanted to talk about the office opening that was due to take place in a few days, another topic forced its way out. It was one we had talked about a few sessions earlier, namely the idea of losing or dropping something. She said she had had a horrible dream about it.

Dream. A string of pieces of liver came out of her vagina. She was horrified, desperate, and full of anxiety, and stooped down to feel what it was and to pull the chain of pieces out of herself. Then she dreamed about a woman who wanted to give her mother such a piece of liver, which her

mother refused.

Associations. The patient repeated her description of her horror and revulsion. This was followed by descriptions of the anxiety she had about losing a child during pregnancy. She thought about the noteworthy stooping position she got into to overcome her anxiety. And the patient had in fact frequently gone into a stooping position to relieve her anxiety. She would not be entirely on the floor, but half on the tips of her toes and resting her buttocks on her heels. The way she overcame her anxiety was similar to how she touched her genital region. The patient concluded about her dream that she obviously was afraid of losing control down there. "Yes, it's true, I was always afraid of bleeding to death during my period."

In passing, she mentioned that she had been able for the first time in years to eat at the same table as her husband. This was a positive change that must be seen in connection with the working through of various anxieties.

265th Session

After yesterday's session she had been very happy; her husband had sent her flowers via Fleurop but without sending a message. But now she was disturbed because she had had a ridiculous idea. She thought about exchanging a pair of shoes she had bought the day before. The idea had crossed her mind that it would be nice to drive to the train station with a patient she had met at the ward and who had a car. Now she was disturbed by the idea and had feelings of guilt toward her husband.

Consideration and Interpretation. In my interpretation I took into account that the patient spent some time at the ward before the session. In passing I noted that the patient she had referred to had shown an interest in her for some time. I pointed out to her that she was acting as if she had not done anything to encourage him.

Reaction. She said she had to admit that this was the case.

I responded by pointing out that this was the reason she avoided sitting opposite a man on

a train. She then admitted how good it made her feel for the man to be interested in her.

Consideration. This was probably a displacement of transference. The patient she referred to was an older, married man she assumed had known many women. She had earlier complained several times that her husband was so boyish, lacking paternal features and experience. She transferred incestuous desires to this patient.

Interpretation. In a relationship with an older, more experienced, fatherly man—through a sexual relationship with me—she sought the confirmation she had not received earlier because, as she had dreamed, her father only had intercourse with her mother. Now she had guilt feelings for having these desires, which she tried to suppress.

Reaction. She said this was 100% right and, besides, her husband was sometimes fatherly.

Consideration. Since the patient's incest anxiety kept her from letting her desires become part of her relationship to her husband and their only expression was split off, their marital relationship had become impoverished, i.e., unconsciously she kept her husband at the level of her brother.

In her *response* to my corresponding *interpretation* , the patient added that this must have been the reason that she had not been able to have sexual contact with her husband for such a long time.

275th Session

The patient assumed (correctly) that she had just met my wife in the hallway of the hospital, and had become very upset and would have like to have run away. She said it was not any of her business to be here now and to talk about personal things.

In response to a question, the patient added that in comparison to my wife she not only felt empty but also small. People often think she is a single, 17-year-old girl.

Consideration. The patient experienced the coincidental meeting oedipally. She felt guilty for her

incestuous desires and warded these guilt feelings off by, on the one hand, pushing them into the sphere of symptoms, and on the other saying of herself that she was much too small. In this way she erected a wall against her incestuous wishes.

Interpretation. The patient had recently dreamed about a woman who was pregnant and was in my room. I interpreted that she thought she could not be the one, thus telling her mother, so to speak, "I don't have an illicit relationship with my brother/analyst."

The patient picked up this line of thought. We spoke about another form of behavior she used to hide her desires. The analyst should be the seducer and have the say, such as in setting the time for the sessions. The subject was once again a visit to see her mother. I told her that she was not coming to me now to get a rest at her mother's and to let her know that she was small and helpless and was not going to the man (the analyst as father).

She picked up this idea and said yes, but also that she could not imagine anything more beautiful than to visit her mother with a baby. She had even had this fantasy toward me, namely to pay me a visit with her husband and the child they desired and she hoped one day to bear.

Follow-up. The positive identification that the patient slowly formed with her own sex diminished her anxieties about being pregnant and giving birth. It is highly probable that this also made it easier for her to conceive. For the record, Beatrice X has been healthy for some 20 years and is the mother of several children. All the important data for judging her case to be a success are positive. The patient has remained free of anxiety and is leading a satisfied and happy life with her family.

8.4 Acting Out

As we have explained in detail in Vol.1 (Sect. 8.6), the traditional understanding of acting out has undergone a significant transformation in the last few decades under the influence of object relations theories. The current theory of technique takes a different view of both the phenomena

referred to by this concept and their origin. Acting out and the related phenomenon of acting in are especially good means for demonstrating the consequences of the polarization between classical insight therapy, with its emphasis on interpretation, and the therapy of emotional experience. This polarization goes back to the controversy between Freud and Ferenczi that psychoanalytic practice did not pay sufficient consideration to experiencing. Cremerius (Cremerius et al. 1979) called for analysts to surmount this polarization by asking "Are there *two* psychoanalytic techniques?" The attitudes to the phenomena traditionally referred to as acting out offer a good opportunity to attempt to integrate these divergent and one-sided approaches.

The phenomenology of acting out is very diverse, yet as soon as we go beyond a descriptive phenomenology in psychoanalysis we encounter the question as to the functional status of individual acts. Since this status consists of individual and dyadic aspects, it is necessary to examine the acting out, whether performed in analysis or outside it, within the context of the momentary transference and countertransference processes. Its function can be either benign or malignant. The patient who caught a glimpse of the analyst's wife while searching for a female identification figure demonstrated her ingenuity in overcoming a fantasized deficit; the patient we described in Sect. 2.2.4 destroyed the basis of therapy by constantly prying into the analyst's private sphere. In that regard we also discussed the fact that the patient's behavior was partially dependent on the analyst's personal situation and the particular form that her therapy took. Since examples of what is customarily called acting out can be found in numerous other places in this book, here we will restrict ourselves to describing two examples of "acting in," which at least since Balint's description of the new beginning has lost its negative meaning.

First Example

Ingrid X came to her first session after the three week Christmas break and began by making the statement that she wanted to show me something. Without waiting for an answer, she went to the couch, knelt down, and began to spread out a game of tarok. I was taken aback, and she asked me to sit on the stool next to her. She placed the cards the same way they were

on New Year's Eve. She said she had rediscovered our understanding of her life history in the cards.

We examined the individual cards, considering many details, and she explained which of the figure's features led her to have which ideas. At the center of attention were trophy cups, which either were full and stood for life, or were knocked over and symbolized unlived life. She was particularly touched by a figure in which she saw herself depicted as a lonely hermit.

At the core of her self-interpretation was her mother, who would not give her a sealed cup, who did not seem to begrudge her anything.

After the patient had explained these details, I felt that she expected me to make the one or other supplementary comment. I was supposed to participate in this summary of what we had already achieved. Then she seemed satisfied, packed the cards together, and laid on the couch.

If there were a catalogue of the unusual situations that have occurred in the career of an individual analyst, then this experience would be part of mine. Unusual for me was especially the matter-of-factness with which everything happened. For me to have refused and cited a rule as the reason would have done more than hurt her feelings.

The patient then described a dream rich in facts. The first image referred to my office, and was followed by other scenes, alluding among other things to a love affair that ended recently. While telling me about her dream, she commented that in the dream she was attempting to put an estate into order.

Without relating the dream to our relationship, Ingrid X continued, describing how she had spent Christmas with her husband. They had had to cope with the familiar problems. The patient's need to provide as complete a report about her holidays as possible and to tell me about them made me pause. The wealth of details she had mentioned led me after about a half hour to point out to the patient that she wanted to bring her experiencing along and had started the session by telling me about the unusual item she had brought along. This led her to

reflect about what was happening.

P: Yes, it's important to me. To bring them along, to tell you everything. By the way, I also do this when I'm not here, speak with you and let you take part in what preoccupies me.

She then described that she had been able to continue the dialogue with me on her own for about two weeks. At that point this inner relationship seemed to have ended abruptly. It was not without pride that she told me that, together with others (friends and acquaintances), she had managed to continue this kind of self-communication.

In this connection I had to think of a question—which I asked the patient—namely whether there was a temporal connection between the loss of her inner relationship to me and the game of tarok. She confirmed that there was; this insight was a surprising gain for each of us. We concluded that the loss of the inner relationship was compensated by her retreat to a magical level. The world of the tarok game took the place of the absent analyst, and was used at the transition from one year to the next to cope with our common past and the future that awaited us. Our understanding of her desire to inform me about the result of this card game constituted a link between the period before the holiday interruption and that in front of us. Ingrid X recalled her emotionally important relationship to her violin teacher, to whom she could always bring anything she wanted. If she had practiced enough, there had always been enough time left for her to show the teacher her interesting books or her new pair of roller skates. Her vivid description of this consoling experience led her to recall the painful memory that her mother, who had been very involved in her career, had not been there enough. For numerous reasons, however, the patient had been in a position to find satisfactory substitutes for some of her chronic disappointments regarding her relationship to her mother.

Our understanding of the acting in on the basis of her own life history led to the statement that we were in a kind of violin teacher relationship. In reaction to the long separation, the analyst (I) became the disappointing, unavailable mother, and then, in the role of the violin teacher, had to make it possible for the patient to bring something playful along. He especially had to be able to appreciate her ability to find substitute solutions, which the patient was

justifiably proud of. These solutions can fail, however, if the disappointment is too strong. As an example she then mentioned that her father-in-law had not made the effort to find a present that suited her, simply giving her an art book he had received from some company for Christmas. In this example she was able to feel her longing for personal attention, which was hidden behind her previous opportunities for coping.

The game of tarok can be viewed as an attempt—successful in this situation—to replace the loss of the inner object "analyst" by turning to a nonpersonal stage on which she could see a summary of our previous labors. The break mobilized a negative mother transference: Who or what is the filled cup that her mother (the analyst) did not begrudge her? To ward off the associated affects, the patient was able to take advantage of an idealizing mother transference in the form of acting in, in order to communicate her feeling of loneliness ("the lonely hermit").

Second Example

Despite his successful career and his numerous interests—making him into someone everyone in his large circle of friends enjoyed talking to—Theodor Y felt lonely and insecure. His outward appearance did not correspond to his negative self-esteem; he considered himself to be completely unattractive.

His father had died in the war, and his mother had had to work hard to enable several children obtain a good education. In addition to their poverty, however, his mother's depression had been a burden on the patient's childhood and adolescence. He became really aware of his homoerotic inclinations after puberty. He came for therapy after his homosexuality while under the influence of alcohol had created a social crisis.

In the 350th session he anxiously recalled an experience that had occurred about 15 years before and after which he had increased his efforts to make homosexual contacts. He had been together with a woman for several months and had had a good sexual relationship with her. He had been planning a trip with a friend, and his girlfriend had been disappointed and enraged that he had not wanted to take her along. While on the trip, he had found out to his consternation that the two of them (his friend and his girlfriend) were going to marry. The

patient had completed the trip with his friend as if nothing had happened. This description came as such a surprise to me that I spontaneously said, "You didn't even have any harsh words with your friend." In my countertransference I had put myself in his position and expected him to react jealously, without taking into consideration that such a triangle offered numerous kinds of gratifications which would make the absence of normal jealousy comprehensible.

He came to the following session much earlier than usual. He was outraged over the smell of stale air in the room and stormed to the window. There was a short verbal-averbal confrontation during which he pushed the window wide open. For a while we stood close together. Since it was very cold outside and although he was right about the air, I soon said "That's enough; now we can close it."

Theodor Y immediately began speaking about the subject of yesterday's session. While listening I noticed that I was still preoccupied with the initial scene, which he did not mention again, and wondered if there was a connection with the subject the patient was talking about.

A: [After a while] I think I've hurt your feelings, both in the last session and just now again.

P: [Vehemently] No, no, I simply need fresh air.

A: Judging from what has just happened, perhaps you felt criticized because of the matter with your friend.

Even at this second attempt, the patient was not convinced, but turned the tables:

P: I think it's rather that your feelings are hurt and you are mad because I'm denying you your stale air.

He spoke for a long time about aggression and evil as such, before turning to the current situation.

P: And now I'm even contradicting you and feel terribly anxious because I'm afraid that you are very mad at me. Here I can sense that you're the clever one . . . . I'm anxious now, and am

afraid of your aggression . . . or of mine? . . . . If you aren't so perfect? . . . . Yesterday you said, "Very interesting." The important analyst is interested in me, or . . . yes, what is "psychologically" highly interesting is what you're actually interested in.

This was followed by a longer monologue, before he finally paused.

P: Am I gabbing it to death?

A: It really seems to me as if you had taken over my role as well, and in that sense you have out gabbed me.

P: Yes, somehow I guess I'm afraid. [Pause]

A: I wanted to tell you that I assume I made a mistake yesterday, and that is the reason I have referred to how you've acted today—you've never come in that fiercely before.

Once again Theodor Y denied there was any connection between the two starting points of my construction and got lost in general philosophical thoughts. Toward the end of the session I attempted once again to inject a consideration into the dialogue.

A: I would like to ask you to listen to it one more time; it might be that you disagree completely. I think that I see something that's impossible for you to see at this time. Perhaps your hurt feelings are also related to my comment about "very interesting."

This statement had the immediate effect of calming the patient, even though he had a dubious look on his face when he left.

After the session I had to ask myself what the meaning of the smell was that led him to tear open the window. Is the fact that my interest in him is "only psychological" really what stank?

Theodor Y began the next session with a conciliatory offer:

If you manage to convince me about what you felt yesterday and said, the business with the window . . . then I'll have learned something. It seems typical to me. And because you said

it was significant. And because I didn't notice it.

A: If you ask me like this, are you curious now, or are you still concerned about yesterday's disruption and want to conform now?

P: No, I don't think so. I thought that you're waiting to see what happened . . . . So what can you show me? I'm an idiot. I can't get it. Still, it's true, my anxiety has decreased . . . I tear open the window, and then you close it, that tells me something . . . The result is a lot of confusion, insecurity, a disturbing scene.

A: You didn't talk about it like this yesterday.

I gave this interpretation with the positive intention of emphasizing the positive in the development of his thoughts from yesterday to today.

P: Yeh, yesterday I couldn't know everything, notice it, and say it at the same time.

Theodor Y thus reacted promptly to a hidden critical aspect of my interpretation.

A: Yes, you're right about that.

P: So, I'm an idiot.

I wondered if he was now accepting my latent criticism. I decided to make another clarifying statement about yesterday's incident.

A: I realize now that it made you feel much more insecure than I had thought or perhaps even could have known.

P: Tuesday's session was about my friend. When you criticized me for not having had it out with him, in that situation, well I felt like a fool.

Theodor Y now mentioned an anxiety that had been a less obvious burden yesterday, and the confusion that was associated with it. I thought of the title of one of Fassbinder's movies,

"Angst essen Seele auf" (literally, anxiety eat up souls [sic]).

A: Anxiety isn't just there, it also destroys, it keeps you from reaching your potential. Even in speaking. Anxiety devours souls.

P: Good . . . . Yesterday morning, at work, before the session here, it was just the same; the secretary told me to get lost. It was horrible. They're all stupid . . . . And I'm the little boy who doesn't understand. My boss, too; he's stupid. And me the little boy, not reaching my potential . . . . Really a vivid description, that anxiety devours souls. There is a strong similarity between the scene at work and the scene at the window, the same anxiety. Good God, you're right. If you had seen me at work. My little helpless boy's soul caught in the web, naked and exposed and pitiful. You'd have been overcome with pity, "The poor . . . . "

A: Me, out of pity, and you out of a feeling of shame.

P: [Baffled] Feeling of shame? Perhaps I'll manage via a round about way. Who am I? My analyst has the same feeling toward me that I had toward the secretary. She was very frightened, pitiful when I finally beat it. And then I think that I want this and that and you've just got to keep your mouth shut . . . . Then the old officer's attitude comes through, with rage, outwardly hard, etc., but it doesn't help.

In my thoughts the patient's wish to submit to his friend and his girlfriend was linked with the current transference situation; in each he was just left standing there. He was not able to be a rival or to argue because the betrayal had struck him so deeply

that he was paralyzed. My comment that he had not confronted his friend was in the same vein. By criticizing him, I "castrated" him.

A: Perhaps we could say that everything happened yesterday because you felt yourself criticized. That would be an answer to the question you raised at the beginning of the session, about what I can tell you today.

P: Yes. [Longer pause] If I don't confront things, then it's a lack of masculinity. That works. That hits me where it causes me to act. Just as you observed, and how I acted here yesterday with the window and coming early today and this morning at work. People get nervous if you tell them the truth. Sensitivity, that's it. But what is truth?

Theodor Y began holding an intellectual excurse about the question of truth that became incomprehensible. He was probably looking more for the *emotional* truth.

P: It's true that my feelings are unclear, yet accurate is my sensibility, my vulnerability. That's true. And that I'm not a man . . . . And the link between the feelings is the decisive item. It has to rhyme. That's healing. The fact that it rhymes reestablishes a whole. You could play a role in it. [Long pause] That I couldn't see it? Now I'll take a look at what happened at the window from your perspective.

Theodor Y reconsidered the scene at the window.

P: At the window I really felt castrated. Because you set me a limit. I made such a big deal out of it, yesterday I didn't notice it . . . . But that's no reason for you to close the window right in front of me. It's all true. My inflated masculinity, the aggression. I would kill to prove myself as a man. I want to have my way, even murder if I had to . . . . I'm not feeling any better now . . . . I can feel my solar plexus. Yesterday I had real pain and was all confused . . . . Then you say once again that I'm a hypochondriac.

This was a statement that was typical for the patient, half ironic, half serious. He always thought that the other person would realize the seriousness of the situation despite the veil he put around it and although he tried to protect himself from it.

A: I believe that I should now try to give you some help.

P: Can you?

This was another ironic question. Behind it I sensed disbelief and amazement.

A: You would be a hypochondriac if we couldn't understand why you feel castrated. You are not a hypochondriac if I can understand that it's your distress that causes you to have such thoughts. It's better if you can feel the acknowledgment in this distress, that you feel yourself to be so small, castrated, or whatever the right word is for it. Acknowledging this would be the help. Then you wouldn't sink so far, resorting to murder or suicide.

The patient was then able, in associations that moved him very strongly, to accept my (the analyst's) capacity to tolerate him and to set his own limits, and in this way turned to the working through that awaited him (Bilger 1986).

8.5 Working Through

8.5.1 Repetition of Trauma

The polarity into catharsis and working through has been carried over into the dispute about the relationship between experiencing and insight. In our opinion the polemics of this dispute become superfluous if we assume that one aspect of the analyst's skill is to link the present with the past in an affectively significant manner. In such moments the traumatic experience can be repeated under new and more favorable conditions, enabling the patient to actively master what had previously been governed by passive attitudes. Freud described this in the following general terms:

> The ego, which experienced the trauma passively, now repeats it actively in a weakened version, in the hope of being able itself to direct its course. It is certain that children behave in this fashion towards every distressing impression they receive, by reproducing it in their play. In thus changing from passivity to activity they attempt to master their experiences psychically. (Freud 1926d, p. 167)

In the following we excerpt a few sections from a course of treatment that Jiménez (1988) has provided a comprehensive documentation for, and comment on it. Our goal is to show how the trauma is repeated in transference and describe the roles catharsis and working through play. The analyst in this case facilitated the patient's recalling of the traumatic experience and its

subsequent working through by making a literal reference to the homosexual seductions by his father; this created a realistic and distanced attitude in the therapeutic relationship. After this turning point the patient widened his capacity to distinguish between his lived experiences with his father in the past and his new experiences with the analyst (Strachey 1934).

Treatment Report

Peter Y, a highly educated 40-year-old man, visited me at the advice of his priest because of the sexual and affective difficulties he was having with his wife. In the first sessions he spoke a lot about his general dissatisfaction with life. He had had traumatic experiences with his alcoholic father, who had homosexually seduced him several times while the patient was 11-13 years old, practicing oral sex (fellatio) on him. The father-son relationship was limited to perverse episodes since the father was almost always away from home on business and the seductions occurred regularly when he returned home during this period of time. The patient spoke about these episodes surprisingly objectively in the initial interview, immediately adding that he was not homosexual but did suffer from premature ejaculation, which was a danger to his marriage. He described the focus of his life history as being his inhibitions toward women, which were in contrast to his wealth of fantasies. He was almost constantly in a state of sexual excitement; this was a source of great torment, which he was only able to escape temporarily by means of masturbation.

What had motivated the patient to seek analytic help at precisely this time became apparent during the first sessions. The reason was his anxiety that he might repeat with his own son the traumatic experiences he had had with his father, i.e., that he might perform fellatio on his son.

Despite the severity of the disturbance there were no psychopathological indications that would have led me to suspect a borderline case. On the contrary, I came to the conclusion that it was probably a severe character neurosis.

At this point it is helpful to make a few remarks about diagnosis in psychoanalysis. We agree with

Kernberg (1977) that a patient cannot be considered a borderline case solely on the basis of fantasies containing archaic elements. This would be just as unfounded as a diagnosis of a perversion on the basis of perverse fantasies. Descriptive psychopathological and structural aspects must always be taken into consideration. Many people would have to be classified as severely ill if only the contents of unconscious fantasies were considered, which would mean that the diagnosis would lose its most important function, namely that of making a distinction. Taking the formal aspects of unconscious fantasies, i.e., the structure of their contents, into consideration means to judge them in the context of the personality. The purpose in doing so is to detect their consequences on behavior in general and on the structuring of the therapeutic relationship in particular.

Reenactment of the Trauma in Transference

After the analysis had continued for about 6 months, which are not summarized here, the tension in the sessions gradually began to decrease. Peter Y was a good dreamer. His dreams and associations facilitated the task of understanding the transference and reconstructing his unconscious life history. The material provided insights into different layers of his identification with his mother and father.

The patient's sexual relationship with his father varied from one dream to the next, enabling me to gain insights into deeper layers. In one dream his mother showed him her breast in a very provocative way. And he also saw his girlfriend and mother lying on a bed, wearing makeup as if they were whores, and turned away from both of them. He saw himself living in a very dignified manner, like a bishop, going into a monastery, without responding to the requests of both women, who pleaded with him to change his mind. In the 192nd session, Peter Y described a dream containing numerous versions of his traumatic experience: "I was having sexual intercourse with my wife, but in a very unusual manner. I was masturbating into her vagina. At the same time we were kissing, and this was the really important thing. Each of us achieved an orgasm and ejaculated with our mouths into the mouth of the other."

The patient's recollections testified to his heroic attempts to escape from his distressing oedipal and pregenital sexual desires that were directed at his father and mother and to achieve peace in the monastery. Yet there his anxiety took on a new content, namely his fear of being seduced by other novices or by the priests.

At a deeper level, Peter Y's fixation led him to experience all interpersonal relationships as sexual provocations that disturbed everyone involved. The perverse acts and oral-phallic gratification during puberty increased his unconscious fixation to the maternal breast. For his unconscious fantasies I accordingly played the role in transference of the seductive parents. He rapidly switched between the paternal and maternal roles he attributed to me; this rapid alteration of symbolic interaction was facilitated by the confused division of his body image into self- and object representations.

The tenderness and kissing constituted the really important relationship in the dream mentioned above. Of course, in transference this was also a repetition that included all the compromises that had formed. At the level of symptoms, his premature ejaculation was an example of such a compromise. In transference the patient stimulated me into making interpretations by describing exciting dreams and putting words in my mouth, just as he had ejaculated into his father's.

Regardless of whatever other unconscious wishes Peter Y might have had, it was necessary to proceed from the fact that he was exceptionally confused and humiliated by his father's behavior. Gradually I was able to recognize that in regression the patient experienced my interpretations to be intrusions robbing him of his autonomy and forcing him to assume a feminine position. He was involved in an intense and sexualized verbal exchange that offered each of us narcissistic gratification, he by referring to significant dreams, to which I responded by making "brilliant" interpretations.

In addition to these fantasies, Peter Y exhibited other transferences. The rivalry with me was expressed in dreams with political and aggressive contents, about power struggles etc., and in acting out in transference. It was clear to me that by telling me about so many dreams the

patient made it impossible for me to make detailed interpretations. I pointed this fact out to him numerous times, interpreting it as ambivalence. Furthermore, when I thought it was wise to interpret a particular aspect of a dream, he responded too quickly by saying "Yes, of course" or "Yes, that's true," only to continue his topic without showing any sign of being impressed. I was irritated that he did not reply to what I had said and felt his "yes, of course" to be more a sign of his desire to be pleasant or even to subjugate himself. This passive aggressive behavior corresponded to his character traits and enabled him to control the course of the sessions. Later it became evident that he had in fact listened to and remembered the interpretations I had made. Thus following a session in which he, as he later said, had the feeling that I had restricted him, he dreamed that he had attempted to drill a hole into the ground, using a heavy and sharp steel pole. Then a general came, claimed the pole was his property, and stuck it in his mouth, which in the dream the patient had interpreted to be a religious ritual. Yet even during the dream the patient felt a strong sense of panic because he had rebelled against those in power, and also felt enraged at the humiliation of having to tolerate the "pole" being put into his mouth. While he was still half asleep the pole changed into a penis.

Commentary. After the analyst and patient had discovered that both the act of interpretation itself and the contents of the interpretations had traumatic side effects, it was logical to view the general as the intrusive father (analyst), especially since the patient himself had made this interpretive identification while waking up. The patient's helplessness was thus repeated in transference, and the patient felt as little justified to resist the general as he had his father. Or is it more accurate to say that he never—neither with the general nor with his father—really *wanted* to put up any resistance? This perverse act provided a compromise satisfaction for a number of wishes and fantasies in one. To mention several aspects, his longing for his long absent father found a satisfaction in which his father made himself entirely dependent on his son. In ejaculating the patient himself became the general, and at the unconscious level used the mouth as a kind of cavernous opening with numerous meanings and also identified with the person sucking. Finally, the fact that there was a link between the patient's deriving pleasure from power and his rage at its misuse cannot be overlooked. His dependence on his father (and at a deeper layer, on his

mother) and on instinctual satisfaction was tied to the misuse of power.

In contrast to this transference constellation and after intensively working through his difficulties, he described dreams in which a more realistic positive transference was expressed. In them I was pictured as a teacher patiently instructing his pupils. Predominant was, however, a homosexual transference with a rapid alteration of the feminine and masculine roles.

In contrast to the problems in the therapeutic relationship, the patient described his increasing satisfaction with his daily life. His capacity to work was raised by his greater sense of balance, and he successfully asserted himself against his boss. He noticed a reduction in his inhibitions toward women, and there was also an improvement in the disturbance of his potency.

Following this the patient started acting out sexually, which continued for a lengthy period of time and gradually assumed significance in transference. He began an erotic relationship to a girl who came to clean his house several times a week; this secret relationship was limited to extensive caressing, which as a rule ended in an ejaculation without emission. One purpose of this acting out, in addition to other unconscious meanings, was to relieve the burden from the homosexual transference with me. If the latter increased, the patient missed a session and excused himself subsequently, saying that he had been able to spend the hour alone with the girl at home.

During this period the homosexual transference always manifested itself as something that pursued the patient and that he attempted to resist. The repetition of these fantasies and their intensity led me to infer there was a strong fixation in the negative phase of the oedipus complex, which because of the traumatic experiences in puberty could not develop into a positive identification with his father.

In order to give the patient more support in overcoming the confusion of his identity, I changed my strategy of interpretation by contrasting the present, realistic aspects of our relationship with the positive and aggressive pregenital repetitions. My goal was to overcome

the eroticization that the patient sought. I now realized that frequently precisely those interpretations that especially moved him satisfied his homosexual fantasy. After interruptions the patient had unconsciously awaited the moments in which his father seduced him after returning home (he was only home for some 3-4 months a year on average). We had been moving in a vicious circle for far too long. We were an analytic couple in which the patient, with his dreams and associations, stimulated my interpretive work, the latter both satisfying him and also making him feel violated—a sadomasochistic circle. Whatever I said was to him a confirmation of my homosexual interest in him. When I realized this, I began to exercise more restraint and attempted to interrupt this vicious circle by frequently remaining silent.

After we had discussed this problem repeatedly, the patient described the following dream in the 385th session: "I wanted to pick up an important document in an office or maybe the results of a test in a doctor's office. I was surprised to discover it was a lawyer's office, and it a document from a court. I was surprised again because in reality it was the police headquarters. The chief submitted me to a rigorous interrogation while at the same time caressing me very tenderly. I ran outside and took a bus to get home, only to notice that by quickly getting in the rear door I had taken the wrong bus and was riding in the wrong direction."

The combination of the patient's associations and my considerations enabled me to make the interpretation that he had come to analysis looking for an attorney who was supposed to protect him from his father who seduced him and from his mother who made him feel disturbed. In the course of his analysis it had become increasingly difficult for him to distinguish between his new experiences with me and his childhood relationship to his parents. He claimed this was due to the fact that something which was completely hidden was being repeated in the present relationship and that it was very satisfying. Then for the first time in the analysis I called his father a homosexual and an alcoholic, which made him feel very disturbed and led him to recall a dream he had recently had. He saw a door that had many rusty padlocks and that definitely had not been opened for a long time. He associated a room used for storing bottled gas. I explained to him that he had just told me that it was difficult for him to open the door to his memory for me and thus to be frank about what had happened with his father because he was afraid of its very explosive contents. He then mentioned his immense shame and his

anxiety about revealing to me his homosexual wishes and fantasies. The analysis had been going in the wrong direction because the "back" door had been *confused* with the "front" door, just as I had been with his father.

Commentary. We have emphasized the word "confused" in the analyst's report because it marks the turning point described in more detail in the following summary of the treatment. By distancing himself from the patient's perverse father and seducing parents, the analyst had distinguished himself through an act of judgment, which presumably clarified the confusion that had resulted from the traumatic experience and that apparently had not diminished as a result of the interpretation of the continued homosexual transference. The patient took the interpretations all too literally, at face value, presumably obtaining numerous satisfactions and both expecting and, probably, fearing that his relationship with the analyst would end the same way as that with his father. Yet the analyst had apparently passed his test, finally convincingly separating himself from the father. The effect of such clarifying assurances should not be underestimated. It is necessary to establish a position outside the repetitions to overcome such confusion. With regard to such *confusion* we recommend that readers turn to Sect. 9.3.2, where we cite a patient's criticism of an interpretive technique that failed to put the patient's new experiences with the analyst and the repetition into a balanced relationship and thus to interrupt the repetition.

The actual incestuous and homosexual abuse of children is the cause of serious traumatic experiences because it transgresses limits whose purpose is to guarantee autonomy. Such security is required for human desires and fantasies to develop, in order for children to be able to distinguish between inside and outside within the many layers of social reality. The sexual abuse of children by their own parents or other adults destroys this space, which is taboo for many good reasons. Oedipal and incestuous wishes and fantasies obtain their deep anthropological significance precisely from this taboo, i.e., from incest actually not occurring. Otherwise a hopeless confusion of the generations results which has catastrophic effects on the formation of the identity of the children and adolescents. As this case history demonstrates, a deep insecurity

seems to remain after homosexual seductions or after father-daughter or mother-son incest. Afterwards everything seems possible. Real incestuous experiences undermine the child's confidence in a fundamental manner (see MacFarlane et al. 1986; Walker 1988).

Consideration. The dynamic of the session described above deserves to be emphasized because it was under its impact that I changed my therapeutic technique. In retrospect I believe that this change was not only the result of my reflection but also the result of a genuine working through by the patient, which took place parallel to the homosexual transference described above. My interpretation that Peter Y confused me with his father in transference emphasized the aspect of repetition or, in other words, the distortion that the transference caused because of its roots in the past. Yet I had the feeling that I had in some way contributed to the development of this transference constellation. The second interpretation emphasized the plausibility of the patient's perception in the sense elaborated by Gill and Hoffmann (1982), not the distortion.

In hindsight I believe that I could have stated much earlier or more clearly how this repetition in transference developed. In any case, the consequence of the emphasis I put on the difference was that from this moment on the patient's healthy features started playing a predominant role in overcoming the trauma. The fact that I showed myself to be a real person distinct from his homosexual father formed the basis of my attempt to interrupt the circular projective and introjective identification.

Commentary. The issue here is a fundamental one, namely how a psychoanalyst fulfills his functions to enable the patient to achieve change and to overcome traumatic experiences. In transference, repetition is one side of the coin and is labeled "similarity." In this sense it is completely plausible, accurate, and realistic that this patient experienced the analyst's efforts to gain influence as being intrusive or seductive. The other side of the coin is that the word "differences" must be taken seriously. It is not the discovery of *similarities* that leads out of repetition, it is the experience of *differences*. As we mentioned with regard to the confusion, this problem affects all of psychoanalysis and is not limited to one school. In the Kleinian school, the

question of how new experiences lead to change, i.e., interrupt the circular processes of projective and introjective identification, was neglected for a long time. It is obvious that the therapeutic effect of a psychoanalysis does not consist in repeating traumatic experiences and creating circular repetition in transference, but in interrupting them.

Catharsis

The information literally gushed out of Peter Y during a short period encompassing four sessions (the 341st to 344th), when he, in great turmoil, described the sexual episodes he had had with his father. This was the first time he had mentioned his great longing for his father while he had been gone and how he had been happy about his return. He described how his father began to drink and became merry, how the tender touching began and the excitement mounted, which ended with the father kneeing in front of his son and sucking his penis until ejaculation. He described his conflicting feelings: the sexual desire, but also the anxiety, shame, the strong feeling of triumph upon ejaculating into his father's mouth, his later sensation of guilt, and his feeling of domination over his father. This report was very emotional, in complete contrast to the obsessive style characterizing the initial interviews. After this catharsis it became clear to me that the conscious recollections of these episodes that he had previously related were devoid of any and all feelings. He told how he, following an unspoken agreement with his father, had kept these events a secret from his mother and decided after two years to end the episodes because he was feeling more and more insecure. He had the support of his priest. It then became clear to the patient that his image of an aggressive and actively seductive father was incomplete. He realized that his father was weak and an alcoholic and that he had established a secret collusion with him to their mutual satisfaction.

Overcoming Traumatic Experiences

The catharsis paralleled the patient's distancing from his father, which could also be seen in the changed nature of transference. Especially impressive was the fact that Peter Y managed to develop a relationship to his son that was free of anxiety. His new experiences in therapy made it easier for him to assume paternal responsibilities and to empathize with his son. He

tried to find out how he had wanted his father to be. The eroticization decreased, and his capacity for reflection—self-analysis—increased. The patient acknowledged my work and accepted what he had learned in analysis as something new. The sessions became calmer, and the patient reported fewer dreams. As a matter of course, I made fewer comments and interpretations. The patient also acknowledged his homosexual longing for his father, which stayed very strong for a long time, yet understood it was a substitute satisfaction and compensation for the lack of things that father and son had in common, with the accompanying depressive reactions.

The following dream was from this period:

P: I was walking on a street. An older gentleman was walking toward me, taking up all the space, so that I had to step off the sidewalk. I was carrying a gigantic, very long roll of wrapping paper under my arm. I walked further and noticed that somebody was trying to take it away from me from behind, and it was getting difficult to hold on. It was the older man who was bothering me from behind. I went into a house, opened the roll of paper, and saw a giant Christmas tree with every imaginable decoration and kind of lights. It was lovely and very impressive. The room that I was in had a small window to an adjacent room. I could see a couch and a man, apparently dead, lying on it. I was afraid. I took a closer look and noticed that he wasn't dead, but very ill; he was hardly breathing. I calmed down. I went even closer and saw that it was me. In the back portion of the room there was a priest who was holding mass from a very cluttered baroque altar. He was wearing a richly decorated cassock. There was a giant clock on the wall above the couch. It was a kind of cuckoo clock, and from time to time figures—wooden puppets like Pinocchio—came out, including bishops and generals, who made ridiculous gestures of submission, bowing and showing their reverence. I thought it was repulsive.

By analyzing the dream it was possible for us to approach the patient's inner, live core; he was still breathing although he was almost dead and inhibited by the roles he had adopted. Almost all of his associations to this part of the dream belonged to the topic that Winnicott referred to as the "false self" and that had become the patient's second nature. In the dream he

had also submitted to me, the analyst. In my opinion this dream was very useful in terms of a reconstruction, yet it seemed especially interesting to me because of its significance as an indicator of the psychoanalytic process. The history of the patient's therapy was recorded in the layers of the dream. Three parts can be distinguished in the dream. The first part presented the period of the analysis in which the patient felt disturbed by the interpretations; he felt they were an attempt to destroy his phallus from behind. In the second part the patient unfolded, at a deeper level (inside the house), his triumphant narcissism. This probably corresponded to the period in which he found satisfaction in transference as well as to the period in which he discovered the little window—the significance of analysis for him—which offered him access to a part of his self. This part was repressed and contained an "inner world" of identifications that had been grafted on and of religious idealizations; at the same time it was also the seat of his more lively qualities. Especially interesting here was that in the part corresponding to the third area of the dream, in which even deeper inner features were expressed, the analyst was represented by a cuckoo clock that gave the time and expressed, one after another, the various roles that the patient had played in the course of therapy.

Peter Y reported a decrease in the enduring sexual arousal that used to plague him. The frequency of his compulsive masturbation also decreased and was limited to weekends and other interruptions of therapy.

Commentary. In the course of therapy the patient's attempts to cope with his traumatic experiences and to change from being passive to being active became more and more successful. Freud's understanding of this essential component of the effectiveness of analysis, which we referred to at the beginning of this section, can also be expressed in the theory of projective and introjective identification if the latter are taken to represent communication and interaction. The turning point in the case presented here was characterized by the joint discovery of patient and analyst that both the contents of the interpretation and the act of interpretation itself had unnoticed and unfavorable side effects. The confusion was facilitated by the analyst's therapeutic technique, and the patient experienced the therapeutic relationship from the perspective of his traumatic experiences with his father. The patient managed to make new experiences after this

"confusion" had been clarified. After two years of seducing each other and letting oneself be seduced, the analyst was finally in a position to understand the meaning of the repetition of the trauma in the analytic relationship. The work in this time provided not only indirect satisfactions via the partial repetition in transference, but also prepared the way for a catharsis and for the patient's working through.

8.5.2 Denial of Castration Anxiety

After having hesitated for two years, Arthur Y decided to enlarge the region he covered as a salesman by expanding into an area that a colleague had neglected for a long time. The lack of contact to customers in this area had caused the sales there to be far below average. Arthur Y was convinced that it would be possible to increase the sales in this region several times over without any great effort. Despite the general dissatisfaction with the easy going—even lazy—colleague, who was also a drinker and had become a burden to the company, Arthur Y had hesitated for a long time to make a decision about enlarging his sales area. Pity and his scruples had kept him from taking action and blocked his ability to consider whether there were any solutions that might not harm or even ruin his colleague's career. His unconscious identification of expansion with sadistic destruction and his immediate shift to masochistic identification with the victim had long been in balance and kept the patient from being able to expand his field of operations or to become more successful. This sophisticated man had, for the same reason, also not been able to find an acceptable solution that satisfied his motto of live and let live.

The interpretive support I provided, which was directed at his unconscious equating of expansion and destruction, had enabled Arthur Y to become more successful and to overcome his inhibitions about enlarging his sales region, which he did without inflicting any substantial harm on his colleague. He had found a good compromise.

P: I don't feel anxious any more about getting ahead with this matter. It's connected with being potent, in the widest sense of the word. I have the suspicion that there are different ways of showing potency. One way to be potent is, after all, to be successful in an area where

another failed. Am I making some kind of a shift? Then I could withdraw sexually even more from my wife. Nobody could be mad at me. Most importantly I'm the devoted father doing everything for my family.

A: The fact that everything is to the benefit of your family is a relief to you. Couldn't you get more sexual pleasure? Maybe something inside you—your ideas about purity and the boundaries of shame that you feel automatically—constitutes inhibitions keeping you from having pleasure.

P: That's the problem, namely that I'm really quite happy the way things are. I'm doing quite well, and therefore it's not worthwhile to tackle this issue. Who knows—I have the feeling-what's going to come and cause me to get all worried. I much prefer, a thousand times over, having my inner, emotional peace and quiet. I'm happy and satisfied and take pleasure from success, perhaps less pleasure from sex than may be theoretically possible, better than—I simply have some reservations—than letting everything get started again. I don't want to be exposed to the danger of emotionally falling as low as I was a couple of years ago. If I could choose to have a realistic increase in pleasure from sex combined with returning to my earlier state of anxiety, then I prefer things the way they are a thousand times over. Yes, I'm very shy about getting involved.

A: Why are you worried that things could become the way they were several years ago, that you could fall so low, that sex is a source of such distress, of more distress than pleasure?

P: In commercial terms, that I'd be making a bad deal in order to make a theoretically better one, which I don't really want because things are fine the way they are. That I'd be taking an uncalculated risk.

The thought of the risk made the patient go silent. He remained silent for several minutes until I continued:

A: So it's clear that you fear the distress of making a bad deal. The possibility of having more joy and pleasure is just theory.

The patient then made a comparison.

P: I'm sitting in a restaurant and eating a good meal. Somebody comes over and says he's a surgeon and that if I let him operate on me, he would operate on my tongue and put it in a bit differently, giving me more pleasure from eating. The operation is connected with the risk that my tongue might not grow on correctly and there might be terrible complications.

A: There are all sorts of terrible consequences one could think of if your tongue wouldn't grow on. This image is a radical expression of your distress, and I'm the restaurant's manager.

P: No, the surgeon.

Consideration. I obviously treated everything as if it were less serious because of a reactivation of my own castration anxieties. The surgeon, and not the manager, was obviously the source of danger. Although I immediately became aware of this, later in the session I again played down the danger of a threat, using the word "snack" to refer to the witch's cannibalism in Hansel and Gretel.

A: Oh, yes, the surgeon, not the manager. I was thinking about the restaurant manager.

P: No, the manager is completely neutral; he just provides a good meal.

A: So the surgeon. Then it's understandable that you're hesitating. There's good reason. The surgeon who made this proposal.

P: It's not that far-fetched. I been through it dozens of times, for instance with Professor Z. I was having problems with my knee, and he seriously proposed cutting out bits of the bone because I'm slightly bowlegged and letting them grow back together straight, removing the bowleggedness and my problems. In the meantime I have hiked through all of Germany—without the operation. And Professor Z is a famous orthopedic surgeon. I just wanted to say that the comparison of the operation and my tongue isn't so far-fetched after all.

A: Yes, the comparison is very accurate. It's not far-fetched at all. Your comparison is even much better because it's linked with other things, with all the threats that were not directed at your tongue even though people talk about having a sharp tongue, but instead with the punishments affecting the organ of pleasure, namely your penis. Everything that might happen, all the stories . . . anxieties about contagious illnesses, injuries after masturbation, and other such things, with X and Y and others [references to several persons from his childhood and adolescence].

P: I just observed something interesting on me. While you were mentioning this list, the thought went through my mind that I hadn't been told what some parents tell their sons, namely that if they grab down there then it will get very big and then it will be cut off. I thought of this example, and while I thought about it, my recollection changed. I'm completely sure now that my grandmother said something of the sort to me. It's resurfaced in my memory.

A: Your momentary experiencing might be involved, so that you first established some distance by saying that it hadn't happened to me. First you negated it. First you established some distance to it, and now you are much closer to it.

Commentary. It is instructive that Arthur Y was able to recall this forgotten disturbance and threat with the help of distancing, i.e., a lessening of his anxiety. He may have adopted this tactic from the analyst without noticing it. The analyst had first, because of a countertransference, minimized the dangers in order to be able to later acknowledge them.

P: Parents use the threat to make their children afraid. Is it still being used? [Analyst confirmed.] Yes, it's nonsense. It puts a boy in a dilemma if he takes everything seriously. On the highway just now I was driving behind a truck filled with pigs. One pig stuck its snout out the back, and I thought, "You poor pig, you don't have a chance to escape." The difference to humans is that the poor pig wasn't aware of what was coming. It may have been afraid, but it didn't know where the truck was going. A pig's emotional life is probably different from a human's. The pig's hopeless situation reminded me of certain situations in my own life where I felt the same way. I was worse off than the pig, because it doesn't know

what's coming.

A: You were worse off, but you also had another chance, by saying just a moment ago that people tell such stories but that you were never involved. First you denied something disturbing, to save your snout, your tail, your penis—"I'm not involved." And then, after you achieved some security, then it became possible, I think, for you to consider it conceivable or probable that it might have happened to you, too. The denial lessened the anxiety, just like your knowledge that your penis is still there. That's one part of your memory, that it gets big, and pleasure is the reason you get punished.

Commentary. This exchange is exemplary, with regard to both therapeutic technique and the theory describing how anxiety originates and can be overcome. An individual's anxiety is linked with fantasies, which is the reason that all neurotic anxieties, by definition, originate as expectations. It also creates space for protection and defense mechanisms, which is the object of the analyst's interpretation that proceeds from the security the patient had gained. Starting from a secure position, it was thus possible for the patient to cope with his anxiety because he knew he had rescued his penis.

P: Yes, when a child's penis gets hard, he can't hide it if his pajamas reveal its shape or if he is half naked.

A: Or the morning erection, which is a natural phenomenon, the "water stiffness," which is linked with the urge to urinate.

P: I've just thought of something else. I can remember it very precisely. When I was a young boy, maybe 4 or 5 years old, I wore shorts and had the habit of reaching up my pants' leg. There was a picture of me, a snapshot that showed me with a small girl in a sand box. The picture was enlarged and put up on the wall. I can still hear my grandmother say, "Look there, so that's how you do it. You have to stop doing that, otherwise . . . ."

I'm not as sure about my memory of her saying that as I am about my doing it and about the photograph that was on the wall. I don't know if it was right for the picture to be

enlarged and put up. It disappeared long ago, but I can still see it hanging there. And there are a lot of feelings attached to the picture and my memories of my grandmother. It would be better not to have to talk about it because I don't want to have to go through these years again.

A: These bad memories are very closely tied to pleasure. You can't imagine that pleasure could be separated from the inhibitions and anxieties. The anxieties connected with the touching seem to come back first, before the pleasure. If your wife wants more from you, if she desires you, then it is closely linked with distress and danger, and then you experience your wife both as a little girl and as your grandmother, who turns into a witch. When your penis gets too big, then it is chopped off. Just like with Hansel and Gretel, only there it was a finger, a fat finger.

P: Yes, I know, people attempt to interpret so much into these fairy tales. Why can't the fairy tales be left for what they are?

A: Yes, of course.

Commentary. The analyst agreed with the patient, and probably precisely for this reason the patient did not cooperate in playing down the danger.

P: [After a long period of silence] It's completely logical. Hansel is locked in the cage and gets a lot to eat and gets fatter, and the witch can tell from his finger. Very fat people have very chubby fingers. It can be left at that. And then we're back at the beginning again. Everything can be left the way it is.

A: Yes, leave everything the way it is to avoid being exposed to the danger depicted in the fairy tale, namely exposed to the danger of becoming the witch's snack.

P: Yes, but snack makes it sound too pleasant.

A: Yes, I just played down the danger and that is surely inappropriate. But the consequence was, after all, that you were able to make it clear how horrible it was. You emphasized that

everything should be left as it is. Yet part of the story is how Hansel and Gretel deceived the witch about the fattened finger.

P: Yes, by sticking out a thin stick.

A: Yes, it was dangerous. And you hid your penis. Maybe you've continued hiding like this by hiding from your wife and from yourself, too. And then there's less pleasure. There is an automatic inhibition.

At the start of the next session Arthur Y was silent.

P: It took a while for me to make the transition. It's a completely different world in here. I read a newspaper article a few days ago. Just by chance I glanced at a picture of a fox in a trap; its paw was caught in it. The article was about the cruelty of the devices used to catch animals. Many of them end in a wretched way, and hunters use the innocent word "trapping" to describe this cruelty. "Trapping." Even while I was reading, I thought that this story was going to make me worry a lot. I can sense the feelings again that I thought I had long overcome. Now I feel immensely better, and for a long time I've meant to ask how safe I am against having a relapse, a word I don't like. The word brings back all the misery that I played down in my memory, in my experiencing. The feeling of despair comes back immediately.

A: I don't think it's a coincidence that you're asking about it. You can certainly recall how miserable it was to be the prisoner, just like the fox who is a victim. I think your distress is connected with the topic of our previous session. You are worried that I will set a trap for you, and pose a danger to you if you become more involved in sex. You described a horrible image about a tongue that's operated on, cut off, and doesn't grow back together right.

The patient claimed he had "forgotten" the entire scene and asked "Was it a dream? No." I reminded him of his fantasy about his tongue that was operated on and sewed on incorrectly or would not grow together at all. The patient recalled the surgeon, but the object, the part of

the body that was to be operated on was completely gone.

A: There is a terrible danger, and I believe that the story about trapper, who enticed you to leave your hiding place, continues this topic.

The patient reminded me that I had played down the danger to Hansel in the fairy tale.

Commentary. We would like to draw the reader's attention to the unconscious defense processes that can be deduced from omissions and displacements. The organ, the penis or its substitute (the tongue), was omitted. It remained vague what the intentions of the surgeon were. The action was interrupted. The patient was then able to recognize the playing down with reference to the analyst and, by means of this objectification, to cope with it.

The analyst interpreted the closing of the trap as a symbol of his castration anxiety. The scenes from the last session were repeated, including especially the denial and the function of distancing himself from his anxieties. The patient spoke once more about the photograph, which probably served to constantly show him what he was not supposed to do.

P: Yes, that's the way it is after being liberated from anxieties and compulsions. Yesterday I visited my new region, and there are some very scenic spots. I particularly liked one hotel, which I've noted down as a place to stay on future business trips. Earlier I would never have had the idea of stopping at such an establishment. Yet I'd like to bracket out the sex. I would really prefer to act as if it weren't there. I even avoid my wife when I feel that she's going to make an advance.

A: I presume you avoid a number of things and then don't have the pleasure that might be possible.

P: Yes, I would like to do without desire.

A: You aren't committing yourself to a new sacrifice. It's more like with a salamander; people say salamanders lose their tails when they are in danger. You've created a sense of security

like the salamander's, who's gotten past the dangers. You express your concern that there might be more desire. To me your concern that symptoms might return if you had more desires is an indication that there are a number of things still latent within you.

P: Yes, and that's the reason that I mentioned sex. Otherwise I would simply accept the restrictions.

A: Your wife is your reminder. What does she remind you of? A distressing seduction?

P: No, of a demand that I can't meet. To me it's an unreasonable demand, a . . . [long silence]. I have the fewest inhibitions after I've drunk some alcohol.

The patient came to speak of the proximity of the sexual organs to the organs of defecation. This was how he explained his shyness.

A: You're reminded more of the shameful and humiliating situations, of how you dirtied your pants every day, not of the relieving expelling, but of the humiliations.

The patient had the idea that the cleansing really had to be done in advance and prevent spontaneous desire. "Complete lack of desire is the best protection against every kind of sexual involvement and the distress that comes from it." Precisely in marital intercourse, which is not inhibited by any restrictions, complications, or conflicts and in which sex has been quasi-legalized, his inner warning lamps lit up particularly strongly. This comment convinced the patient that he had internalized conflicts and anxieties of his childhood and that they now began showing their effects, even though he knew better. In their otherwise happy marriage, intercourse was a disturbance and premature ejaculation or anxiety about impotence were frequent, although his merry wife gave him encouragement and he himself did not have any conscious scruples. Yet he could not do anything against his revulsion and shame. The patient summarized his concern in the words, "Whoever gets himself in danger dies as a result."

8.5.3 Splitting of Transference

The purpose of transference splitting is frequently to find suitable objects for desired identifications. At the same time, this splitting can also result from a defensive goal, namely to keep identifications from occurring or being stabilized by rapidly switching from one object to another.

Recently Clara X had made up a story about a hermit who lived on a mountain and who was supplied with the goods he needed by a woman who lived in the valley. To get some relief, this woman had frequently sent a younger girl up to the hermit. The patient represented herself in this "coveted" creation.

The patient talked about this story and the hermit with a friend she spent an evening with. They departed, wishing each other sweet dreams. Laughing, she told me that she really had dreamed about something beautiful. The next morning she had not been able to remember the dream immediately. Bit by bit the patient developed the following dream image:

P: It was a big family reunion. You were there, and for sure my previous therapist, Mrs. Z. There were a lot of people there with whom I'm acquainted and who I somehow feel to be my spiritual family. And my real brother was there. All of us wanted to fly to my home town by helicopter, to visit my parents. We waited for the helicopter for quite a while, but since we weren't in a rush I managed to have a pleasant conversation. We traveled together, and there was plenty of time to talk. I also talked with you; we were standing at the window and looking out. You were to my left, and the character of our conversation was different than here—a little more ironic, a little more playful, with lots of allusions. My father would have said teasing. You came a little closer and nudged my shoulder, just like my father could have done. Trying to turn me on, in a friendly way, but perhaps also a little pushy, like children can be when they try to push each other off the road in a game.

In response to my questions, the patient provided additional information to her dream report, especially regarding the meaning of the phrase "turn on." The patient emphasized the

friendly nature of this contact, yet it also contained an implication of aggression. The patient knew the colloquial connotations of the word, but in the dream it was not disturbing. She recalled her dealings with boys during puberty, which in hindsight did not seem repulsive, bad-mannered, or unpleasant, and she said literally, "That is one of the levels accessible to me, just like earlier when I roused myself to look for contact with boys my age. I wasn't able to make eyes at them or to flirt. Whenever it was possible I attempted to make body contact in some tomboyish way by suggesting some small game." Then she turned to speak about her husband. "I'm always on the lookout for some wonder weapon to draw my husband out of his reserve."

I established a connection between the past and the present by pointing out that her old and her new families were together and visited her home town. Clara X said jokingly that it showed how much of a family person she was.

P: I really like being right in the middle of things. It's a feeling that I don't have in my current family, I mean with my husband and child; I don't feel secure and protected. I can feel a strong centrifugal force, but also the compulsion, a coercion, that I'd better stay there. There's an immense tension between the two forces. In the dream I thought I was at the right spot. On the other hand, in the last few days I've recalled how the funny story about the hermit continued. Well, the coveted girl went up to the hermit, hugged him, looked at him, and said, "What should we do now?" At this the hermit stood up and excused himself. "I can understand what you mean, but unfortunately I can't help you at the moment. I've just realized that I have missed a lot in the last twenty years." He then left his mountain and moved into the old woman's hut. The young girl turned right around, went home, and found herself a lover from the neighborhood and spent the night with him. The next day she walked up the mountain and set fire to the hermit's hut, burning it to the ground. You might say, well, he doesn't need it any more.

I made a reference particularly to the young girl's hurt feelings. The patient responded that this was the reason she quickly looked for someone else, but wasn't satisfied with the substitute. He was simply a substitute. I then interpreted the transference aspects of the story.

A: It seems logical to assume that you've portrayed me as the hermit and your earlier therapist as the old woman who had sent the hermit supplies for years, and your therapist did have her office on a mountain.

In making this interpretation I had not taken into consideration the fact that the patient definitely did not view her earlier therapist as an older woman, but identified with her and through this identification had fantasized a positive outcome of the oedipal rivalry. A friend of the patient's said that it was possible that the hermit would accept the young girl's offer and she would move into his hut.

P: "And what would the old woman do now?" my girlfriend asked. I just laughed, and without thinking about it promptly said that she would get rheumatism. I was absolutely certain that the older woman would later suffer from this chronic illness, and only afterward did I remember that my mother had actually suffered from rheumatism for years. In that moment it was clear to me that my mother was the older woman, the way that I saw her or the way she presented herself to me. "I sacrificed twenty years of my life and put off my own goals and desires, and then my own daughter threatens to have a fling with the man I took care of, the hermit." Yet my mother would never have been able to aggressively have her own way.

I then focused on the issue of aggressive rivalry, especially with regard to her own inhibitions that resulted from her sympathy from her mother. As a consequence of them, she was not able to openly express her own qualities of a young girl. The patient in fact felt inferior to her own daughter. She summarized her situation in very moving terms.

P: Yes, in the story I'm both persons, first the old woman and then the young girl, and even today I don't know for sure who I really am.

A: You looked for a solution that could lead you out of your dilemma, namely not to be either one and instead be a tomboy, or spiny, or covered by a shell like a turtle.

P: Yes, I decided not to be a woman. I considered it the best solution for the entire family for

me to step back and stay there.

I pointed out to Clara X that her girlfriend had encouraged her to have a beautiful and exciting dream and had given her the advice to enjoy something before falling asleep. "Yes, she approved of my consumption of candy." We then went on to talk about the table manners at her girlfriend's and at her own house, especially about the difficulties of coordinating the needs of the children with those of the adults. (One of the patient's symptoms was that she secretly ate candy at night and, as she herself said, had shifted the satisfaction of her needs in that direction.)

In connection with the patient's dream the topic shifted to the question of how difficult it was to create a prosperous, cozy, and enjoyable atmosphere at home and that this difficult task should not be left entirely to the wife and mother. The patient went on to complain about her husband, who rejected her requests that the two of them eat out or go out alone some time. She was most able to enjoy herself, aside from her displacement to nighttime, when she was together with her girlfriends. Excusing herself for using the fashionable word "frustration," the patient complained the denial was not her greatest source of despair, which was rather the fact that her husband or men in general complained that everything was her fault. She vigorously complained about her husband's lack of understanding, and that he said her problem was responsible for everything; on the other hand, he was unwilling to contribute anything toward uniting their divergent interests.

While acknowledging the real difficulties, I pointed out that she had required a long time to be able to admit her own needs and that there might still be many ways to convince her husband—just like the hermit—that he should try a different approach. At the end of the session the patient despondently remained convinced that everything was in vain. She said her husband simply took her to be a monster and something unnatural, and that she therefore wanted to at least free herself from constantly feeling guilty and for being ashamed of her own failures.

It was obvious that this name calling had hardened the attitudes of the patient and her

husband, and that they were becoming increasingly alienated from each other. Just as obvious was that the patient obtained relief by attacking her husband, who for his part considered her to be all the more a monster. In a concluding interpretation of the transference I emphasized that everyone was involved in determining how much room for maneuvering there was, both in the primary family and in the fictitious one (the analytic family, i.e., her relationship to her female and male therapists). In the story about the hermit she had made the discovery that he too was not immune to her wooing.

In the next session the patient referred back to her dream.

P: In the last session you said something that was very important to me. I mean that I felt pity toward the old woman. I had said that the woman got rheumatism. Yet I experienced her like I did my mother, who sacrificed herself for her family for twenty years, denying her own desires and longings. At the same time, as her daughter I felt so attached to her that I did not want to struggle against her. Or how should I say, well, I would have felt it unfair and mean for me to puff myself up and force her out of the nest. Then you said something along the line that this was the reason it was particularly difficult for me to accept the competition with my daughter. I want to ask once more whether you really think that we're competing. I see it that way, but I can't help thinking that it's completely ridiculous. And yet it always comes back.

Clara X gave a, as she described it, ridiculous and banal example of how she had become upset at her daughter's being proud of being able to get dressed faster than she could.

I reminded her of the solution to her conflict that she had arrived at out of sympathy—her compromise to be neither the one nor the other but to have found a third way, the nonfeminine and tomboyish way.

P: That's right, but it's a step too fast. It's tremendously important to me for somebody to understand me. Even that would help me to be a bit more gentle in the ridiculous struggle that I have each day with my daughter. How much is innocence and how much doe she do on purpose? It's extremely difficult for me to separate reality and what I notoriously do

wrong. Is it always like that?

A: Do you mean the rivalry between mothers and daughters?

P: Yes, it sounds brutal. Worst of all is the firm belief that it just can't be, for God's sake. Out in the open everything is very harmonic, but under the table we can't stop kicking each other in the shins.

A: Yes, in the open you can't compete and be rivals. You're struggling for having and possessing and out of envy. This envy is one side of your rivalry. Another is who is faster at making themselves pretty.

P: Yes, as an adult I have so many more possibilities, much more room to decide. Yet, on the other hand, I view everything as if I had a much worse starting position and had to give her a powerful shove; but then I feel sorry again. It's probably related to the fact that when I was young I actually trained myself to do without and limit myself. This was a good approach at home, to be neither the one nor the other, not to oppose my mother but to stay a step behind her and to behave like a tomboy. In this way I got quite a bit of approval from my father. He approved of having such an uncivilized son, half a son. In some hidden way I was thus able to get his support and interest. He probably would not have been able to do much with a vain, pretty little daughter; so it was a fantastic solution for me, and I was very good at learning to act that way. So I'm not too amazed that I can't get any further.

Stimulated by a letter from her brother, the patient then turned to the question of female creativity. Her brother had touched on it, mentioning in passing that he had frequently fantasized about what it would be like to be a woman. Clara X said it was probably the opposite of a woman's wish to play the male's sexual role once and was quite natural. Yet what common family experiences were involved?

P: I assume that he made the same observations I did, just from the perspective of a son. I mean, my brother suffered from the fact that our mother viewed herself to be a victim, as if

there was no joy in life. As if she could not have done anything but spend decades taking care of the hermit.

The patient sighed and then noted questioningly that I had related myself to Ms. Z, her previous analyst, in the last session.

A: Both of us were depicted in the dream. Yes, Ms. Z lived here on the mountain for years. Of course, it's not clear what the relationship was, whether it was out in the open or out of sight.

P: To me it looked different. I don't consider Ms. Z to be an older woman but a young woman who is independent in every regard. She was here but then became independent. She did not take the sacrificial route like the old woman did; no, on the contrary, she is happy go lucky, like a snotty little brat.

Clara X identified with her previous analyst, who had made her own way. She related details from correspondence with her, one of which was about a painting by a Pre- Raphaelite depicting the Annunciation (see Sect. 2.4.7). The painting was shown in a book on "the crazy sex." Immaculate conception is a hot subject for people who, like the patient, want to avoid sexuality.

P: I thought that it couldn't be true. Mary, her entire body and facial features were those of a young girl suffering from anorexia and she stared with an astonished look into the future that had been imposed on her. "Help, I'm supposed to be a mother. I don't want to, not at all." Fear and anxiety. When I wrote to Ms. Z that I wanted to draw this picture, she wrote back asking why I didn't draw a different figure, one of a woman sitting in bed and looking into the future and exuding confidence. Well, for the first I stopped drawing.

A: Yes, you could draw your future and your picture as you wish. Things don't have to continue as they are forever.

P: My husband is still deeply resigned to it.

The patient described her attempts get closer to him and also how strongly she was still dominated by a subliminal aggression. The session ended with a story she told about a couple getting together and trying to make their feelings fit together. This showed that the transference was centralized after all.

8.5.4 Mother Fixation

Heinrich Y was a 35-year-old man who had suffered since late adolescence from depression, which severely incapacitated him. It had led him to undergo a four-year supportive psychotherapy while a student. Most closely tied to his mother, Heinrich Y was a bachelor living in his parent's house. He largely denied having a positive image of his father. Although he had lived in another city for several years while attending a university, it was only at home and from his mother that he found the complete care and attention that he demanded.

Heinrich Y was the fourth of five children and in his opinion had always been the least favored. Distinct inferiority feelings had even overshadowed his childhood and puberty. From his comments about his earlier therapy I concluded that he had been able to find security and support from the directive technique employed by the older and religious female psychotherapist. As also demonstrated by the present report, his ambivalence remained suppressed.

At the time of our therapy, the patient was again living with his bigoted mother, who admired him, took care of him, and also controlled him by helping him to plan his dates with women. She patiently bore his repeated outbreaks of depression. The stable character of this neurotic living arrangement could also be seen in the fact that a colleague had expressly told him a few years before that psychotherapy was essential. An offer of analysis at that time had foundered on his ambivalence. The patient had instead had hypnosis and homeopathic cures, each of which had satisfied his passive expectations and had effects that were short-term in nature.

The ups and downs of his moods were closely associated with admiration and

confirmation; if the latter were lacking, his mood was in danger of switching to depression. The fixated behavior he displayed toward his mother provided him security; he was always able to obtain her attention and care. His conscious motives for living in his parent's house were both laziness and the opportunity to repeat his chronic complaints against his father. Because of his pronounced hypochondriac nature, he forced his mother to base their daily meals on the particular color of his morning bowel movement.

His contacts outside his family were limited, being restricted to people who had to satisfy specific desires. They were primarily women with whom he enjoyed recreational activities; he rejected any further-reaching claims they might make. At the same time he was looking for the "woman of his life," one who united all the desirable features spread among his various contacts. He had professional contacts to men, but shied away from permitting closer friendships to develop.

The crisis that led him to seek treatment was precipitated by his anxiety that he might have made a girlfriend pregnant and be held responsible. His initial attitude was characterized by great insecurity and distrust, which went so far that he refused to pay for therapy. After several months I managed to overcome his doubts to the extent that the external conditions for an analysis were finally established.

Several months into therapy (86th session) Heinrich Y referred to the factors that had radically changed his life recently. He mentioned, among other things, his relationship to his analyst. Since he had met me, he had for the first time had the feeling that somebody was there for him, that he was welcome, and that he could speak. This praise contained an element of anxiety that his warm feelings might have something to do with homosexuality.

At first I calmed him, saying that trust and homosexuality were two completely different things. My motive was to emphasize the differences in order to be able to better expose his unconscious identifications. My plan worked. He said he was afraid that things might go further. "I can't give you a hug," something he would have liked to have down at the beginning of the session. He said this development had started about Easter, i.e., a number of weeks before,

when after a vacation break he came to the first session with the feeling of going to his lover.

I had noticed the increase in his positive feelings in the past weeks, but had not interpreted them. I now suggested that he give me a more precise description of his anxieties.

P: I mistrust myself about whether my feelings are entirely gentle. I sometimes fall in love with boys [apprentices he met at work], from a distance, especially in ones who look like I did as a boy, especially with blonds.

At this point he stopped and was silent for a longer period of time. I inquired whether he had recalled something that he was particularly ashamed of.

P: Well, just a thought, one I've had frequently but always pushed away immediately. If I could fuck a real ass some time, that would be a fantastic story.

A: Yes, what would be so fantastic?

P: Naturally I'd be the one who was active. My partner could be either a man or a woman; in either case, I don't want to see the front. Only the movement would be important, just this in and out. I'd finally have a sphincter that would take tight hold my penis.

Later in the session he disparaged the role of women, warding off his castration anxiety, by criticizing their "limpy holes," which he was afraid of falling into. This was the reason the other fantasy—the encircling snugness—exerted such an unbelievable fascination on him. Yet he had always brushed this thought away quickly whenever it came to him because, he said, it was impossible to speak with anyone about it.

A: When at the beginning of the session you told me about your moving feeling that you have found something new here, namely somebody who is there for you and listens to you, then this probably also meant that you can tell me about such fantasies without being rejected.

The patient then felt secure enough to tell me for the first time about his masturbation practices, which he preferred to having intercourse with women because he could stimulate

himself precisely where it was most pleasurable. His glans was somewhat too sensitive, and he liked to stimulate himself on the shaft of his penis. The fantasy of using his hand to imitate a sphincter was particularly stimulating for him.

Important with regard to my considerations about how to proceed was that I let him have the active role and did not offer any deeper interpretations, such as that his comment about "limpy holes" might be based on a terrifying fantasy about being consumed (castrated) by a woman. At the end of the session I therefore only emphasized that he had kept these thoughts to himself until now because he was insecure about whether he would be rejected.

The patient began the following session by telling me a dream about a ski course, which he had had after the previous session.

P: While skiing we were in a group led by a woman, who told us that we were all incurably ill. She expected us to drown ourselves in a lake. I was afraid of dying and said that I didn't want to die. I managed to move over to one side, and all the others followed her command and drowned. I saw their heads in the water and called out to them, "I'm sure I'll find somebody who can cure me. You can die, but I want to live." I then fled to the other shore.

This woman reminded him of "Emma," the pejorative name he gave his earlier therapist. She had once told him that she had had a patient who had killed himself in her waiting room after four years of therapy, probably to keep him from doing something similar. At the time he had thought, "I'll kill myself to show the bitch that she's incompetent." He added that his wish to kill himself had been strong at the time, but that he now wanted to live, not to die. He said he was also somehow mad at me for not having immediately begun therapy following the preliminary interview. Then he distanced himself from the strong affect of his criticism. With decisiveness, he referred to the thoughts about committing suicide that he had had in the period before therapy actually began. Over and over again he worked himself into a tirade against me, making me responsible for his condition at that time. He said I should have offered him more hope during the preliminary interview; he had wanted more carrots, as it were,

although he himself knew that it would only hold on for a couple of days.

At this point I managed to redirect his attention to the expectation he had in his dream of being saved. He immediately picked up this reference; yes, he was looking for a savior, someone to rescue him. He recalled that the passage "You might die, but I want to live" stemmed from a psalm that he prayed three to five times a day. He had chosen his earlier therapist because of her Christian orientation, but then felt that she had exerted substantial moral pressure on him. She had, he admitted, helped him get through a difficult period while he was at the university—like an admonishing teacher—yet she had also morally extorted him, saying that if he did not forswear his dirty fantasies, he would end in a terrible way, just like the other patient before him.

Heinreich Y then associated that he had been together with a girl the day before and they had been affectionate in public. Out of pure excitement, he had developed a large swelling in his upper arm. He felt he could uproot trees, while girls would be much too weak to do so.

With a view to the homosexual element of transference that was developing I gave the following interpretation. He hoped that I would be strong enough to survive the boxing match with him that might come of his stored power. The patient laughed heartily and freely. Clear traces of tears were visible in his eyes when he departed.

By means of my interpretation I turned the passivity of a dream looking for a savior into the active position of a son looking to conquer a spot of his own in the world via a test of strength with his father. My interpretation followed the consideration that the patient's derogatory, frequently clownish self-representation was rooted in his attempt to defend himself against strong feelings of rivalry, in order for him, in the position of the helpless boy at the mercy of the castrating mother, to find a masculine identification with his father. The analogy to the boxing match was supposed to express this, a test of strength at the limits of playful reality and encircled by the boxing ring. The fantasy about his preferred form of masturbation that he detailed in the previous session—a powerful sphincter-like ring on the shaft of his penis—also contained a conflict with homosexuality and pleasurable body feelings.

In the following sessions it became clear that the patient spoke to me by first name in his inner dialogues, using a form of address that is used for small boys. He compared his own powerful athletic figure with my own and did not believe that I would be up to a physical confrontation. He used the actual difference in size, being himself the largest, to disparage his hated father. In the first phase of therapy the patient had created the image of him as being a weak and worthless do-nothing. After the war, when the patient was 6 years old, he had not managed to reestablish himself in his own profession. He had not managed to provide sufficiently for the family, working only at part-time jobs.

In terms of therapeutic technique the point was to indicate what "the other shore" was that the patient was looking for in order to liberate himself from the powerful, caring, and consuming clasp of his mother. This theme was discussed again in the further course of the therapy. It became concretely clear how situations in which he was enclosed in an encircling space represented for him the pregenital mother, with whom he had to maintain contact and who, in the form of interchangeable idealized women, determined his social life. This was again shown by a dream, which was about a grave danger. The immediate precipitant for this anxiety was that the patient had decided, after 18 months of therapy, to leave home and look for an apartment; he even made concrete plans to build a house of his own.

The patient's first comment was that I had closed the curtains (to protect the room from the sunlight). "When I'm able to close the curtains in a house of my own, that would be wonderful." Then he described his efforts to find an apartment, which was turning out to be difficult. He said that although he was increasingly beginning to react to things allergically at home, he did not want to leave in anger, but simply to become independent. He added that he had recently had two very funny dreams about being in danger. He then described the following dream.

P: I was carrying a backpack and walking through an underpass, accompanied by an Italian woman. She told me to be careful: "There's a gang; they're going to attack you." The woman was gone as I left the underpass, and then two men did come up to me. The one tore my backpack away from me and tossed it to the other one. I wasn't able to defend myself. It's terrible; in such dreams I'm always the loser.

His first association was about the Italian woman. Heinrich Y had frequently told me that the woman of his dreams was a black haired beauty with smoldering eyes, like the woman in a picture hanging on the wall of his parent's living room.

P: Where does it come from? It's happened so often recently; I have an exact mental picture of the dream. As long as the woman is there, nobody does anything to me. None of the bad guys does anything to me. Yesterday I went hiking with a woman I recently met, and I happened to think that there was always a woman present every time I've been tested. It's obvious that I can't cope with life without having a woman nearby. What does the backpack mean? People take my things away from me again. [He then came to speak of his fantasized future wife.] I believe I have to reach an agreement on maintaining separate property, or even better, for my wife to pay me rent. Maybe the two bad guys are also my tenants.

I asked about the underpass.

P: Well, it's just a bunch of nonsense. But yes, the underpass; I think I remember my duties, and next year is going to be a difficult one. The people might be the decisions I have to make in connection with the building. Ever since I was a child one of my important tasks has been to ward off thoughts that might be unchaste. I see in thoughts the danger of eternal damnation. You can have unchaste thoughts in a fraction of a second, a cardinal sin. If you die at that moment, then you're damned for all eternity. That's especially bad. And here it's really bad because I have to, or at least can, say everything. In the evening I often have to think, "Boy, at work today you really said some things. Who's going to use it as a trap for you?"

A: Your associations to the underpass could be nonsense or unchaste.

P: [Laughing] Yes, I immediately have to think of something, put it in, the cunt, go into a deep hole where there are a lot's of dangers waiting. The woman in the dream told me not to be afraid. Maybe when I have the right woman some time, I won't be afraid any more and can go into the hole without getting worried.

A: Maybe there's an unchaste side to the backpack, too.

P: [Laughing] Well, the young boys, they might have been about 14, maybe the young boys were a symbol. Perhaps they took my bag away from me. [Long pause] Today I'm again having doubts about the work here. It costs so much; my money is just running away—DM 77 for you and DM 30 for the time it costs me, making a total of DM 107. I believe I'm looking for arguments against our work here, to cut back. When the days start getting longer again, I'll have to cut the Friday session. Maybe the underpass means that I can't see any light in analysis. Maybe you are the woman and the underpass means that I have to submit to you. I think that it's no different here than in other places; I'll always prefer to submit in order to really be on the safe side and be sure that everything will be alright.

A: That means that I'm supposed to protect you against the bad guys, against your own bad thoughts.

P: Yes, hold off the unchaste ideas, yes that would be real nice. The only dangerous thing here, that's really the only evil. I think I'm really proud of myself, that I got something out of the dream. I'm really overwhelmed.

A: How old were you when you were a bad boy and had unchaste thoughts?

P: Oh, I used to be radical in fighting off everything. No, that's not quite true. Naturally I used to read some things secretly, for example about artificial insemination. It always gave me a hard-on. Once I even saw a naked breast. When I was 18 I read a book and it only said that two people had slept together. Boy, was I excited. Of course, I mentioned it during confession. So crazy, I was an ass, ruined my life. I'm 35 now and haven't managed to live yet. Thank God, it may not be too late for everything.

A: Is everything really still in the sack, in your backpack?

P: Well, I feel so impotent, as if somebody had stolen my bag. I'm generally incompetent. Of course, I cope with life, but not in the way I think about it; there I'm impotent. I had

imagined doing so many things. [Pause] I've got a lot on my mind. I think I'll stop this stuff with the girlfriends. I don't want to tell you anything; I'm so ashamed. My new girlfriend congratulated me for not having married Rita. They know each other. I think I feel ashamed toward you. You're sure to really criticize me now. Saturday I met one in A.; I really made her fall in love with me. That was Berta, and Sunday I was with Claudia. I think all these contacts to women just cause me a lot of trouble; sometimes it's a real struggle to keep them apart.

A: All these contacts to women give you the feeling that there's still something in your backpack.

P: Yes, it's a kind of protection for me. As soon as there are more, then it starts, and they try to get my backpack. And that's why I'd never get married in winter. It would take the last energy I have, and going skiing is still my greatest love. Then I simply wouldn't have any strength left in reserve. [Pause]

A: You feel ashamed because you're also afraid that I will condemn you here.

P: Yes, a while ago it was very strong, a little less now, but I still have thoughts that I can't immediately talk about. For example, right now I see the cross section of a vagina. It's a fantasy that overwhelms me, that really takes hold of me, and the more I do against it, the clearer the image is. I remember that a teacher once distributed booklets on sex education. One picture in it showed the genitals in union. I have the booklet in a cupboard that I don't use much. Sometimes I happen across it, and then I get it out and look at it. I want to see something like that some time, really be there, like going back and forth. That's why I like to stand in front of the mirror and jerk off because I have the feeling I can really see it in detail. It's just important that it isn't simply gone. There's this constant feeling with women, the feeling that I lose sight of it. I once told Rita that she should do it with her hand, I preferred it that way, because then I could see everything. Watching is really important. I'm just split. In fantasy I would really like to have a good fuck, really going in and out, but in reality I can't take my eyes off it.

A: You become afraid when you lose sight of it.

P: Yes, when I lose sight of something, then I lose control of it. I got a hard-on that Claudia admired, but as soon as I wanted to put it to use it's gone. I think it really has something to do with anxiety. If I could only trust the girl. Maybe, when I really have a woman I can trust some time, then it will be alright. I'm sure it's not because of the fear of having a child; I don't think so any more.

A: You're really very ambivalent to women. On the one hand there is this anxiety, and on the other in the dream the woman was the one providing protection.

P: Yes, it's really funny. On the one hand I want to have one and can't trust her enough. I think I have a great need for success. I see my increase in energy as a measure of the therapeutic success. I only have strength in the chest, too little in my head and too little below my waist. I simply don't have the juice. I just had the idea that as soon as my house is finished, I'm going to get a sandbag and start boxing.

Commentary. If we consider the beginning of the session from the patient's perspective, we can assume that he experienced the office as being restrictive, and with reference to the dream it was logical to equate the underpass with the analyst's office. He needed the eye contact to the analyst to control any possible aggressive acts. Consequently, the interruption of his eye contact led to the activation of various dangers, resulting—in transference—in his fear of being ruined financially. However, his subordination also protected him from his anxiety of loss, with is multiple determinants. In analysis he experienced the anxiety localized in his penis, over which he had visual control, in his relationship to his analyst, and it was there that the numerous nuances of the subject of separation in transference were unfolded and worked through.

8.5.5 Commonplace Mistakes

Technical mistakes are inevitable. They play an important function in the process that A. Freud (1954, p. 618) referred to as the reduction of the psychoanalyst to his "true status." By admitting

his mistakes, the analyst facilitates the elimination of idealizations.

By technical mistakes we mean all the deviations that an analyst makes from the middle line formed during the respective dyad and that ideally is extended from session to session without any substantial digressions. Important is the fact that we define the middle line dyadically. Based on his experience with an analyst, each patient develops a certain feeling for the customary *atmosphere* he expects in the sessions. Since the analyst's behavior is guided by rules, after a short while the patient can sense which attitude the analyst has to this or that subject.

An exchange of opinions takes place in the psychoanalytic dialogue. It is customary for misunderstandings to occur occasionally and for them to be clarified and overcome. The mistakes an analyst makes are, in contrast, facts that cannot be corrected but have to be acknowledged, and their *consequences* interpreted if at all possible. Mistakes, in particular, make it clear that the analyst's capacity for understanding is limited by his personality and his incomplete knowledge. This makes something of the analyst's true status visible. Malpractice, in contrast, implies deviations that lead to lasting damage as certified by a court.

The relationship between *therapeutic alliance* and transference must be taken into consideration when mistakes are evaluated. There is general agreement that the therapeutic alliance should have reached a degree of sufficient stability for realistic perspectives to be predominant despite the fact that fluctuations might still occur, especially during the termination phase.

In the psychoanalytic dialogue the interplay between transference and countertransference is rooted in the emotions and thoughts the analyst and patient have—whether mentioned in the dialogue or not—about emotional and cognitive processes, some of which are accessible to self-perception. Now we have to consider what the psychoanalyst contributes to the patient learning in the course of time to recognize his true status. As we can see from the memoirs of Lampl-de Groot (1976) about her own analysis, Freud facilitated this process by making the interplay

between the transference neurotic and "normal" aspects of the relationship apparent from his behavior. Such conspicuous differences are today probably only offered by a small number of psychoanalysts. It is therefore all the more important to look for other means that can lead to the elimination of idealizations.

We can no more expect a more realistic attitude to develop on its own and to appear as a phoenix out of the ashes of the transference neurosis than we can for the transference neurosis itself to develop without the analyst doing his part. The predominance of the therapeutic alliance in the later phase of therapy, as assumed by Greenson (1967), is process dependent inasfar as this shift takes place if the analyst has taken preparatory steps in the direction of termination when suitable themes are being discussed. Very appropriate in this connection are interruptions for vacations because they contain everything in miniature that is related to separation and its working through.

We would now like to describe two situations that are suited to clearly indicate the consequences mistakes can have. They intensify fluctuations between transference and working alliance that ultimately point to the separation at the termination of therapy.

The first point consists of the last session prior to a vacation interruption and the first session afterwards. This interruption occurred during a phase of treatment in which the patient had repeatedly raised the issue of *termination* . I did not feel that the transference neurosis had been worked through to a sufficient degree for me to have already started thinking about terminating the therapy. In my opinion it was important for Dorothea X simply to consider the topic itself. In the last session prior to the break we talked about whether she would still be dependent on being able to locate me mentally, i.e., whether she would be potentially able to reach me, at least in writing, in an emergency. I was uncertain, and the patient realized it; I showed my uncertainty in not telling the patient where I would be but, after hesitating, adding that I could be reached via my office—"in an emergency"—and would be in the office once in the middle of the break. In contrast to her earlier states of severe depression and anxiety

neurosis, I judged that in the current situation she would hardly have a need to contact me; yet I was still uncertain, and this uncertainty led me to make a compromise offer. Dorothea X did not need to contact me during the relatively long vacation break, and came to the first session rested and free of symptoms. While greeting each other I responded spontaneously to a hidden allusion she made to my vacation by expanding on a comment she made about the nice weather to refer to my vacation as well. For the moment I acted without reflecting on what was happening, and my spontaneity stimulated the patient to make comparisons to the last session prior to the break. She compared my momentary spontaneity with my previous pausing to contemplate, and on the basis of this comparison she drew conclusions about how sick or how healthy she thought I felt she was. As I thought more about this problem, was silent for a longer period, and did not pay attention to her subsequent comments, she sensed my mental absence. She interpreted my distracted silence as a withdrawal that she feared she had provoked because I had taken her comments about the session prior to the break to be criticism.

I explained to Dorothea X the reasons for my contemplation and my being distracted, telling her that I did in fact have to carefully consider whether it was necessary or therapeutically useful to give a patient my vacation address. She responded by mentioning a series of other observations, all of which indicated how important it was for her to participate in my evaluation of her condition because she gained self-confidence from the confidence I placed in her ability to take stress. By acting spontaneously and naturally, I had transformed *her* image of me as a overly worried psychoanalyst into one that was more accurate; my spontaneity, she said, made her healthier. The more confidence I placed in her by reacting "naturally," the more confidence she said she was able to gain in herself.

Many topics take on special importance at the termination of a therapy. Dorothea X had noted with great and visible disappointment that she increasingly viewed me more realistically although she ardently tried to ward it off. This process of normalization was further eased by several other mistakes and an incident in which, in her opinion, I "really bungled" something. This bungle was that I had advised her to soon go for an examination when she thought that she was pregnant, something she both desired and feared, and as a widow and mother of grown children could not imagine—among other reasons because of the danger to the child from a

pregnancy at her age. In her opinion a conception could have taken place as early as several months before, and time was precious if an abortion was necessary. It turned out to be a false pregnancy, and the changes her body had undergone were typical of one. Although I had not overlooked the wish aspect and the hypomanic happiness she showed while describing her condition, she had unconsciously taken my comment about the urgency of a examination to be a step preparing for the abortion of the (transference) child. It was impossible for me to make up for my bungle. She herself became aware, however, that her false pregnancy was a misguided and vain attempt to make up for an earlier abortion. Her longing at this time was directed toward having a harmonious relationship, which came true inasmuch as her friend would have welcomed a pregnancy if it had occurred in a different phase of life. That this phase was gone for good was something the patient became painfully aware of. My mistake thus contributed to her achieving a more realistic attitude to her life.

I had lost a gem from my crown by not understanding her deeply unconscious desire. Yet there were several other situations that contributed to deidealizing my role. A topic must be mentioned in this context that arose during the termination phase and that had a connection to an earlier situation in therapy. While we were playing through the termination of therapy at that time, the patient had asked me about the role that aggression played. She understood me to say that aggressive topics might reappear at the termination. I could not recall making this statement, but I had obviously caused a misunderstanding that—while uncorrected—continued to be my "mistake" because such a statement would have to obstruct the termination and put a taboo on aggression for a patient who suffered precisely from the anxiety she might hurt someone's feelings and was constantly striving to compensate. The patient had in fact drawn the consequence from my mistake that she could not be aggressive because she would then enter the phase of termination and no longer be in a position to offer compensation for the damage she inflicted.

In this context a unique resistance manifested itself. It consisted in the patient consciously raising other topics for discussion; although working through these topics had a high therapeutic value, the patient brought them up in order to avoid or postpone aggressive transferences. She described "typical ways women are nasty" and mentioned numerous examples for how the envy

and hypocrisy of woman bothered her. At the same time she developed a deep longing for harmony and togetherness with a woman. By this time the patient had become aware of her ambivalence toward her mother and the neurotic repetition associated with her without being able to admit the full extent of her longing. The defenses still active in her were demonstrated by an exclamation she made in one session, "If only I were a little lesbian!" She changed after I immediately replied, "In that sense, we're all a little lesbian."

By these means aggressiveness was avoided in transference and shifted to her relations to women. It could also be said that the patient displaced her mother transference, acting it out or discovering it in her relationship to the women she knew.

Working through her ambivalent relationship to her mother ultimately provided the basis for an increased capacity to be more aggressive in transference, as demonstrated by the following example. Dismayed and with intense inner suffering, the patient experienced, for example in her clever manipulating, especially while shopping, that she was much more her father's daughter than she had wanted to believe. She was tortured by the fact that she had unconsciously adopted his petty figuring, which she found repulsive. In order to overcome this form of behavior and to be different from her father, she had incidentally always insisted on paying a portion of the costs for therapy herself. She did not submit any claims to the insurance company that would have covered all the costs, instead only submitting claims to another insurance organization that only covered part of the expenses, leaving her to pay approximately DM 40 herself. This self payment amounted to a financial burden that her family was able to bear without it requiring any substantial sacrifices of her or her family. The patient experienced the fact that she bore part of the costs as an expression of her independence in her relationship to me as well as toward her father. Her inner tension between her intention to have a free and generous attitude toward money and, on the other hand, her father's superego dictate to be frugal and her own inclination to petty figuring was clearly demonstrated by a delay in preparing a bill; the delay might have led the insurance organization to refuse to make its payment in full. This additional burden would have been too much for the patient to bear, and the "father" in her would have won over her autonomy.

Her observation about how I reacted to her comments about my mistakes further increased her insight. She noted that I made great efforts to avoid making mistakes, and I naturally acknowledged that misunderstandings do occur and that they were my responsibility. My verbal admission of my mistakes was, however, apparently accompanied by an ideal of flawlessness. Dorothea X wanted a psychoanalyst who was sovereign in human matters but who could also give an averbal signal that mistakes were part of the trade and a part of life. As a matter of fact, this patient did open my eyes to the fact that my own ambition kept me from accepting the fact that mistakes are commonplace events, and from being able to deal with them in a more magnanimous manner. Dorothea X sought a role model for magnanimity, in order to be able to gain a new, i.e., more magnanimous, attitude to herself.

8.6 Interruptions

From the point of view of diagnosis, it is logical to consider whether interruptions precipitate typical separation reactions, regardless of whether they are more characterized by anxiety or by depression. From the point of view of therapy, however, it is decisive that the analyst provide assistance in a manner that contributes to increasing the patient's capacity to gradually master such reactions. We therefore recommend that the analyst also consider measures to bridge interruptions.

Example

Clara X came to the last session before Christmas.

P: In the last session a person has either got nothing to say or . . . or something important on his mind but that he can't remember. [Silence] I simply don't want to tackle the topic of separation. I have the impression that I've always evaded it. Sometimes even by getting sick. I'm sure it's connected with my anxiety toward emotions.

A: Your anxiety about emotions you can't control . . . leads you to avoid some painful things, but not merely painful things. The less filled with emotions, the more intense the pain of

separation turns out to be. And avoiding emotions causes separations to be more painful than they would have to be; it leads to a feeling of deprivation, an issue we talked about in the previous session. We're talking about the provisions for a journey.

Consideration. Various ideas were combined in this interpretation. I presumed that Clara X was in a state of chronic and all-encompassing privation because of her eating disturbance. In connection with temporary interruptions or even the final separation, a patient's longing to obtain compensation for the deficit increases. At the same time, at some level of consciousness some kind of balancing takes place. Although anorexic individuals attempt to deceive themselves by appearing helpless to themselves and others, in some corner of their mind they are completely aware of their great longing for their hunger to be satisfied. The limitation of one's needs, even when this takes the extreme forms of abstinence, is an attempt to avoid all the disappointments that in fact do frequently accompany an increase in unconscious longings and desires. My interpretation was thus based on the assumption that it is easier for a patient to separate from the analyst if his vital needs are satisfied. The pain of separation can in this case also grow: "All desire seeks eternity, deep, deep eternity" (Nietzsche, *Thus Spoke Zarathustra*). In this regard the metaphor of "provisions for a journey" is a paltry offer for bridging the gap despite its numerous connotations.

Clara X drew my attention to the fact that I had frequently spoken of provisions for a journey prior to interruptions, something I had not been aware of.

A: My favorite words cannot simply produce the provisions for a journey.

The patient wondered whether she had ever had the experience outside of therapy that provisions had helped her get over a separation. Long silence, sighs. After about three minutes she asked what a person could do to cope with separations, adding that one method was to think about the reunion.

P: What do you have to say about it?

A: To reunion? You're thinking of the reunion, of bridging the gap and continuing, and of the new beginning as a link. A reunion provides perspective.

P: Unfortunately I can't find any perspectives. January 12th—the next session. By then I will have forgotten all my good resolutions for the new year. At any rate I hope you don't show up with your leg in a cast [she knew that I was going skiing]. And I hope that you have something of your vacation. Maybe you'll even get a tan. [Then she asks directly] Are you going away together with your wife, or alone in order to be able to think without being disturbed?

A: Hum, what would you prefer?

P: [Laughs out loud] You're not going to plan your vacation according to what I prefer.

A: It's important to know what you prefer. You're probably ambivalent, making it not very easy to answer. To have the peace and quiet to reflect and write would probably be easier if I weren't distracted by my wife. From that point of view you would probably prefer to send me on vacation alone.

P: Perhaps I'm thinking along a different line, about your wife most of all. Maybe it would be boring for her if your thoughts took possession of you; it would be monotonous for your wife. Then it would be better to stay here and work. Let's say, my tendency in your wife's place would be to go along for a week after the holidays, for relaxation and skiing, and then to leave you to yourself for another week and in that week, who knows, go somewhere. If you have something meaningful to do, to do something for yourself, to visit friends.

A: That's a very wise solution, thinking about my wife in this way, and meaning the best for me and her and yourself. Because it also means that I would have eight days to dedicate to thinking intensively about you.

P: I wasn't assuming that you would think about me; I assumed that you would think about your

patients in general.

A: If I think about my patients, then that includes you too. That you weren't thinking about yourself most of all is connected with the fact that you, how did we say it once, are afraid of your uncontrollable emotions and desires.

P: I'm not so sure about that. The situation is a little different. If you reflect while one of us is gone, well it's something that makes me feel rather uneasy. [Two minute pause] Maybe I'm afraid that you'll reach some final decision and I can't say anything about it.

A: Oh, perhaps because you'd be excluded.

P: Parents think about how to raise their children when they aren't around, and make decisions.

A: And that is why I said that it's important whether you benefit from it.

P: Simply the fact that it happens like that would be a denial of my rights, even if it did benefit me. [She continued ironically] Yes, that's how it always is, everything is for the child's own good, and it's still a disconcerting idea.

A: The idea is disconcerting, but you also often have some thoughts of your own, about me, between sessions, and I'm not there either.

P: That's something I avoid.

A: Because you'd take possession of me without my being able to say anything. It's eerie. You experience very intensely that I take possession of you in my thoughts and control you and deny you your rights. Obviously an important reason for you to avoid thinking about me or anything else that belongs to me.

Commentary. The analyst assumed that the patient had such intense claims to possess him, keep him, hold on to him, take possession of him, to deny his rights, that she—via projective identification—was afraid that the analyst also had control of her. In the patient's language this

was that her rights were being denied. The issue was the control of oral impulses, which however cannot be so complete as to prevent disturbances from being felt. On the contrary, the more aspects of one's self that are denied and return in projection, the larger the anxiety about being overwhelmed orally from the outside, i.e., by the analyst. (On introjective identification, see Sect. 3.7).

P: The other item, the one that's eerie, is . . . is this wondering. I know it from my mother. It went in the direction of masochistic doubts about everything she might have done wrong, in the direction of guilt feelings and pessimism, sorrow and so forth. I don't like it. And now I'm going to say a outrageous sentence. A mother is supposed to believe in her children and that means in herself too. That doesn't mean that you won't make any mistakes; that's not the point. It's the anxiety, the doubts about what will happen that really makes life miserable for her. That's also what I think of in connection with this wondering, that it could go in this direction, and I don't want it to happen like that. I could imagine that for you primarily negative things come out when I talk about my ideas like this. Most of all you think that she just can't stop talking about cardinal sins, she'll never manage to stop smoking, and she won't manage with the eating either, so everything will stay the way it's been, and otherwise she may talk about the good fairy at the junction, and then she's up and ready to make her own way, drags a breakfast up here and wants a child, and a couple of weeks later has decided she doesn't after all. And then she hangs around for a while. You just can't really understand her. Everything is very immature, and otherwise there's the feeling, yes, what is there then!

A: And now our reflection has come to a very satisfying conclusion.

P: [Laughs loudly] At the moment I don't think so at all.

A: Well, for me it has, namely the conclusion that I've understood why you don't want me to think about you, and why you avoid thinking about me. Because you are so terribly anxious of taking possession, of denying my rights, of not worrying about what I want, what I think, but that you want to take possession, uncontrolled. Now I've also understood why it's

so difficult to stop smoking, because stopping would be very sensible for your health, but it's logical for psychic reasons that you can't stop doing it because you concentrate all your desires in it.

P: With the taking possession, there's something to it; I'm afraid so. Dominating and possessive, I'm afraid of it. How much of it is true and how much is my fear?

A: Both. You are like that and you are afraid of being much more tyrannical that you really are, because everything is locked away in the basement, where the potatoes are rooting, driving lascivious roots. In light they would turn green.

Commentary. The supportive and encouraging side of this interpretation seems to be based on the view that the libidinal forces rampant in the dark might take on an eerie shape and then actually become dangerous for more than an individual's preconscious premonitions. A consequence of this is that evil and destructiveness are dependent on development, i.e., are variables that depend on unconscious defense processes, as we explained in Vol.1 (Sect. 4.4.2). It was Freud's opinion "that the instinctual representative develops with less interference and more profusely if it is withdrawn by repression from conscious influence. It proliferates *in the dark* , as it were, and takes on *extreme forms of consciousness* " (Freud 1915d, p. 149, emphasis added; a correct translation might read, ". . . as it were, taking on the form of extreme expressions").

P: But when I go down into the basement, then I'm seized by immense horror; I close the door again right away. You can't look at those things. Once in a while I take a peek. Well, toward you I can't feel it; I have a block, but in the family I notice it occasionally. I really can't judge how far I do it and how much it's my desire once again because I would actually like to have the say about it and have everything under control. The mother of the brigade. What I say is how it's done. I'm completely shattered if I don't get my way. When I take a closer look, then everything gets confused. First I get enraged, and then I withdraw, and usually I withdraw before I get enraged, because of my fear that I might become enraged. But why do I have to smoke if I'm possessive?

Consideration. I recalled the sensations I had from smoking and stopping.

A: You've got something in your hand and take it inside you. You inhale, absorb it. At this point you can finally be greedy and desirous and give up your block.

After this there was a relaxed silence that lasted about five minutes. The patient said "merry Christmas" upon her departure, and I returned the good wishes.

Commentary. The last interpretation probably provided relief and led to relaxation. The analyst encouraged the patient to achieve oral satisfaction even though it is located at the level of a substitution. Yet such substitute satisfactions are vital to the severely ill and contribute to easing separation reactions. Transitional objects facilitate the bridging of gaps.