Psychoanalytic Practice: Clinical Studies

The Psychoanalytic Process

Treatment and Results

Helmut Thomä
Horst Kächele

The Psychoanalytic Process: Treatment and Results

Helmut Thomä and Horst Kächele

e-Book 2016 International Psychotherapy Institute

Table of Contents

The Psychoanalytic Process: Treatment and Results

Introduction

Some of the psychoanalytic treatments presented in this chapter go back to the form of systematic case study we mentioned in Sect. 1.3. Nostalgia is not the reason that we refer back to therapies that are long past; the reason is that the long follow-up periods are an excellent basis for discussing the *outcome of therapy* . The research into the process and outcome of psychoanalysis that we have initiated in Ulm has developed out of our experience with systematic case studies (Thomä 1978) and the investigation of interpretative actions (see Sect. 8.3); the results of this research have motivated us to adopt a new understanding of the psychoanalytic process (see Vol.1, Chap. 9). More is expected of this research than we can present in this textbook, which for didactic reasons must have a broad clinical basis and include a large number of different cases. The combined research into the process and outcome of psychoanalysis with respect to individual cases, which we and others have propagated, is still in its infancy (Grawe 1988). If we were to describe such cases in the necessary detail, then this textbook would consist of only one of them.

The important therapeutic changes in cases other than those presented in this chapter can be followed without any great effort by reading the individual cases referred to throughout the book in sequence (see the index of patients at the beginning of the book). In addition, Sects. 5.1-5.3 contain descriptions of typical excerpts of an analysis, selected with regard to a series of dreams, and Sect. 6.3.1 contains an excerpt of an analysis prepared for a referee within the peer report system of applying for health insurance coverage.

This chapter begins with a section entitled "Anxiety and Neurosis;" we know of no better place to discuss this important topic. This section (Sect. 9.1) provides the reader a survey of the psychoanalytic theory of anxiety, which is followed by the case studies in which anxiety played a central role (Sects. 9.2-9.5). Since neurotic anxieties play a significant role in every treatment—even where they are not openly manifest among the primary symptoms—anxiety constitutes an important general indicator for

evaluating the success of therapy. It has furthermore proved necessary for us to discuss several central concepts of the general and specific theories of neurosis. Thus following the presentation of a case of neurodermatitis (Sect. 9.6), we discuss nonspecificity (Sect. 9.7), regression (Sect. 9.8), alexithymia (Sect. 9.9), and the role of the body in the psychoanalytic method (Sect. 9.10). Finally, in Sect. 9.11, we invite the reader to confront the problems involved in preparing a systematic psychoanalytic case study.

9.1 Anxiety and Neurosis

We will now provide a short survey of the theory of anxiety, before turning to several specific forms of anxiety. Although we argued the necessity of a differentiated consideration of affects in Vol.1 (Sect. 4.2), we are justified in focusing on anxiety in this section since many affects have an anxiety component. As Freud (1926d, p. 144) once summarized, anxiety is "the fundamental phenomenon and main problem of neurosis."

In making a diagnosis, analysts usually proceed from the specific nature of the anxiety manifestation. One important criterion for differentiation is the more or less close link of neurotic anxieties to a particular situation. Anxiety neurosis is characterized by free floating anxiety, which seems to appear for no apparent reason and is therefore experienced as inevitable, uncontrollable, and potentially fatal. Both the concept of anxiety neurosis and the first complete and still valid description of its symptoms stem from Freud, who distinguished in diagnosis between the syndrome of anxiety neurosis and neurasthenia. He used the term "anxiety neurosis" to refer to this syndrome "because all its components can be grouped round

the chief symptom of anxiety" (Freud 1895b, p. 91). Among the bodily disturbances that occur in an anxiety attack are, according to Freud, cardiac dysfunction, cardiac palpitation with arrhythmia, tachycardia, breathing disturbances, nervous dyspnea, sweating, trembling and shaking, attacks of diarrhea, and locomotional dizziness. Characteristic of anxiety neurosis are that it is manifest in attacks and is accompanied by hypochondriac expectations.

Frequently one component of the syndrome assumes a predominant role in the patient's experiencing, and it is not unusual for the anxiety to be tied primarily to one symptom (e. g., the tachycardia, nervous dyspnea, sweating, or diarrhea). The syndrome of anxiety neurosis and the

numerous manifestations of its components afflict a large number of the patients who come to analysis. Among those described here are Beatrice X, who suffered from a breathing disturbance (Sect. 9.2); Christian Y, whose primary problems were arrhythmias and sweating (Sect. 9.3); and Rudolf Y, who had diarrhea when he was overwhelmed by panic attacks. There can be no doubt that anxiety is the fundamental problem in every neurosis and in the psychic component of the genesis and course of many somatic illnesses.

It is instructive to demonstrate the changes that have occurred in the last hundred years by referring to the complex of symptoms called anxiety neurosis. During this period of time our knowledge of the somatic correlates of anxiety—i.e., the physiology, neuroendocrinology, and neurophysiology of anxiety—has increased substantially. On the basis of epidemiological, neurochemical, and therapeutic studies of anxiety illnesses, the American Psychiatric Association's classification (DSM-III, 1980) subsumes under the term "anxiety disturbances" a series of psychic disturbances such as panic attacks with or without agoraphobia, social and simple phobias, compulsion, and posttraumatic stress reactions. This classification attributes a dominant role to the special subgroup "panic attacks" as a prototype of other anxiety disturbances. For example, in the most recent revision (DSM-IIIR, 1987), agoraphobia was not viewed as a subform of the phobias, but primarily as a consequence of previous panic attacks, which have led to avoidance behavior. Of interest to the psychoanalyst here is the fact that the diagnostic criteria for the newly defined subgroup "panic disturbances" are largely the same as those Freud described for anxiety attacks in 1895. In his first description of anxiety neurosis Freud also viewed agoraphobia as a consequence of such an attack of anxiety. On the other hand, the physiological understanding of anxiety that Freud (1895b) had considered the basis of anxiety neurosis and panic attacks was submitted to a revision in psychoanalysis long ago. One reason was the discovery that free floating anxiety merely appears to occur for no reason. In anxiety neurosis it is possible for a wealth of nonspecific and unconsciously perceived danger signals to precipitate an anxiety attack because of an increased disposition for anxiety resulting from an individual's particular experiences. This discovery led Freud, in his epoch-making study *Inhibitions, Symptoms and Anxiety* (1926d), to revise the psychoanalytic theory of anxiety. One important passage reads:

> Real danger is a danger that is known, and realistic anxiety is anxiety about a known danger of this sort. Neurotic anxiety is anxiety about an unknown danger. Neurotic danger is thus a danger that has still to be discovered. Analysis has shown that it is an instinctual danger. By bringing this danger which is not known to

> the ego into consciousness, the analyst makes neurotic anxiety no different from realistic anxiety, so that it can be dealt with in the same way. There are two reactions to real danger. One is an affective reaction, an outbreak of anxiety. The other is a protective action. The same will presumably be true of instinctual danger. (Freud 1926d, p. 165)

The advance in Freud's explanatory model consists in the fact that the anxiety reaction was traced back to a danger situation:

> We can find out still more about this if, not content with tracing anxiety back to danger, we go on to enquire what the essence and meaning of a danger-situation is. Clearly, it consists in the subject's estimation of his own strength compared to the magnitude of the danger and in his admission of helplessness in the face of it —*physical helplessness* if the danger is real and *psychical helplessness* if it is instinctual . . . . Let us call a situation of helpless of this kind that has been actually experienced a *traumatic situation* . We shall then have good grounds for distinguishing a traumatic situation from a *danger-situation* . . . . The signal announces: "I am expecting a situation of helplessness to set in," or: "The present situation reminds me of one of the traumatic experiences I have had before. Therefore I will anticipate the trauma and behave as though it had already come, while there is yet time to turn it aside." Anxiety is therefore on the one hand an expectation of a trauma, and on the other a repetition of it in a mitigated form. Thus the two features of anxiety which we have noted have a different origin. Its connection to expectation belongs to the danger-situation, whereas its indefiniteness and lack of object belong to the traumatic situation of helplessness—the helplessness anticipated in the danger-situation. (Freud 1926d, p. 166, emphasis added)

Anxiety, as "the fundamental phenomenon and main problem of neurosis," demonstrates its central position in the psychogenetic and psychodynamic explanation of symptoms. The latter arise in order for the subject to avoid specific danger situations—signaled by the increase in anxiety—and the helplessness (trauma) associated with them.

Despite the far-reaching revisions, many ambiguities in the psychoanalytic theory of anxiety have remained, as a survey by Compton (1972a, b, 1980) convincingly demonstrates. Freud never repudiated the idea of anxiety as transformed libido. Rank's theory of birth trauma, although rejected as an explanation of neurotic anxieties, continued to serve as a model for the pathophysiology of anxiety. Freud went on "to overemphasize energies which from the start had interfered with the development of a psychoanalytic theory of affects" (Compton 1972a, p. 40). We agree with Rangell that anxiety, "which is *always* a signal of the *danger* of *psychic* trauma, is always a reaction to its presence" (1968, p. 389, emphasis added). It is the imminent and present danger which causes a panic attack or a state of free floating anxiety. Unconscious motives can be regularly discovered by the psychoanalytic method.

Waelder (1960) criticized that the term "anxiety signal" does not precisely reproduce the sequence of endopsychic events. He postulated that fear or anxiety does not constitute an essential element in the

sequence "perception of danger-adaptive reaction," and rather that a "danger signal" is biologically necessary to precipitate certain reactions. According to Waelder, this signal does not need to consist of a sensation of anxiety; he suggested that one speak of a danger signal instead of an anxiety signal because in this sequence the sensation of anxiety is not or not yet contained in the signal itself. The fact that the awareness of psychic or physical sensations of anxiety increases to a degree that makes it impossible for the real or imagined danger situation to be avoided sheds light precisely on chronic states of neurotic anxiety. The reason, according to Waelder, is that in these states there is a constant danger signal together with an incapacity for active coping.

Expressed in terms of behavior theory, the danger (threat) elicits an emergency reaction (Cannon 1920). The evaluation of the danger leads to either escape or attack, depending on the anticipated relative strengths of the threat and what is threatened. Anxiety and anger are the emotional correlates of escape and attack and have, via feedback loops, motivating power. A danger signal can thus trigger either an anxiety signal or an aggressive affect.

The difference between *real* and *psychic* helplessness is blurred in anxiety attacks, creating a ongoing trauma whose effects are cumulative. The paralyzed and blocked action potential thus gets stuck, so to speak, at the stage of the unconscious schema, where purposeful action is dedifferentiated. Repeated defeats also stimulate the blocked unconscious aggression that, in the sense of Freud's instinctual danger, now even leads to an increase in anxiety. It is thus no coincidence that the affect physiologies of anxiety and of aggression are very similar.

If the analyst proceeds from the phenomenology of the anxieties described by the patient, the dangers seem to be clear. The anxiety about becoming insane is a condition whose many aspects reflect all the subsets of feeling and acting that the patient himself experiences, ranging from the "insane" loss of control to the disintegration or destruction of his previous identity or self-esteem. What the anxiety neurotic is ultimately afraid of thus seems to be clear: the destruction of his existence, which in his experiencing can either take more the form of his social ego or of his body-ego, i.e., his body image.

Even at the phenomenological level, there are discrepancies in how members of this large group of patients experience their conditions. These discrepancies constitute a starting point for the

psychoanalytic method. For example, a distinguishing feature of the feared event is that it does *not* occur. Whoever is afraid of becoming insane or dying from an infarct does not experience such a fate any more frequently than is statistically probable. Indeed, these anxieties even seem to speak against the actual manifestation of a psychosis or an infarct. Yet such statistical data are not convincing to the patients themselves or only have a short-term effect. Important is the observation that anxiety neurotic patients are quite able to bear real dangers and that they—aside from their imagined anxieties—have no greater anxieties about dying than healthy individuals do. It is thus not true that anxiety neurotics think, to use everyday terms, that they are more important than they really are or that they, because of a pronounced narcissism, cannot accept the idea that life is finite and death inevitable. Precisely because an individual cannot fully anticipate his own death, at most experience it in his imagination and by analogy, the end of life remains a secret that is the object of speculation and fantasies. Every thorough examination of an anxiety neurotic consequently discloses that the anxiety the patient experiences about *dying or being destroyed* expresses a disguised *anxiety about life* . This opens psychoanalysis an access to the origin of helplessness, according to Freud's theory of anxiety, and to overcoming it with the help of therapy. In therapy the anxiety about death or the loss of one's physical or psychic existence (e. g., anxiety about cardiac arrest or a psychotic loss of control) is transformed into biographical situations of danger and helplessness that the individual was originally unable to master and that he now, under more favorable conditions, can overcome. A sequence of events regularly occurs in therapy that permits the analyst to draw conclusions about the origin of neurotic anxieties. The neurotic anxieties about dying, whose numerous manifestations have become symbolic for being left alone, loss, and destruction—and which the affected individual submits to in disturbing passivity—can be dissolved into life-historical elements and reintegrated. During this process there is usually not a linear reduction in neurotic anxieties and their transformation into weaker real dangers that can be experienced and overcome in the therapeutic relationship. In fact, anxieties that have multiplied to become symptoms can reach extreme intensities in transference. Part of the analyst's therapeutic skill is to apply technical rules in a way that the transformation of anxieties linked with symptoms into an interactional context promotes the patient's wellbeing and cure. The following general rule may aid in orientation: The more severe an anxiety disorder and the longer it has undermined the individual's self-confidence, becoming an anxiety permeating every aspect of existence, the larger is the potential for interactional anxiety to be rekindled in the therapeutic relationship. We agree with Mentzos (1984) that the anxiety about dying that is

experienced by the anxiety neurotic develops on the basis of displacements and other unconscious defense processes, which in therapy can be traced back in the opposite direction.

In summary, we would like to emphasize that a linkage is established between anxiety, as an affect, and the helplessness that can occur in typical danger situations. A central place in Freud's theory is occupied by the anxiety about object loss or the loss of the object's love, i.e., separation anxiety; castration anxiety is a special instance of this and therefore subordinate to it. A *depressive* reaction often predominates in object loss (see Sect. 9.3). The common denominator of anxiety and depression is the helplessness toward losses that are real or experienced psychically. Häfner described these observations, which can be explained in psychoanalytic terms, in the following manner:

> If we proceed from the manifest anxiety disorders, such as panic attacks, generalized anxiety syndrome, or agoraphobias, then we also, depending on the severity of the anxiety syndrome, come to the 40%-90% of those affected who have already been through one depressive episode or who are also suffering from depressive symptoms . . . . Anxiety, as I have previously tried to demonstrate, has something to do with the threat of dangers. Anxiety can have something to do with losses, being left alone, or more universal threats to one's own existence and what is of value to it. One of the reasons for the frequent joint manifestation of anxiety and depression probably consists of these elements of a threat to one's existence, which differ only marginally. The connection between the two can be sequential; the transition from severe panic states to generalized helplessness and depression is an example of a process that takes place rapidly. A slower transition from anxiety states to depression is frequently encountered in the course of severe anxiety disorders, in which the anxieties spread through several spheres of life, block activity and self-security, and sometimes lead to a continued increase in the helplessness an individual experiences. (Häfner 1987, p. 198)

It is essential from therapeutic perspectives that the danger signals corresponding to a specific helplessness be recognized; just as important, however, is to find forms of coping that lead out of the helplessness and extend the patient's scope for action. Just talking out loud may help the person groping in the dark, enabling him to gain reassurance of his self.

The psychoanalytic theory of anxiety in our opinion not only explains a complex phenomenology extending from the apparently empty existential anxiety to psychotic anxieties, but also clarifies the points different therapies proceed from. This makes it all the more surprising that—to use a phrase from Hoffmann (1987, p. 528)—an "overly rushed biologization of human anxiety" was accompanied by the conception of a biologically rooted anxiety disorder that disregarded the knowledge that psychoanalysis and psychosomatic medicine have compiled on free floating anxiety for almost a hundred years. Margraf et al. (1986) mentioned that until recently no particular significance was attributed to Freud's complete

clinical description of anxiety attacks. D.F. Klein (1981) and Sheehan and Sheehan (1983) have designed biological models of the anxiety attack; in these models the biological arguments merge in the concept of "panic attack." According to them, the apparently *spontaneous* manifestation of the anxiety attack differs qualitatively from the anticipatory anxiety that can be found in phobias. Another distinguishing criterion for these authors is the difference in response to psychopharmaceuticals. Tricyclic antidepressives and monoaminooxydase inhibitors seem to be more effective for panic attacks, while benzodiazepine derivatives induce a symptomatic improvement in anticipatory anxieties. These authors have presented a biological model of endogenous anxiety and panic attacks without acknowledging that these anxieties occur in reaction to *unconsciously* feared precipitants that as such are inaccessible to the individual concerned yet are amenable to successful analysis. A drug therapy of anxiety that is limited to the somatic symptoms and ignores psychic causes has also been the object of strong criticism by behavior therapy, as shown by the controversy between Klein et al. (1987), Klein (1987), and Lelliott and Marks (1987).

The anticipated influence that the worldwide spread of the DSM-III system may achieve in this regard is a cause for concern. In current psychiatric research, primarily biological hypotheses are being considered for the origin of panic attacks. This has resulted in a primacy of psychopharmaceutical therapy for anxiety disturbances, as opposed to psychoanalysis and behavior therapy. Insufficient attention is being paid to the psychodynamic precipitants and psychological factors of anxiety attacks. A very large number of patients are thus receiving one-sided—and consequently inadequate—pharmacological treatment regardless of whether it is possible to demonstrate that the anxiety attacks have psychic precipitants. This is the case although anxiety disorders exhibiting a more or less complete manifestation of the syndrome described by Freud belong, together with alcoholism and depressions, to the most common psychic illnesses. In an anxiety attack a biological pattern rooted in a personal disposition manifests itself when there are situative precipitants. It is a conspicuous feature of medical history that the central significance of Freud's description of anxiety neurosis, as a pathophysiological syndrome, has been rediscovered while the psychic conditions for its origin and course have been neglected. Even beta-blockers only alleviate the somatic symptoms constituting an important aspect of the manifestation of anxiety, such as cardiac palpitations. We agree with Häfner that the psychic processes leading to anxiety states as a rule cannot be overcome by a drug therapy:

> The most that can be achieved is that the blockade of severe anxieties enables the affected individual to successfully use his own capacities to cope with anxiety. Chronic states of anxiety, especially anxiety neuroses, require psychotherapy. (Häfner 1987, p. 203)

The overreliance on tranquilizers in treating psychic disorders can be seen, for example, in the fact that tranquilizers are taken by about 10% of the population of the USA, that they rank third among prescribed drugs, and that the value of their annual sales in the FRG amounts to DM 240 million.

In fact, the symptomatic effectiveness of tranquilizers has not been demonstrated to be statistically significant precisely for patients with neurotic disorders and symptoms of anxiety and depression. The patients treated with placebo in these comparative studies also showed clear improvements, particularly in long-term treatments. This demonstrates the significance of the general therapeutic factors that enter into treatment via the doctor-patient relationship and the psychological and psychotherapeutic orientation of therapists (Kächele 1988a).

A disposition to anxiety reactions, which is often referred to as a trait, can be transformed into an acute state of anxiety by a multitude of danger signals (see Spielberger 1980). In extreme cases, almost every stimulus can precipitate an anxiety attack and turn, if left untreated, the free floating anxiety into a chronic condition. At the other end of the spectrum, even if it is not possible to draw a firm distinction, are the phobias, which only precipitate anxiety when there is a circumscribed stimulus or specific situation that the patient can avoid. Greenson (1959) reported that diffuse anxiety states resembling anxiety neurosis are manifest at the beginning of many phobias, in which a secondary linkage between the anxiety attack and the associated situation is drawn by means of causal attribution. The individual is free of anxiety insofar as he avoids the phobic object, e. g., the spider, snake, mouse, open square, bridge, or airplane.

A distinction is commonly made between a diffuse and undirected anxiety and the fear related to a concrete danger. This distinction has, as Mentzos (1984) has emphasized,

> lost in significance in ordinary language because the word anxiety is also used with regard to a concrete danger. Yet it still seems sensible to differentiate between more diffuse, less organized, undirected, somatic anxiety reactions, on the one hand, and more structured, organized, desomatisized, and clearly directed reactions, on the other, even if in practice it is not always possible or desirable to draw a sharp distinction between anxiety and fear. In the fewest of cases is it possible to proceed from either this or that; on the contrary, there are countless nuances in the continuum from diffuse anxiety to concrete, directed fear. (Mentzos 1984, p. 14)

An anxiety that first appears in a specific situation may later possibly be precipitated by other, similar situations. This stimulus generalization takes place to the degree that avoidance behavior increases as a result of negative reinforcement. Avoidance in turn increases the anxiety about a danger situation, which can be an additional reason for the disproportion between the observed precipitant and the severity of the panic attack.

Disproportion here means that the patient reacts psychosomatically as if he were in great danger. If the conscious and unconscious ideas that anxiety neurotic patients have about threats are taken seriously, then there are good reasons for the manifestation of the anxieties that are freely floating and only appear to lack an object. The threats experienced by the anxiety neurotic are so overpowering because he cannot avoid the situation precipitating the anxiety; destruction is thus ubiquitous. To common sense, the person suffering from anxiety only imagines dangers that either do not exist in reality or are greatly exaggerated. Modern clinical diagnostic procedures contribute to this mistaken attribution by frequently detecting minimal deviations that are incorrectly considered to be its cause or a part of the anxiety neurosis instead of an equivalent or correlate of the anxiety. Doctor and patient then believe they have found a specific cause, which can result in temporary relief when therapeutic measures are undertaken. Yet the disappointment is all the greater when the removal of the node in the thyroid or some other treatment does not achieve the desired results. There is hardly another clinical condition that is so frequently misdiagnosed by modern medicine as anxiety neurosis and its multifaceted forms.

Countless *circumstantial diagnoses* based on symptoms such as eye flutter, sweating, and trembling serve to maintain the patient's distress and reinforce his anxiety. Diagnostically it is often difficult to find the (psychic) precipitant of the somatic equivalent of the anxiety, and accordingly it is impossible for the patient to find relief by avoiding the precipitating situations, as the phobic patient does. Since the individual with cardiac neurosis or heart phobia cannot distance himself from his heart as if it were a spider, this syndrome belongs to anxiety neurosis, but at the transition to hypochondriac states. The term "heart phobia" is therefore inaccurate phenomenologically and psychodynamically. Bowlby (1973) has also suggested a clinically convincing manner to differentiate the phobias, which Hoffmann (1986) has recently drawn renewed attention to. The agoraphobic is not afraid of the market square but lacks in this situation the person providing security, i.e., a "regulatory object" (König 1981). Richter and Beckmann (1969) also described a differentiation for cardiac neurosis. They described two types, distinguishing

between their reactions to separation anxieties. As a result, there are substantial differences in the therapeutic difficulties posed by anxiety disorders and their subforms.

Psychoanalysis relies on the healthy elements of an individual's personality even more than somatic therapy does. The more severe the anxiety disorder, the smaller the space from which the patient is capable of mastering, with the analyst's assistance, the conditions of the anxiety that are rooted in his distant past and revived in the present. If the patient is extremely insecure, it is essential that the analyst employ supporting measures to strengthen the patient's position to the extent necessary to ensure that the patient can reflect on his situation and perform trial actions. Verbal relief is often insufficient in states of acute anxiety and agitation, making it necessary for tranquilizers, antidepressives, and beta-blockers to be used against the concomitant somatic symptoms. Essential is that this supportive use of medication be included in the *psychoanalytic* plan of treatment and be subordinate to it (see Benkert and Hippius 1986; Strian 1983; Wurmser 1987).

The more diffuse and free floating the anxiety, the more difficult it is to master it. In such cases it is therefore important to work with the patient to discover where the anxiety is transformed into object-related fear, in order to gain a sphere in which to overcome the patient's helplessness. This psychodynamic process goes hand in hand with a phenomenological differentiation between anxiety and fear. The more successful one is in objectifying the anxiety and recognizing what the patient is afraid of, the greater the opportunities for mastering the perils of the object that originate in the patient himself.

This differentiation has had great significance in the psychoanalytic theory of development because maturation is defined there as the change from diffuse anxiety to concrete fear. Consequently Mentzos, despite his reservations against a sharp differentiation between anxiety and fear, argues

> that one [should] proceed in developmental psychology from a tendency toward maturation and thus, for example, consider diffuse, somatically experienced, and apparently unfounded anxiety states in adults to be a regressive reactivation of ontogenetically earlier modes of anxiety, or at least assume there has been a disintegration of a later, more mature pattern of anxiety. (Mentzos 1984, p. 15)

We agree with Mentzos that the capacity to control anxiety is an indicator of ego maturity. Knowledge of the prototypical fundamental anxieties of children thus facilitates the diagnosis of neurotic anxieties in adults.

In conclusion we would like to mention several principles of therapeutic technique that have shown their value in the psychoanalytic therapy of anxiety disorders, regardless of severity. Essential is to promote the patient's capacity for integration as opposed to the stimuli precipitating anxiety. The statement that precisely the severely ill anxiety neurotics suffer from ego weakness says nothing else than that the threshold for emotions is lowered and apparently banal desires appear as "instinctual anxiety" and precipitate a danger signal resulting in anxiety. The technical consequence of this description is complete reliance on the analyst's function as an auxiliary ego. Chronic anxieties lead to a loss of self-confidence and self-security. In his function as an auxiliary ego, the analyst can contribute to the patient's capacity to extend his sphere of action by providing encouragement in the form of acknowledging what the patient is still able to accomplish. This direct and indirect support must be underpinned through the specifically psychoanalytic tool of interpretation. Self-security and self-confidence grow, for example, to the degree that "superficial" anxieties, which Freud referred to as social and superego anxieties, are eliminated. Proceeding from the surface into the depths is a tried and proven therapeutic technique, which we have discussed in the introduction to Chap. 4. Of course, following this rule achieves little if at the same time concomitant acknowledgments of the patient's remaining capacities are carefully avoided out of a false understanding of the rules of neutrality and abstinence. Coping with neurotic anxieties is eased if we take advantage of all the possibilities offered by the mastery theory of therapy.

In severe, chronic anxiety neurosis with panic attacks, distressing defeats have continuously raised the *unconscious* potential for aggression so high that there are hardly any harmless wishes left. For example, the anxiety that one may die from a heart attack is unconsciously frequently linked with aggression that is directed precisely against the people that the patient relies on for protection. The resulting dilemma would obviously be reinforced, to the disadvantage of therapy, if an analyst proceeded to interpret anger on the basis of this connection. Helpful interpretations are oriented on the patient's capacity for integrating affects. The patient's self-confidence grows in the relationship to the analyst if the latter provides suggestions from the position of an auxiliary ego. Ambivalences always have the effect of increasing anxiety and should therefore be called by name where they are accessible to the patient. In accordance with this, the patient increases his capacity to distinguish unconscious fantasies, which in light appear less sinister than they do in the dark of the night.

We encounter anxiety, which constitutes the fundamental problem of all neuroses and their gradual resolution, in numerous examples in this volume. Moderately severe anxiety neuroses—all those suffering from the syndrome Freud described, which includes the cardiac neuroses—are very accessible to psychoanalytic therapy. Long-term follow-ups verify enduring treatment results, even for very severe anxiety neuroses (Thomä 1978).

9.2 Anxiety Hysteria

Anxieties and hypochondriac fantasies about one's body are a frequent and at least sporadic manifestation accompanying the hysterias described by Charcot and Freud. The contents of the anxiety provide a secure access to the patient's experiencing and also indicate that physiological deviations are the equivalents of affects. In this regard the analyst must pay special attention to the patient's fantasies and *private theory* of his illness; it is otherwise impossible to recognize that, for example, nervous breathing difficulties are the somatic equivalent of an anxiety neurosis.

Hysterical symptoms—as originally meaningful achievements and fragmentary actions—should especially be expected if unconscious portions of the *body image* are incompatible or contradict the *physiological regulations* . Most important in the process of *conversion* is that incompatible fantasies are displaced within the body image. The concept of *displacement* refers to a mechanism that plays an important role with regard to the development of hysterical and phobic symptoms in both the theory of dreaming and the theory of neurosis. Compromise formations are formed in dreams and in the genesis of symptoms by means of displacement, and psychoanalysis--as the psychopathology of conflict—has demonstrated its clinical effectiveness in the therapeutic resolution of these compromises. One reason for our emphasis on displacement is that this process is helpful in comprehending both the unconscious fantasies about body image of the individuals described below and their production of dreams and symptoms. The presumed transformation of energy, which Freud linked with the theory of conversion, is an obsolete hypothesis. Readers who first wish to gain information about the theory of conversion and body image should turn to Sect. 9.2.1.

Symptoms

At the beginning of treatment Beatrice X was 24 years old, had been married for 2 years, and did not

have any children. For some 8 years she had been suffering from cramped breathing accompanied by a feeling of constriction and severe distress. These symptoms appeared for the first time in the year of her father's death, who died from a chronic cardiac disorder accompanied by difficulties in breathing. Her condition, which was diagnosed by an internist as a nervous breathing disorder, had worsened for about 2 years, making her fear that she would suffocate. She incessantly coughed and cleared her throat throughout the entire day (nervous cough). During her honeymoon her anxiety increased so much, particularly while eating in the company of her husband and then also in the presence of others, that the patient had had to eat her meals alone ever since. Her symptoms were accompanied by abstruse fantasies about her body: terrible experiences of emptiness; she thought her thorax was empty and no air went into it; thought she was too weak to breathe and that the air escaped as it does from a porous ball. Then she would feel as if she were a steel pipe. Coitus was impossible due to vaginismus.

Beatrice X frequently squatted, since she somehow felt safer crouching on the floor. It was intolerable to her for an empty space to be in front of her or "to be empty in front." She therefore sat completely cramped while driving. Countless incidental acts betrayed her great inner distress. She found support by playing around with whatever objects were at hand. She controlled herself and her surroundings.

The following information, reported by the patient at the beginning of her analysis, deserves to be emphasized with regard to events preceding her illness:

From the age of two until 15 the patient was in the habit of masturbating by making a jumping sliding movement her mother referred to as hopping. Her mother's prohibitions made this hopping into something evil. Her own old anxiety about having injured herself reappeared in her later symptoms.

The patient avoided hopping on her father's knees. The revival of incest desires in puberty brought forth stereotype dreams. In these dreams something terrible always happened between her and her father, and she woke from an orgasm. A rewarding daydream recurred frequently during a long period of time, namely that she had a blister on her lower arm that a doctor had to open. This frequent fantasy was accompanied by great pleasure.

She had practiced her oedipal incest desires in games with her brother. He had wanted her to

stroke his penis, and used all his effort to maintain his self control. That he did not twitch a muscle made him into a model of masculine self-control that others should imitate and made him an example of "control." After these controlled satisfactions the patient went into the bathroom to have cold showers. Her mother must have had some premonition because she separated them. The patient later believed that her parents never had intercourse since they did not sleep together.

In hindsight the patient dated the onset of her breathing difficulties back to when she was 15 years old, the year she successfully suppressed her self-gratifications (i.e., the hopping). The patient was overcome by her first severe anxiety attack after she had met her future husband; their relationship became more intimate about a year before they married. At first the patient was afraid to have intercourse, and she and her friend initially limited their contact to mutual stimulation and gratification, which however was more intensive than her experiences with her brother had been. The patient's hysterical somatic symptoms became more severe following her first anxiety attack and particularly following their honeymoon. Beatrice X's symptoms belonged to those of the syndrome of anxiety neurosis. The addition *anxiety hysteria* is justified because of the primarily oedipal sexual contents of her anxiety, yet the pejorative meaning of the word "hysterical" makes it advisable for it not to be used in any correspondence or in discussions with the patient or family members. To discontinue using this traditional term in scientific discussion, however, would amount to a cover-up. Hysterical mechanisms and contents are pathogenic factors that continue to be frequent in anxiety neurosis.

In this treatment report, prepared about 30 years ago, the focal points of therapeutic technique are related to specific assumptions about psychogenetic relationships. The systematic description of this treatment covers more than a hundred closely typed pages. The successful psychoanalysis lasted about 350 sessions in all. For external reasons Beatrice Y twice had to be admitted for in-patient treatment; during these periods six sessions were held each week. In the interval and afterwards the patient came an average of twice a week until she was cured. Beatrice X has remained essentially free of symptoms since then, leads a harmonious family life, and has several children. She has coped very well with the burdens of life.

To make the sequences stemming from later sessions more comprehensible, we would like to mention that a multifaceted transference neurosis was formed during the first period of in-patient

treatment. The patient's dream language was rich in symbols, which provided an immediate access to her still infantile sexual theories and to the hysterical disturbances of her body image and the anxieties that were associated with them. Her dream metaphors were unusually closely connected with her unconscious body image and its different layers. Reversing displacements, i.e., referring to these "transferences" (in Greek, *metapherein*) by name, played an important role in transforming her unconsciously disturbed postural language.

Analysis of Beatrice X's imitations led to specific questions about the psychogenesis, for instance about the significance of her unconscious feeling of guilt, which was gratified by her punishing herself by having the same symptoms her father had had. Everyday excitement and the observation of accidents made the patient become violently agitated because they reminded her of her father's illness and death. After his death the patient had continued her father's illness with her own symptoms, her shortness of breath and her anxiety. By means of these symptoms she had maintained ties to her father, who had long suffered from heart disease and shortness of breath.

The similarities in the symptoms, specifically the shortage of breath, had even been noted by her family doctor, but the patient had not caught his allusions to it. It often takes a long period of preparation for insights into such imitations rooted in unconscious identifications to be made *therapeutically* productive. Of course, the process of making a patient aware of unconscious identifications that can find their symbolic expression in hysterical symptoms is facilitated when the patient practices the imitation of particular features in his own body.

After long preparation the ground had finally been paved in the 123rd session for the patient to understand an imitation. The patient disclosed her longing to be linked with her father in conscious fantasies. The pain and mourning that were linked with her separation from her father were revived. She became certain, by means of a *transferred idea* , that it is possible through symptoms to maintain a relationship for a long period of time and despite a final separation. She then referred to her gift for observation, but only after making many apologies and revealing a bad conscience that even she found suspicious. Finally after making many reservations, Beatrice X made derogatory statements about my peculiar manner of walking and how I moved my arms arrhythmically.

Beatrice X had pantomimed her observations for herself outside the session. This attempt at imitation became a significant event in the attempt to recognize her unconsciously anchored identifications and the concomitant affects. Her derogatory comments about me took the same line as her old feelings of guilt toward her father. In this session she cried passionately for the first time.

The following later observations are relevant in this context. In her associations she first mentioned something external, namely that I had talked to her earlier in the ward to make sure that the session was actually at 5 p.m. She said I had looked tired and tried to get me to cancel the session. This was followed by the following series of associations that are instructive for the genesis of her symptoms and my comprehension of them. Her father had often been tired and, especially in the years of his illness, hardly in a condition to have his meals at the table. He was asked to, and he made an effort. I gave the following interpretation: You were obviously afraid then that something could happen to your father while eating; as short of breath as he was, the potato you gave him might mean his death. Today you wanted to prevent me from also becoming exhausted, and possibly weakened or even suffocated, from the things you served me.

Since there had already been an allusion in the session to an earlier dream about hedgehog meat, I incorporated this allusion into my interpretation and told her she was afraid of giving me something harmful, such as the hedgehog meat with its spines, which would not agree with me. (In this earlier dream she had regretfully given someone hedgehog meat.)

The subject of her *identification with her sick father* was further resolved. This problem can be illustrated with regard to one small detail in transference. Beatrice X requested that the window be closed, but called this wish horrible. Interpretative work led to her father and the fact that he had been constantly short of breath—so that the window had to be kept open—and to tension at meals, which increased as his condition worsened. In hindsight the patient had the feeling that her father simply could not take it any more. I offered the interpretation that she was now anxious that I could not take it anymore, either, with the window closed and being very exhausted.

The other line of interpretation was her anger at her father, who was only concerned with business. At home the family had to be careful not to disturb him, but precisely at meals there was conflict. Beatrice X herself was a mediator, the one who could not bear the conflict and her parents' talk about divorce. The previous night she had had a dream, namely that the firm was ruined. She had walked with her mother through the destroyed building and said that everything her father had build up was ruined. In transference she showed similar feelings, concerns about me, and the criticism that I did not care for my own family either.

Displacement Downwards and Upwards

We would like to supplement our theoretical comments about body image and displacement by describing a clinical example in which breathing constituted the starting point with regard to symptoms.

Two Dreams. The patient, in great desperation and anxious horror, saw herself surrounded by numerous little men, as if they were rubber dolls. These little men exploded one after another. The patient tried to find some support and held on to a rope that somehow hang from the sky.

In the second dream she was on a bridge together with numerous other onlookers. The main action in the dream was a shark hunt. From the bridge they could see how a shark that tried to fight itself free was drawn into a small boat. Although it swung its tail back and forth, it was killed by a spear thrust into its belly.

Since Beatrice X, as she recalled in this connection, had previously dreamed about a rope on which she had been drawn down into the depths, the relationship to this earlier manifest dream content was established first. In the previous session we had really jumped from one topic to another, familiar items being considered without any profit. I established a connection between the explosion of the little men and her anxiety that a condom might rupture. These ideas led us to talk once again about her compulsion to control.

I silently assumed that that her anxiety about such a rupture might somehow be linked with her castration anxiety. I considered this hunch all the more because we had discussed the unusual positions she took on the couch. She was always a little diagonal, because in this position she had the feeling that she had better control of the situation.

Her comments about her posture stimulated me to fantasize that she had obviously overcome her castration anxiety by using her body as a phallus, as Lewin (1933) had described. Peculiar was, however, that her anxiety was that she would get less air when stretched out than when she was stooped over a little. At this point she became aware that her playing with her body served to discharge excitation. We talked about her masturbation being her attempt to overcome her feeling of emptiness by touching.

With regard to the fish dream, I interpreted her inclination toward taking revenge on me (analyst) by alluding to the fact that she took revenge on the fish—i.e., the penis that tried to force its way into her, just like the rocket in another dream. In this connection the patient had recalled an earlier dream in which she drove into a path that was too narrow. Her recollections and transference fantasies could not be linked to unconscious oedipal conflicts.

That evening Beatrice X continued her self-analysis and at the next session admitted that she had kept an important association to her dreams to herself. She said that according to her feelings the bursting of the little men definitely had to interpreted in connection with a series of fantasies she had had before, during, and after her defloration.

Next she surprised me by giving a precise description of her honeymoon trip, the first night, and the following day. On the second day she had gone swimming with her husband in the sea and had felt that—as she said—there was a hole in her and could not control what went in or came out. These were the words she used to describe her body feeling after her defloration, and I added: "When you went into the sea, you had the fantasy that water could enter your vagina, just like air when you were outside." This meant, in her dream language, that a fish (penis) could also enter her.

Beatrice X actually believes up to this very day that her vagina continues to rip further and further apart. In this connection she recalled an earlier dream. The notches in a fly's wings she had dreamed about were, according to her, definitely the kind of tears that happened during defloration.

The patient now added that she then had the desire—which she found completely incomprehensible—not to eat together with the other guests. This disturbance thus also began shortly after her defloration, at the same time her breathing disturbance became more

severe. She immediately sensed that this was an *upward displacement* . It was the attempt to exert control where it was possible by means of her voluntary muscles, to at least close the "holes" there.

The interpretation of the fish dream led further. The patient talked about her revulsion at fish, which she had felt since her honeymoon. She also had an aversion to the smell of fish, which resulted from the analogy between the smell of fish and that of ejaculation, which now became conscious.

I also interpreted her aggression toward her husband, telling her: "You had pain, felt hurt, and therefore took revenge on your husband and his penis. In the dream you had him kill the shark; in reality you often hack up your husband."

In the previous session the bursting of the little men, the rubber balloons—in an association she mentioned that the entire matter was like the bursting of soap bubbles—had led to a different allusion that was initially not productive. I had the thought that the bursting represented a still unclear association to the pleasurable fantasy in which she had had a blister on her lower arm that a doctor had opened. The patient could not recall whether she had then thought that something had been in the blister. The idea did not go beyond an allusion.

In the 131st session Beatrice X did not mention this "blister" again immediately, not until after she had talked about her vacation, referring to the fish dream and associations about eating fish. She started this line of thought by saying that although they had stayed at a good hotel, she had discovered a mouse in the bathroom, which then disappeared. She fantasized that the mouse might have hidden in the toilette. The night after this she had a very repulsive dream.

P: I had a bowel movement. In it there was a large fish.

The patient had already had the idea that she produced something to demonstrate her independence. I interpreted that she had something in the dream that otherwise entered her, not leave her. After this interpretation she recalled the dream she had had the previous night.

P: I had a blister on my nose. A man came who opened the blister with a pin, but what came out was that I had the same kind of pin hidden in the blister.

This dream seemed to fit her dream about her anal excretion of a penis. I summarized the patient's associations in a transference interpretation. She then said that she would very much like to read my notes to finally know what I thought about her; she often asked herself what I would write after a session. The interpretative work proceeded as follows. The secrets she presumed were in the report were probably precisely the hidden item—the assumption that I did not think much of her as a woman—and she now thought that she had to attach a very high value to the hidden element. I interpreted her private revenge as the unconscious idea that I, just like her husband, wasted her beautiful associations, her bowel movement, her money, and her ideas in order to make a beautiful project and to become an ever greater person, architect, and analyst, while she believed she had to sacrifice everything and always ended up empty handed (an allusion to the pen with which I wrote and her husband used in becoming a successful architect and to it as a symbol for a penis).

Her nervous cough has disappeared almost entirely. In the past few weeks she has been able to eat together with her husband for the first time since their honeymoon. Their sexual relationship has become more satisfying, and she pays less attention to contraception, even though her anxiety about conceiving and bearing a child has increased.

Summary. Our goal in describing the two excerpts from this analysis of anxiety hysteria is to let the reader take part in a partial resolution of symptoms. Both the patient's unconsciously anchored imitation of her father's symptoms and the displacement from bottom to top were partial causes that were resolved, resulting in a significant improvement in the symptoms they had caused. The fact that symptoms continued to exist is an indication that other unconscious conditions were active. And in fact other anxiety contents then moved to the focus. Birth anxiety took the place of some earlier symptoms; i.e., there was a change in symptoms (see Sect. 9.5). Noteworthy is the alloplastic structure of her new anxieties in comparison with her previous hypochondriac anxieties. It is always a positive sign when it is possible to ease the autoplastic representation of conflicts, i.e., their far-reaching internalization, which is implied in the differentiation between autoplastic and alloplastic processes that goes back to Ferenczi (1921).

In Sect. 8.3 we describe the resolution of these neurotic anxieties and present a *sequential protocol* .

9.2.1 Conversion and Body Image

Anyone who accepts Darwin's description of emotions, which has retained an exemplary character for modern theories of affects (see Vol.1, Sect. 4.2), does not have to face the problem of conversion—i.e., the hypothesis that psychic energy is transformed into physical energy or excitation. To reach a diagnostic and therapeutic understanding of many functional syndromes, it suffices to view them as an unconscious expression of emotions. The expressive meaning of hysterical symptoms is *not* restricted to sexuality. Freud attributed *conversion* to Darwin's principle of the "overflow of excitation" (Freud 1895d, p. 91). In the case history of Elisabeth R., he wrote, for instance, "All these sensations and innervations belong to the field of `The Expression of the Emotions', which, as Darwin has taught us, consists of actions which originally had a meaning and served a purpose" (1895d, p. 181). Many such examples of symptoms in which, for example, aggressive impulses find unconscious expression can be found in Freud's case histories.

It is not necessary to resort to the assumption that there is a conversion of psychic energy into

physical energy for us to comprehend that hysterical symptoms are, according to Freud (1895d, p. 133), unconscious fantasies that have become visible in disguised form. The *causal* assertion in this sentence is retained even without the expression "through conversion" (such as a *transformation* of psychic energy into physical enervation). Hysterical symptoms and many functional syndromes are fragmentary sensory or motoric acts that, because of defense processes, are expressed only partially (pars pro toto). The ideational component, i.e., the idea and the goal, is no longer accessible to the patient himself. This is the basis of causal and prognostic criteria for clinical validation.

The mind-body problem, which cannot be resolved empirically anyway, can be ignored just as can the related "mysterious leap from the mental to the physical" (Freud 1916/17, p. 258). Hysterical symptoms are rudimentary and originally meaningful events and as such their psychophysiology is no more mysterious than are purposeful acts (Rangell 1959). The fact that psychoanalysis took the theory of conversion to mean the transformation of one form of energy into another is a particularly clear demonstration of how far astray it has been led for decades by the economic principle (see Vol.1, Sect. 1.1). The psychoanalytic method based on Freud's psychological theory is itself completely sufficient to understand the language of hysteria and to explain the formation of symptoms:

> By carrying what is unconscious on into what is conscious, we lift the repressions, we remove the preconditions for the formation of symptoms, we transform the pathogenic conflict into a normal one for which it must be possible somehow to find a solution. All that we bring about in a patient is this single psychical change: the length to which it is carried is the measure of the help we provide. Where no repressions (or analogous psychical processes) can be undone, our therapy has nothing to expect. (Freud 1916/17, p. 435)

Hysterical symptoms and a group of functional ones prevent affects from completely expressing themselves. A part represents the whole. In such conditions, the sick individual lacks most of all a means of gaining access to his intentions. These are, to quote Freud's words, "kept from conscious processing." The essential fact is that the disruption caused by repression—the necessary causal condition (Grünbaum 1984)—can be reversed by means of *interpretations* . The situation is different with the symptoms of physical illnesses. Alexander, back in 1935 (p. 505), wrote: "It is a methodological error to attempt to interpret psychologically an organic symptom which is the end-result of an intermediary chain of organic processes." This view agrees with Freud's clear methodological guidelines about physical disturbances that cannot be interpreted symbolically (Freud 1910i, p. 217), which brings us to the modern theories of action and affects, and to the view, following Christian, that:

> From the perspective of a theory of action, the symptoms of conversion hysteria constitute the actual genesis of a fantasy. Also important is the outcome of the fantasy, namely precisely not the outcome of a natural and normal action but the realization of abridged opportunities to act in certain scenic simplifications. The following comparison may make this clearer: Complete scenic realizations of body language are embodied in dance theater, where scenes are depicted in body language, but in an artistic manner. The hysterical enactment is, in contrast, more primitive and unartisitic; it is somewhat theatric, which is precisely not artistic. Freud also noted this reduction to a primitive fantasy in conversion symptoms . . . . The symptoms are both a substitute for actions that would otherwise have to be carried out (substitute or fragmentary acts) and expressions of the unconscious conflicts (representative acts). (Christian 1986, p. 81)

The sexual revolution and Freud's teachings have made substantial contributions to making the hysterias and anxiety hysterias that were so widespread in the nineteenth century, and whose symptoms Charcot could have patients reproduce and enact in the Salpetrière by means of suggestion, become so rare in today's society. On the other hand, the same symptoms of anxiety hysteria continue to exist in the "functional syndromes," the increasingly subtle diagnosis of which continues to mount pressure on modern medicine. The disturbed patient—who cannot know that his symptoms are expressions of unconscious emotions—insists that the physician repeat the diagnostic examinations to exclude a hidden and possibly malignant illness. Frequently the result of these examinations is some harmless deviation from normal that, because of its ambiguity, can become the source of new disturbances and lead to measures that are entirely inappropriate for alleviating the patient's neurotic anxieties. The precise reason for this follows from the structure of these anxieties and the development of a vicious circle in which helplessness, hopelessness, and anxiety reinforce each other. We describe these connections in the excurse on the central role of anxiety in psychoanalysis in Sect. 9.1. One of the most fundamental facts Freud discovered was that an unconscious intention is directed at an external object or at its image, and that the latter can be imprinted onto one's own body (or self-image). The specific unconscious fantasies themselves vary from case to case. Analysts are well advised, however, to presume that impulses that have been warded off, i.e., aggressive impulses that have become unconscious, are present in *all* dysmorphophobias, that is in all body image disorders in which the patient subjectively experiences some deformity as being present although in fact it is *not* (Sect. 5.5). This regular observation can be understood if one realizes that in identifications the shadow of objects that have been given up also falls on the *body image* , to modify Freud's well-known metaphor. In this process, a fight in which an imagined or real injury is inflicted on the opponent (the "object") is portrayed on the individual's own body image, by the individual putting himself partially in the other person's place. This process can be the basis both of simple imitations and of mystical participation, for instance, in the suffering of Jesus on

the cross.

Because of the fundamental significance of *body schema* and *body image* in our overall understanding of illness, we discuss this concept in the following section (see the comprehensive description given by Joraschky 1983). The concept of body schema was coined in neurology and used by Pick and Head as a general concept for describing bizarre body perceptions by patients with brain lesions. Head referred to body schema as the frame of reference for body perception, i.e., for spatial orientation and posture. Body schema was defined by him in neurophysiological terms: Man's use of the schema is not a psychic process but takes place at the physiological level (as described by Joraschky 1983, p. 35). Schilder (1923) initially also followed Head's definition, but this creative author later made a special contribution to extending this concept to the subjective experience of one's body, i.e., to the psychic spatial image originating from interpersonal interaction. We will simplify the issue by orienting ourselves on Schilder, who consistently integrated psychological and psychodynamic results into the theory of body schema and who referred to the concept "body image" in his later book *The Image and Appearance of the Human Body* (1935).

From body schema to body image—these key words emphasize the discoveries Schilder made, which have proven to be extremely fertile in psychoanalysis and psychosomatic medicine, even though Schilder himself is rarely cited and this although, according to Rapaport (1953, p. 7), he was one of the most widely versed thinkers in the history of psychiatry. For just this reason we want to cite several representative passages from his largely unknown article "Das Körperbild und die Sozialpsychologie" (Body Image and Social Psychology) from 1933. We will emphasize those of Schilder's views that are of special relevance for therapeutic technique. For example, body and world are correlated concepts:

> The consciousness of substantiality, the three-dimensional image we have of ourselves, must be acquired in just the same manner as our knowledge of the external world. It is continually being built out of tactile, kinesthetic, and optical raw materials . . . . The subjectively experienced body image thus becomes the map of the instinctual impulses. (p. 368)

Schilder gave a brief description of a patient who felt her body had fallen into separate pieces. This was correlated with impulses to tear others into pieces. For Schilder, the desire to be seen is just as original as the desire to see.

> One's own body image has very much in common with the body image one has of others. When we construct

> our own body image, we are constantly attempting to find out what can be assimilated into our own body. We are no less curious with regard to our own body than to that of others. When our eye is satisfied, then we want our touch to be satisfied too. Our fingers force their way into every orifice of the body. Voyeurism and exhibitionism have the same roots. Body image is a social phenomenon, but the human body is never quiet, always in motion. Body movement is either expression or action; it is the body of a person with passions and motives. (p. 371)

After describing a neurotic symptom, Schilder made the summarizing interpretation that the patient plays the roles of numerous people in his actions. He saw this as an example of the fact that:

> one's own body image contains the body images of others. Yet the latter must be given in the patient before he can merge them into his own body image. At one and the same time he lives in his body and outside of it. We have our own and the other body image at the same time. Body image is not the product of an apersonization of the body images of others although we assimilate portions of them into our own body image. It is not a product of identification, either, although such identifications might enrich our own body image . . . . The body image is never at rest. It changes according to the situation. It is a creative construction. It is constructed, dissolved, and rebuilt. In this constant process of construction, reconstruction, and dissolution, the processes of identification, apersonization, and projection are of special significance . . . . Yet social life is not only based on identifications, but also on actions, a precondition of which is that the other person is a person with his own body. There are two conflicting tendencies. The one assimilates the other person into one's own ego by means of identification and related processes; the other, no less strong and original, sets and accepts the other person as an independent unit. This social antimony has the greatest of consequences. (pp. 373, 375)

Schilder's vivid language probably reminds everyone of various facets of their own body image. The constant interaction between one's own body image and that of the other person naturally goes far beyond a comparison according to aesthetic points of view. The relationship of nearness and distance is also part of this social antimony. Proceeding from clinical observations, in just a few pages Schilder provided an overview that emphasizes the social psychological dimensions of the development of body image. Emotions, expressions, and fragmentary acts, in the sense of hysterical symptoms, are thus constantly in a close relationship to an aspect of body image that is more or less unconscious.

The body image is formed in conjunction with the development of the neurophysiological body schema and unites a wealth of representations of conscious and unconscious ideas. These representations can coincide, compete, or even disregard body functions as they are laid out physiologically. Because of its numerous layers, the body image can be compared with a painting that has been painted over repeatedly so that on one and the same canvas there might be paintings that match—or that do not. In this metaphor, the canvas would be the foundation or the neurophysiologically formed body schema, or in even more general terms, Freud's body ego. Incidentally, the individual, as the painter, is and remains a part of his body image because he is linked throughout his life to what has been

drawn in, and because the relationship between idea and image can be dominated by either productive or destructive tension.

9.3 Anxiety Neurosis

Christian Y suffered from such an unusually severe anxiety neurosis concomitant with paroxysmal tachycardia that a long period of in-patient treatment in a department of internal medicine had been necessary. In the preceding years his self-security had decreased substantially. Any banal stimulus, even minimal atmospheric fluctuations, in either the literal or the metaphoric sense, could suffice to increase his anxiety and cause a heart attack. The patient was incapacitated, unable to leave the hospital, and dependent on its support.

The patient had difficulty maintaining his composure during the diagnostic interviews. He described how he had been tormented by insecurity and anxieties for years. He said he had a deep mortal anxiety, was lethargic and depressed, and only continued to live out of a certain feeling of duty toward his parents. For a long time he had planned to commit suicide. His security was just show; he was only able to bear his anxieties and their somatic consequences in or close to the hospital.

An anxiety neurosis with a narcissistic personality structure was diagnosed. The analyst gave the following chronological description of the previous history of the patient's symptoms:

The patient grew up the oldest son in a large family, preceded only by two substantially older stepsisters from his father's first marriage. His mother was overanxious and overcaring, had a special attraction to her oldest son, and was a dominating figure. His father was a successful physicist and for professional reasons had been away from the family for several years during the patient's childhood; even later he was not present very often.

Preschool Period (Age 0-6). Numerous strong infantile anxieties. The patient grew up in the absence of his father and developed a very strong fixation on his mother. This fixation became more intense over the years because of his anxieties about being in darkness and being alone. Father returned when he was 3 years old. His infantile anxieties increased in connection with dreams in which the patient was punished by a man's evil glances or was threatened with physical abuse (with a pair of pliers).

Age of 6-12. A pronounced school phobia improved under his mother's care; for a long time she walked with him to school and did his homework.

Age of 12-22. Death of his beloved grandfather from heart failure. Clinical examination and treatment of the patient for

"cardiovascular disturbances." The diagnosis he remembered—"he had a weak heart"—was accompanied by the recommendation that he be spared physical exertion. This marked the end of a short phase of athletic and physical activity, which changed into passivity and dependence. Starting from the age of 12 the patient was in treatment by numerous doctors for his feelings of anxiety and cardiac disturbances.

The extreme maternal care was linked to the patient's acceptance of her ideals. The boy therefore became excessively well behaved and overconform and restricted his curiosity and activity extremely in order to retain his mother's love. His rivalry to his two younger brothers was suppressed. His school achievement remained far below what it might have been on the basis of his above-average intelligence. He concealed his disturbed concentration and capacity to work by easily achieving average results because of his high intelligence. As long as he reached his goal without any effort, he felt well, but even the slightest stress led to unpleasure and anxiety and shattered his fragile self-esteem. Although the patient had always been well liked because of his good upbringing, he could not remember any phase of his life in which he felt satisfied with himself in any regard or was able to get a feeling of security from an interpersonal relationship.

During puberty he had tried very hard to overcome his fixation on his mother. He was incapable of competing in athletic events. The fact that he had to quit just before winning was typical of his behavior pattern.

The patient attempted, in conscious decisiveness, to free himself of his mother's ideals, without being able to be happy about his successes with girls. His friendships had a narcissistic character and, just like masturbation, gave him more feelings of guilt than satisfaction. He lost the last rest of his self-security when a girl rejected him. This insult led to decompensation and heart anxieties he experienced as an irreparable physical handicap.

Christian X had to interrupt his education because of his symptoms and is incapacitated.

In retrospect we can see that the analyst in this case incorrectly judged the severity of the illness, paying too little attention in adjusting technical rules to the fact that Christian Y was still in the late adolescent phase of development. Since the problem of power-powerlessness is particularly delicate for this age group, the therapeutic technique should have be more characterized by "cooperation as between partners" (Bohleber 1982). In addition, the analyst's therapeutic technique—when the analysis was initiated some 20 years ago—led to immanent mistakes that had unfavorable consequences. For instance, it was too early to recommend that the patient reduce or stop taking medication. Better cooperation between the physicians treating Christian Y would also have contributed to raising his self-security and reducing the number of defeats leading to a further loss of self-security.

The following aspects of the external features of the course of therapy deserve mentioning. The analysis began 20 years ago and was completed after more than 10 years and a total of about 1400 sessions. Christian Y required in-patient therapy for more than 18 months because of the severity of his anxiety neurosis. Starting with the 320th session he was able to continue the intensive therapy of five sessions per week while residing in a halfway house. After a while he was able to walk to the consulting

room and was no longer dependent on the protection afforded by a taxi, which could have rapidly brought him to a hospital if necessary. After three years of treatment Christian Y was able, despite his continuing inhibitions, to start a professional career in another city. At this point, the frequency of therapy was gradually reduced. Thus of the 1400 sessions, 600 were during the first three years and the rest were spread over many years. This case thus includes a long follow-up period. Christian Y is today over 40 and has been successful professionally for years. He founded a family and is a happy husband and father, although he does still complain about a certain lack of self-confidence.

We describe four examples from this analysis. In the following section we present the 203rd session, from the phase of in-patient therapy. In Sect. 4.3 we described, in the context of displeasure as id resistance, the 503rd session in which his lethargy and incapacity to work reached their zenith. Finally, in Sects. 9.3.2 and 9.3.3 were refer to two excerpts from the phase of termination, to which Christian Y provided in retrospect an instructive commentary.

9.3.1 Separation Anxiety

The intensity of the underlying problem of separation is clearly demonstrated in the following excerpt with regard to a precipitating situation. This example shows the analyst's attempt to clarify the patient's conflicting needs and desires.

Prior to this session the patient had told his parents about his dependence on them during a weekend visit. He had never noticed this feeling in such clarity before. His parents had left with friends for a few hours, and the patient felt the urgent demand for them to stay there, to be there for him, and to take care of him. In the hospital three doctors gave him intensive attention, especially since it was difficult to control the degree of his tachycardia attacks with beta-blockers. At this point the patient, probably as a consequence of the analytic therapy, was ambivalent toward the drug therapy; he seems to have identified with the opinion that the analyst openly articulated that he should attempt to get by without medication. At the same time the drug treatment provided the direct support he did not receive from the analyst.

The patient had acute symptoms when he came to the session.

P: I feel queasy again, I have this . . . terrible agitation, shortness of breath, not really shortness of breath, that's exaggerated, but not enough air and heart problems. I haven't taken any medication because you didn't want me to, but . . . I'm not sure what it is, but . . . well, what could it be. [Pause] While I felt this queasiness, several times I felt the longing for you to be with me, and then I realized that I was angry at you, at least I thought I realized it but I couldn't admit how strong it was. Somehow I'm angry at you. [Pause] Well, it's funny; right now I can't think any more at all, and the symptoms are gone, too. All that's left is the annoyance that I was so uncontrolled, and the anxiety that I have somehow offended you.

A: But that is an anxiety that is obviously much weaker than the other one. Are the symptoms really gone now?

P: Hum, yes.

A: That shows that there's a very close connection between intense anger and your symptoms.

P: Yes, and then, whenever I feel as bad as this morning, then I have the desire to scream out loud for somebody. I always have to pull myself together to keep from screaming. Somehow not to be left alone or something like that is what I can think of.

A: And that's precisely what is was: the closed door and "Do Not Enter." Is he going to make me wait a quarter hour again today?

P: Well, I wouldn't have managed to wait this time. I called for the doctor and asked him; I felt so terrible. Now I have intense palpitations again, pounding, not fast . . . . And it must be these moods that I feel when I leave you or home. I apparently inflict all of my indignation on myself. But why can't I learn that it's nonsense?

A: Yes. Because you don't scream and yell and shout at me that way, and I'm the one who leaves you. By not acting that way, you feel more secure, because you think that I would otherwise leave you for sure.

P: Maybe it makes me feel calmer or amazed that you didn't make a face. I didn't think that there was anybody here in the room with you, or I wouldn't have knocked.

A: Yes, you've experienced that I'm not mad. That means that the anger you felt before knocking didn't have any terrible consequences. And then your anxiety goes away a little. Yes, he's not indignant after all, and then the symptoms are gone, the anger is gone, and nothing very bad happened.

Commentary. The sequence of events demonstrated that the patient had already been upset when he came from the ward. Before he came, he had obtained the assurance of the doctor there that nothing could happen. When he arrived at my office, he saw the sign "Do Not Enter." He experienced this moment as if he had been abruptly left alone, and became angry in reaction, but the anger could not reach its goal and got stuck in his symptoms.

Decisive was that the analyst himself mentioned the precipitating factor, the closed door, and the consequences the patient feared. He took the patient's place in verbalizing his aggressive fantasy and named the reason the patient could not shout and scream. Of course, this first step did not solve the problem, although it did clearly demonstrate the problem to the patient for the first time. This can be seen in the further course of the session in which resistance developed against the further assimilation of this insight that was primarily spread by the analyst.

P: Now I'm beginning to feel the anxiety again because I don't know if I can understand what you just said, I mean that nothing happens when I'm really mad.

A: Well, you understood it just a moment ago.

P: Yes, but, hum . . . apparently I know it but I'm still not entirely convinced of it.

A: Yes, you would like my friendly presence to give you reassurance every minute.

P: Yes, that's what I constantly told myself down below [in the ward], that nothing would happen if I'm angry. But that doesn't provide any relief.

A: If I'm not there, you get angrier, and you'd like me to give you reassurance—which in turn just makes you angrier—that I'm there and my posture and friendly expression show you that it's true.

P: Yes, and in this way the whole matter is simply shifted.

A: What do you mean "shifted"?

P: Well, now it's not the anger itself that gives me a headache, but the question of the certainty that nothing will really happen. You've told me and showed me often enough: Nothing happens.

A: Yes, but maybe something else is involved too. Although you would like nothing to happen, this makes me the know-it-all we talked about yesterday. It would be unbearable if I never forgot myself, never lost control and showed that I have feelings, too.

P: Well, I'm in a bad predicament.

The patient was caught up in a dilemma that is fundamental for the maintenance of neurotic processes, a phenomenon which Strupp (1985) has referred to as the "maladaptive vicious circle." When intense negative feelings are directed at the primary role model, the anxiety is focused on being left alone. Yet

fulfillment of the resulting desire that the other person should always be friendly and unchanging only provides confirmation that the difference between child and mother is irreconcilable. This insult precipitates new aggressions, which in turn have to be pacified by desires to cling to the person. How can such a patient be helped out of this predicament? In this case the analyst first explained the dilemma once more, saying "Whatever I do, it's wrong. If I were friendly, it would be terrible; if I were unmoved and less friendly, it would also be terrible." He then suggested that the patient himself inquire whether he sensed an indirect gratification from passively asserting himself in this predicament. The analyst apparently had the psychodynamics of secondary gain from illness in mind and described this conflict to the patient in order to provide him relief. Although this interpretation is theoretically well grounded, it is far too far from the patient's experiencing to provide him any support. It is easy to understand that the patient then fell into a sullen mood, and what followed were long pauses. The attempt to reestablish the faltering dialogue proved difficult and unproductive, the patient growing increasingly angrier and madder that once again nothing new had happened.

To counteract the patient's fantasy that his aggression led to object loss and being left alone and to shorten the weekend interruption, at the end of the session the analyst offered the patient an additional session on Saturday, which he gladly accepted.

After a longer pause, the analyst cleared his throat.

A: Hum?

P: Well, I haven't thought of anything I haven't already said. As long as I'm not completely convinced that you are still there, that my doubts are going to make me afraid again. I have . . .

A: a good means to finally move me to do more for you than sit here and just say something, especially on Friday when the weekend is approaching, to really do more.

P: Yes, but all I can think of is anger. It's the same as before. The anger that I'm alone, always left alone. Or maybe I haven't understood you; maybe you wanted to show me something else.

A: No, it's nothing new, but that's just the point, that nothing new happened again, just words once more.

P: Then there's apparently nothing else to say about it. I'm useless, angry about it, that's all.

A: Useless? I don't know. You're angry.

P: Yes, and I can't even show it. I'm probably even pretty angry, but I talk so suspiciously indifferent.

Commentary. The unproductive period seems to have been overcome. In this session the analyst determined what the affect was, using the differentiation—which in our opinion was too weak—between "useless" and "angry." The anger affect was now directed straight at the analyst and could be accepted by each of them. An important turning point in this session was the acknowledgment of the fact that it was a Friday session—this was a noteworthy point in view of the fact that the patient came to therapy five times a week and spent the weekend alone in the hospital. For the patient's unconscious experiencing, it was the analyst who left him for the weekend, and the patient was therefore more than justified in being mad at him.

A: Well, you're also glad that the anxiety you had when you came in is gone. It's Friday, after all, and you would like to leave with a positive feeling.

P: Well, we had agreed that it's nothing terrible for me to have an outbreak of anger.

A: Yes.

P: On the contrary, it's welcome.

A: You're not entirely convinced.

P: See, and that was the point. Why aren't I convinced, and how can I convince myself of it?

A: You don't want to convince yourself of it. The point is that you want me to convince you.

Commentary. In this transference interpretation the analyst gave one reason the patient held on to his anxiety. The patient refused to accept autonomy, struggling to maintain the dyadic situation in which he was pampered: It was the other person, not he himself, who was supposed to convince him, so that he would always be the winner because the task of convincing him would, like the labors of Sisyphus, always be in vain. The point was to move the patient to relinquish his infantile demands. In the following exchange this position was tested with regard to the role the ward doctor played for this session:

A: So you called the ward doctor to ask whether you could go, whether he thought that you would make it alright, or why?

P: No, I just didn't know which way to turn, no, very simply. I couldn't even march halfway down the hall [in the ward], because I was already so afraid and because of my heart problem, too.

A: And you still didn't take anything?

P: But you said that I shouldn't take anything.

A: Yes, but I didn't mean it unconditionally, you know that.

P: Yes, sure.

A: It's important that you didn't take anything for my sake. I don't know whether you can really manage. Perhaps it was a test of whether you can believe me enough that you can try it?

Commentary. The idea of a test brought up the patient's ambivalence: should he place more trust in the ward doctor or blindly obey the analyst? Was it an unjustified sign of trust, or was he testing the analyst's reactions by involving the ward doctor. Here the analyst seemed to place too much faith in his words.

P: Hum, I would be too afraid. Perhaps, but it seems strange to me. Well, I was really afraid of messing something up. And now I'm starting to feel bad again.

A: Yes, it's getting to be the end of the session, so it's probable that . . .

P: . . . the anxiety is coming back.

A: And your longing to take more with you is increasing.

Commentary. Christian Y received a bonus in the form of an extra session on Saturday, and in this sense he was able to take a lot more with him. After consulting with the analyst in question, it seems probable that he made the patient this special offer because he felt he had not been up to par in this session. Christian Y did in fact get drawn into a situation of conflicting loyalties with regard to his two doctors, and suffered a defeat while attempting to reduce his medication to do the analyst a favor. According to the psychoanalytic theory of anxiety, this repetition of helplessness was a renewed traumatic experience. The analyst's last sentence also did more to promote the patient's helplessness than to overcome it because the feeling of impotence increased when the patient's longing to take more grew without him being able to get it by means of his own action. Several aspects of separation anxiety were worked out convincingly, but a certain helplessness seemed to predominate on both sides about how the patient

could escape his dilemma.

9.3.2 Termination Phase

After this analysis had lasted over 10 years, the primary purpose of the termination phase was to correct mistakes that the analyst had made on the basis of false diagnostic and therapeutic conclusions. Although these conclusions are specific to this particular case, we are concerned with reproducing typical problems that the analyst traced back to his understanding of technique, i.e., to the one he had some 20 years ago. Christian Y's criticism had not only put some things right that had gone wrong during the treatment, but it opened his analyst's eyes for systematic mistakes.

The following is not a retrospective reconstruction of the course of this analysis. In an analysis that is still in progress, the focus must always be on the current moment and on the task of arriving at therapeutically effective insights by means of new forms of exchange and reflection.

In retrospect Christian Y expressed the suspicion that the purpose of my interpretations of the positive transference was not only to change his image or fantasies about the past, but also to invite him to clothe me in his fantasy wishes and, consequently, to confuse me with another. Almost literally he said:

P: I've suspected from the beginning that you're attempting to change the past by using this figure of the "other," which you've given form in various questions, that is to reverse my memory of my mother, which is predominantly negative, and to put her in a positive setting. A patient is in a terrible situation. As a result of the *confusion* that you probably call *transference* , he's the dumb one. For example, he relates his expectations of love to you, and if you go off talking, then I may know intellectually that you don't love me but I'm in danger anyway of making something out of it in my fantasy. I've never claimed that I've never been loved or can't be loved in the future. You've obviously misunderstood that. On the contrary, my mother poured enough love on me for several lives. But whatever might have been important to me or is important now was bracketed out. I don't have anything but the old rejection. The confirmation I was looking for with regard to sexuality and aggression was missing, and that's why I'm afraid of everything that I'm worried about.

What followed was a clarifying exchange of ideas resulting in the statement that the patient was not what he wanted to be, rather a kind of false image of his self. Yet his anxieties did not permit him to want and be more of what he wanted, which was the difference to what his mother had made out of him.

Commentary. This exchange reminds one of Winnicott's false and true self. It must be emphasized that the patient's elementary anxieties made it almost impossible for him to make a spontaneous movement

that he could have experienced as an authentic act related to his true self.

Christian Y then came to speak about the phase of therapy in which he had been sitting.

P: Seeing you keeps or kept me from losing control of my fantasy. And then it's not as easy for a confusion to happen.

A: Not just that you lose control of me, but of you yourself.

P: What's meant is clear.

Commentary. The analyst had let himself be led in the earlier phases of therapy by the idea that the patient's mother—who had treated him as her favorite during his father's long absence--could not have had a purely negative attitude toward his vitality. Now it turned out, however, that Christian Y had taken the interpretations that the analyst had made in this direction as an attempt by the analyst to transfigure the past, specifically as a kind of corrective retrospective illusion, i.e., a kind of self-deception. His suspicion was aroused by all the cautious, subjunctive interpretations intended to stimulate his reflection, such as whether it might not have been the case that his aggressive or libidinal impulses had sometimes been received positively. He said such interpretations might animate him to accept some confusion and self-deception, i.e., to be healed through illusion.

The significance of the propositional nature of the subjunctive case as used in psychoanalytic therapy deserves some comment. For many patients its use has a positive outcome. The subjunctive case is a verb mode that makes it possible to refer to something that does *not* exist. This verb form is thus specific to something that is solely imagined, and has been called by the author Arno Schmidt "an internal revolt against reality" and "even a linguistic vote of mistrust against God: if everything were really unimprovable, there would not be any need for a subjunctive." The role of the subjunctive in the works of Lichtenberg combined, according to Albrecht Schöne (after Schneider 1987, p. 296), destructive potential with productive energy. It is thus no wonder that the subjunctive case enjoys great favor in the language used in psychoanalytic therapy and that expressions such as "what would happen if . . . ," "I could imagine that . . . ," and "wouldn't it be possible that . . . " are preferred to the indicative mode of expression, which specifies what is or should be. Our intention in using the subjunctive case in this propositional sense is to revive the possibilities that have become unconscious.

For people who are inhibited and restricted by compulsive superego formations, cautiously applied hints can provide encouragement that otherwise leaves them sufficient room to make their own choices. Caution is appropriate in order not to evoke resistance. An altogether different situation is that of the large group of patients in whom borders are easily blurred and who therefore are desperate for security and seek clear statements of verbal support. Christian Y belonged to the latter group; he, incidentally, demonstrated to his analyst that the subjunctive case has a destructive potential if it does not have a strong partner in the indicative case. In this connection it must also be mentioned that the patient had memorized and retained his analyst's comments for a long period of time, something the analyst had misunderstood as idealization.

Very slowly it became apparent that his mother's extreme emotionalization had made him very suspicious of positive feelings. He therefore sought a sober and clear form of language and, from a distance, a confirmation of his thoughts and actions in order to successfully partially identify with the analyst.

The patient was angry and said that he had often tried to convince me of how important clear and direct confirmation was to him, to overcome his catastrophic shortage of self-esteem.

He said he was hardly interested in my personal circumstances, but was in the thoughts I had about him. He drew my attention to how important it was for him to become familiar with the context in which my interpretations arose, in order to become familiar with my feelings and thoughts about him.

P: I've always accused you of sitting behind me and having a lot more thoughts than you tell me, and that leads over to another point. I've always been much more interested in what you think but don't mention. You give some interpretations. You expand on some of my fantasies or develop your own, using some images. I don't want it, never have; I've tried to make it clear to you that you aren't permitted to do it. I want to know the notes you jot in the margin, as it were. I don't know what to confuse or transfer means. It's my opinion that it's very different from what a healthy individual normally does, and then I'm afraid, when I confuse you, that you'll make yourself come alive in my fantasies by stimulating some of them. That's not reality, but reality is what I want. When you use metaphors, then I get suspicious. I suspect that you want to suggest to me that this is a part of real life.

I agreed with the patient that insight into the connections that formed the basis of my interpretations would in fact make possible a critical examination, especially when the two sides of an issue were discussed in the dialogue. Out of the world of my thoughts that were open to precise discussion, he was particularly interested in my positive ideas about his sexuality and aggression.

In fact, the theoretical basis of many of the interpretations I made in the course of this therapy was that the patient's neurotic

anxieties stemmed primarily from his anxiety about object loss or a loss of love. Christian Y intensely criticized this line of interpretation.

P: I'm enraged; you said I was afraid of losing my mother's love and that this fear kept me from believing that some sign of affection was left and not everything lost, despite the anger. I took this to be encouragement to vary the image of my mother that I had in my head, the old monument, to make a better mother appear, and I told you each and every time that I'm not going to let you change my past, regardless of whether my mother was really so evil or whether she just seems so evil because I'm so angry. To me it's clear that she rejected this and that, and I'm not going to let you alter it.

A: So, if you were to vary something, then you would be lying to yourself.

P: Yes, then I'd be lying to myself, and I've accused you over and over again of inciting me to deceive myself.

A: But isn't it possible that you're still liked despite your being angry and that there hasn't been a total loss of love? Even though it is asking too much for you to receive affection the same moment that you are inflicting pain.

I then explained to the patient that anxiety about object loss was the consequence of unconsciously active anger.

A: I thought that you were afraid that your anger was so intense, so powerful, that everything would be destroyed and every affection would cease, because in real life the person attacked usually strikes back. And there would be a fight in which you would be destroyed, and it would be too much for me and I would give up and stop.

P: You know, I have a completely different conception, that I don't suffer so much from this or that interaction of anxiety and anger etc., but that my illness is a *deficit* . It's true that my fear has decreased since I've become more aware of how unlimited my anger is. It's become clear to me that the anger inside me is not sufficient to trigger a catastrophe, and here I have the freedom, in the sense let's say of an extended fantasy, to talk about anger or be angry. I know that nothing will happen, but what I don't learn is how to feel satisfied with the anger. In the meantime I've got rid of my more-or-less intense anger, or at least diminished it substantially, but sorrow has taken its place and I've cut off the sorrow branch.

Christian Y then talked about pleasure in speaking and that the point was to link his pleasure to the tree [as a metaphor for himself]. I asked him how he thought he could counter the *deficit* he had just referred to again. He returned the question, saying that this was my field and he did not have an answer. He said it was clear to him that it could not take place via an alteration in his memory. After a long pause I admitted my helplessness as to how this deficit could be overcome today. I pointed out to the patient that he had corrected something, namely my thoughts and actions with regard to therapy.

A: Is it possible that my acknowledgment of the clarity of your criticism might contribute to overcoming your deficit? You've achieved and experienced an increase in self-security toward me.

The patient immediately weakened my comment:

P: I'm always concerned about my relationship to the external world.

A: Yes, and above all about acknowledgment, and I've just given you one.

Commentary. This working through was continued in the subsequent session and in the long termination phase. The consequence of the fact that the analyst had discouraged this patient, who was intelligent and interested in his thoughts, from posing abstract thoughts—for example, clarifying the significance of the concept of ambivalence in discussion during the session—was particularly disadvantageous. The patient had drawn the conclusion from this that everything that had to do with abstract thought and analytic thinking was simply taboo for him. In violating such taboos he felt the anxiety that he was doing something forbidden.

A: It was an outright mistake not to give you more information about my thoughts.

P: Yes, it's often hard to envisage the consequences.

A: Yes, but it had the consequence that it hindered your efforts to become familiar with my way of thinking and to understand connections.

P: Another consequence was, let me put it this way, that I thought you were acting insincerely because I assumed that although you say what you think, you didn't tell me everything you thought.

Commentary. This was the reason for the patient's continuing mistrust. Warmth, tolerance, and empathy made him suspicious. The patient admitted that, also for practical therapeutic reasons, it was essential for the analyst to select from a number of possible thoughts and comments. The subject of self-security and the fact that his deficient self-esteem was a basis of his anxieties again became a focus of attention.

P: I've tried to tell you that tolerance and such things don't really help me. To confuse you with someone else can't be genuine. For me it's just a kind of extended fantasy, nothing real. The real thing would be to reach out to outside reality or to what you're thinking; I can genuinely relate to that. There it's possible to avoid the danger of confusion or clarify what's happened. Yes, in that regard I'm terribly curious; I want to know.

A: Yes, my views, opinions, thinking differs from that of our parents. Something new and different is involved.

Then Christian Y began to speak once more about the difficulties that result form the confusion, i.e., from transference. He had a vivid recollection of a session from long back in which he was very enraged and I had answered in an irritated voice.

P: That was an enormous disappointment; I was mad for once and then you let me have it again. I still haven't really understood how my

confusing you with someone else can have something to do with something coming from you if you aren't affected at all. Yet I've taken some of the actions you use here to be a kind of advanced bridge head that you work from, even if you as a person are far behind it and your actions are still very difficult for me to predict. And I don't really care about what I know about you. What's important is the question of trust and being able to follow what's said.

A: Yes, yes, because—to be brief—I am I and you are you; my goals don't have to be the same as yours.

P: We have to find the things we have in common somewhere else. Since I've been thinking about the question of confirmation, I've tried to force you into an *eccentric position* , so that you're no longer the one being confused but that you could say something about what I'm doing. Then I might be able to find some kind of reinforcement. But for reasons unknown to me you've avoided it. When I talk about anger, then you're still very similar to the one whose toes I'm stepping on. I know that this is a problem that's hard to solve, but if you would say something in that third position, I might be able to draw some gain from it if I could identify with what you say. That depends on your taking a stand and not talking in some disconnected manner and leaving it up to the patient to imagine what your opinion is. I still assert that you don't express yourself in what you say because it's always related to the patient's horizon.

I referred approvingly to the "eccentric position" that the patient invented, and mentioned its advantages.

A: It makes it easier for you and me not to have the great anxiety that would be (and was) present in confusions if you feared and expected that I would react exactly the same as your mother, father, teacher, or somebody else. Repetitions have repeatedly taken place in your life, i.e., confusions.

P: Just look, if you remove the anxiety, the anxiety of punishment and the such, the questions that remain concern the consequences of the punishment.

Commentary. This was a reference to the consequences that the internalization of his experiences had in his persisting superego and social anxieties and the subsequent behavioral difficulties associated with his intense loss of self-security and self-esteem.

The issue was then whether an eccentric position would keep the analyst from reacting sensitively to, for example, aggression and insults. The patient, who was a keen observer, had been able to detect during the period of analysis in which he had been sitting a lot on the analyst's face that confirmed to him the maliciousness of his aggression.

A: The eccentric position made it possible for me to bear the pain and tolerate your actions.

P: But you know that I don't have any logical reason to step on your toes or hurt you in any other way.

A: But I've done some things to you. I've missed a lot of things. I've overlooked some opportunities and I've made mistakes. Your recovery hasn't been optimal, and you still can't do what you want and be entirely satisfied.

P: Well, it would depend on the mistake, I've told you that before, and second you can't inflict any more damage than I brought with me in the first place. And I haven't made any complaints. The problem is only the eccentric position; I swear to you that I wouldn't accept anything [that is not logical], it triggers a multitude of anxieties because I don't consider the confusion to be something genuine. The point is that an original, good feeling about anger cannot be produced. Anxiety and rage cannot be reduced, and the good feeling makes it easier to bear the real anxiety. It's a question of the inner balance, but what I'm striving for is to produce a good feeling. The good feeling, you mentioned it once, but it comes up far too little in the therapy. Since then I'm the only one to have mentioned it.

The patient criticized the analyst for not assuming the *eccentric position* more clearly and for behaving more like someone making a supreme sacrifice and acting as if he tolerated it, which however made it possible for the patient to be angry during the sessions. The patient instead demanded clear statements that the analyst expressly approved of his sexuality and aggression and that they reach a consensus at this level. The patient then drew the following conclusion:

P: Then I could identify with what you say, but not because you yourself are the object, which moreover is allegedly what I'm looking for. I felt this to be dishonest.

A: So I've become an object of confusion. By offering myself to you as an apparent object from an eccentric position, I was unable to show you sufficiently that you yourself also have an eccentric position to this apparent object.

P: Yes, maybe you can say it that way.

A: We're linked and identified via the eccentric position, and that might lead you to better recognize it in little things or to have more inner security and authenticity.

P: Might be, yes, inasfar as we clearly distinguish what is confused and what is real.

A: At any rate, today I've better understood how important the eccentric position is in establishing some distance to the confusions, repetitions, and mistakes, and thus in finding confirmation and security.

Statement by Christian Y

After the analysis had ended, Christian Y generously provided a detailed statement to the reports cited in Sects. 9.3.2 and 9.3.3. His instructive comments were based on the original transcripts, i.e., the

protocols were still uncommented when he read the transcripts. In retrospect, he wrote:

> At the beginning of therapy I welcomed what I've referred to all these years as confusion because I considered it to be therapy's mode of functioning. It was not until later that it took on a negative accent. That was related, in addition to my clumsiness, to the way you handled it. At the time I had the impression that the confusion did not come about on its own, but that you had forced it. You had talked about a "relationship." I always firmly rejected it because I take it to be something interactive and despite my best efforts simply couldn't imagine confusion to be interactive in any way. You really confused me when you said, "it's genuine too." For me the confusion ended at the back edge of the couch. At first I took sentences such as "why not think that you are still being loved when . . . ," "you can't believe that you are still being loved if . . . ," and "perhaps the other person is not as limited as you think" to be allusions to think more "positively." Well, as a matter of fact, I didn't-rationally—have such a low opinion of my goals as my earlier experiences had made me think. As simple considerations, your statements did not go far beyond my own thoughts and were not very effective. So that couldn't be the reason. Then I developed a comparison. I imagined that a "healthy" person lying on the couch and talking about himself would probably confuse you in a "positive" way. I also thought that the figure of the other person, the choice of subjunctive or passive voice, etc. was supposed to help me simply repole my negative fantasies and expectations in the confusion, to confuse you now in a "positive" manner. Symbolically I thus thought that you wanted to move on the screen onto which I projected the confusion in order to achieve change. Now and then you spoke about the rehearsals that I undertook against you. I can't understand it like that. I think that verbal actions, even if they are expressed with all the fundamental and accompanying emotions, are merely copies of the image that the patient has made of you. It's not even a trial action. For this reason alone I was always skeptical when you related yourself to my actions toward you. I was, for example, a little suspicious when I was angry and you wanted to suggest to me that you tolerated my anger. You tended to react in unusual ways when the topic was transferred love or sexuality. I want genuine answers in response to genuine questions.

Of course, the eccentric position cannot be on the periphery because this would make it impossible for the analyst to assume the human significance that is an essential prerequisite enabling him to balance the influence of older figures. This is thus a kind of critical distance that makes something new possible and that also prevents an impenetrable emotional confusion from developing, i.e., a mishmash without boundaries.

9.3.3 Confirmation and Self-Esteem

In the psychoanalysis of Christian Y the analyst had refrained from providing direct confirmation for two reasons: first, in order not to influence the patient, and second, on the assumption that his positive attitude toward the patient's sexuality and aggression was obvious and did not require explicit mention. Christian Y demonstrated convincingly, however, that the subjunctive mode of speech left many things open and that he consequently had not felt he had received confirmation. The patient then went on to describe his professional success.

A: Naturally I've always been pleased by your successes, but I didn't mention it in a manner that would have been immediately obvious to you.

P: Yes, you weren't able to help me as much as you might have because you only described circumstances and assumed that my new self-esteem would develop all on its own. But what good are my changed ideas about myself if I can't anchor them somehow. [Long pause] You once told a joke about a psychiatrist who had a patient who thought he was a mouse but ended up agreeing with the psychiatrist that he was wrong. But if the cat doesn't know that I'm not a mouse any more, then I stay afraid of the cat. The joke in this joke is obvious, I mean what good is the rapport between in here and out there? What I call a confusion [the word that Christian Y used to refer to transference] is not limited to people who are sick or to here, but a general principle of life. Man perceives his environment from a certain perspective. [The patient described this by referring to photographs showing snow in very different colors.] Snow is white, but it's not always white. The color depends on the lighting. Everything I experience is black in me because my parents ruined everything I saw. It's hard for me to experience situations anew without support from outside because they're organized according to the old perspectives and I just can't simply replace them.

Christian Y was very excited—which I pointed out to him—while he described the different colors snow could have.

A: Were you the photographer who used the picture to show the spectator that you know better, that you can show me something too and that you see it more precisely and sharper or at least that your view of the matter is definitive?

P: No, I felt insecure because I thought that it was a silly comparison.

He traced his difficulties in being self-confident back to the absence of positive images.

P: You see, I have difficulty being self-confident because I don't have any positive images of myself. Whoever is self-confident out there has positive images of himself, and he is naive. If he's put into a situation in which he looks bad, then he still relates more to the positive image he has of himself. But I just can't do it; I've had these thoughts for a long time but haven't mentioned them. For me it's an arduous mental feat, an effort to keep things together when I'm confronted by some difficulties. [Pause] For example, if I can't be very aggressive but am confronted by others' aggressiveness, then I have difficulties with colleagues who put themselves in the limelight.

In the previous session Christian Y had told me that he would like to attend another vocational course and had a goal. Having a goal was tremendously important for him. He expressed his pleasure that I explicitly approved of his plan, but was at the same time disappointed that I had not previously approved of his goals.

P: You usually stay neutral, and that's made me terribly angry for a long time. I guessed that you don't want to make any firm comments for scientific reasons.

A: Although it was clear to me that people, especially the ill, need goals, I didn't pay enough attention to the fact that it is not only important for the patient to set goals but that it's just as important for the analyst to confirm them or to make it possible for the

patient to anchor them by providing encouragement. I now see the necessity. It's essential for me to express myself clearly, and then you can disregard it if you want to.

P: That's what I've always said. Otherwise freedom would become a feeling of being lost; that would be the only time you could enjoy your freedom. And to be honest, I can't get a picture of myself as I'd like to be; on the contrary, just thinking about it triggers so much anxiety that I have to stop immediately. I've been moaning here for years, am afraid of sex and aggression and other things, afraid of change, but what I want to be is something I don't know either. The normal person doesn't become what he is on the basis of what he was given, but by interacting with his environment, doesn't he?

A: Yes, exactly.

P: When you act in a neutral manner, then I'm deprived all the more of the environment that I didn't have with the old figures, at least not in the desired manner.

A: Despite all the friction and the aggression, there's no foundation that you can use to distinguish yourself.

P: I don't like my memories of the period when I was so aggressive here; I don't like them. I want to get my way, and actually I want to be furious out there and aggressive in a sensible way; what I expect from you is—now I've forgotten what I wanted to say. I would like support enabling me to show it when I'm in a situation out there. [Pause] A few days ago somebody was talking about psychoanalysis and said that neurotics suffer from a limited capacity to act, but not in my case. I have numerous reactions at my disposal. What I suffer from is that none of the ones that appeal to me seem to me to be right or suitable. The other description seems to me to apply more to compulsives.

The interview then turned once again to photography and imaging.

A: You're a passionate and very good photographer, and photography is a source of your sharpness. You're a very precise observer. Yet you don't want people to become aware of it; it has to stay subliminal. You're so good at your job because you're critical and a precise observer. It's also the source of your anxiety, namely that somebody might notice how sharp you can be. And in hindsight that is why it is so disagreeable to you that you were very sharp and aggressive to me. You don't want to act so uncontrolled. It should be well done, a well grounded aggression. And that is why this is such an important process of clarification, that I can now tell you, and honestly have to tell you, that your criticism was well made. So it's important for your criticism here to be accepted as true and accurate, but there isn't anyone who can't react in an uncontrolled manner.

Commentary. Christian Y made many astute and sharp-sighted observations about the analyst, particularly in the period when the treatment was conducted in sitting, as he wished. At that time he had seen expressions of sadness and irritation on the analyst's face, which he registered as a renewed rejection, as the opposite of encouragement and pleasure at his aggression, a subject that filled later phases of treatment. Without a doubt, the change in position and the opportunities that accompanied it

contributed to the growth of the patient's self-esteem.

P: I recall it as a terrible period; I was so aggressive, and then you made this sad face. As a child I was unable to look at my father's face. He was a bogeyman, and children cried when they saw him. I was afraid of him too; he had a very dark face, dark hair, and glowing green eyes—he was a nightmare. I wasn't able to look you in the eyes either. After a while I managed, when I departed, but I only acted as if I had looked at your face and didn't even see you because I was so afraid of your face. The second thing is that I assign you a certain predominant role so that nothing from outside, none of the old problems, can bother me. I can't discuss everything I want to do with you anymore.

A: As you rightly say, it's easier to identify yourself if there's a clear difference and no mingling.

P: When you say you're happy, well that's more than I demand of you. I've never said I want something great. I'm satisfied with a positive sign. I'm not after something absolute that exceeds all limits, and when I referred to the distance between you and me, then I didn't mean that I'm afraid of closeness. I only didn't want any mingling in the original sense. I thought that identifications were also possible if there was some distance. It is possible from a distance; there doesn't have to be anything personal, and when you're happy it's not for show but real—it simply moves me. Without being overwhelmed by confirmation, I've always emphasized that my mother's position might have seemed so negative to me because it inhibited me and not just because of her overwhelming feelings. Confirmation for me can thus be more emphatic without getting too strong. A few weeks ago I said I felt some anxiety about what you might say to me, but that was simply my uncertainty. If you say that you're happy, then it moves me but doesn't make me anxious.

Commentary. Their mutual pleasure did not stem from latent homosexuality, something which had upset the patient in earlier phases of the treatment.

Change is easier if it involves factual matters or goal-directed work, while interpersonal contact outside therapy poses more difficulties because a patient frequently still has the feeling of being unwelcome. Christian Y described this condition with regard to the problems he encountered playing tennis. When he won, he would almost apologize. His anxiety that playing aggressively would make him unwelcome caused him not to hit the ball powerfully and cramped his style. He correctly assumed that he would improve his capacity for concentration if he could be more aggressive. His anxieties impeded the transformation of his intentions into purposeful acts.

A: Well, perhaps you can find some satisfaction in the fact that your arguments have convinced me, and in that regard you've reached a goal. Of course, I naturally regret that I expected you to take this round about route and that I put some obstacles in your path. But who's happy about the mistakes he makes!

P: You know that I don't want to even consider such ideas. You're supposed to be the one who's happy when I can do this or that, but

you're not supposed to be the one that I have a share in because it reminds me too much of the confusion. And I know too little about it to say that you've made a mistake or that we're taking a detour. I just say that I don't like something and defend myself without being able to say whether I'm right.

A few sessions later Christian Y described a dream that accurately symbolized his condition. In it he was in an airplane that was airborne, and he had overcome a nascent anxiety by recalling his increasing certainty that he could rely on the footing he had found. He had already interpreted his dream, namely his increased confidence in the foothold he had. He summarized his identification with me and emphasized once again how important it was for him that I had taken a positive stance toward his sexuality and aggression. He would not have been satisfied with some atmospheric or tacit agreement. He said he required clear confirmation. For a long time we were then concerned with the difficulties he encountered making his new self-confidence reality outside therapy.

In the course of the session I interpreted his passivity as an attempt to assert his self and protect it against his mother, who on the one hand exhibited hysterical outbursts and on the other expected her son to follow clearly defined forms of behavior, i.e., forced a kind of "false self" on him. This assumption made it seem logical that he had withdrawn and adjusted to her values. At the same time the patient felt that he was actually very different, and claimed he had always wanted to be different, from how he had to appear to be.

The patient was still suspicious of my attitude toward his sexuality. Once again he was unable to continue to talk because he was ashamed. Later he managed to overcome his shame, which apparently was connected with his recollection of earlier sessions.

P: I simply want to, I can's say why; it's strange. I just want to [Pause] . . . I have to turn around; perhaps I'll get where I want to be, namely that here . . . when I demand it of you, I want confirmation. It's a kind of model for something I want out there. I want something from others, and this wanting is awfully problematic for me because I . . . at home I learned that you shouldn't want anything from others if at all possible, and should try and influence them. And especially out there, what I want is to get confirmation from others; that's something that's extremely difficult for me.

A: And then it's clearer where the confusion has just arisen. It was the moment you made the intense demand that I pay attention to you in a particular manner. I satisfied your wish, expectation, longing, and intense demand by saying, "Yes, that's what's important," which I didn't offer in a general way but in a very concrete one. So I did satisfy something.

P: That makes me feel anxious because I . . . .

A: You were confused because you could finally satisfy it.

P: Another idea is tormenting me. I would like to refer to the image of Jacob and the angel that you once mentioned. In a sense, my ideas are too insignificant to get this blessing.

A: Hum.

P: Aren't they?

A: Hum. [Pause] I believe you're using this thought to protect yourself against the overwhelming liberation represented by being blessed.

P: Yes, of course, that too.

A: Hum.

P: Because precisely the confirmation was missing and I had the impression that you were drawing my attention to something else; in a sense I had the impression that all of that wasn't anything for me and I'd just have to learn to live with the limitations. Just like earlier when someone said that I was too small for everything.

A: Hum.

P: Don't know. At the moment I just can't say. I've always assumed that you possess what I'm looking for, but that something has kept you from telling me what it is.

Christian Y recalled that he had asked me about my attitude to sex in the very first interview. In essence I answered that it was less important what *my* attitude was than that *he* reach clarity about his own. He took this comment to be a rejection, i.e., he experienced a lack of confirmation.

My therapeutic attitude at the time was exactly as described by the patient. One aspect of my style of treatment was that I gave evasive answers as a matter of principle. It was only the subsequent correction of my attitude and technique that led to the change which the patient, in his dream, referred to in this session and in other sessions and which made it possible for him to be successful and largely free of anxiety in both family life and business life. It is very probable that the analysis would have taken an different course if I had made an identification possible in the first sessions by offering *confirmation* .

It would incidentally be a mistake to believe that the patient had been particularly curious about *my* sexuality at that time or later. He was only marginally interested in my private life, much more in my attitude to the extent that it might help him establish a positive identification with a value system independent of his mother. At the same time he wanted *distance* . This presumption is a hypothesis supported by many statements the patient made. In today's session, for example, the patient had mentioned the shame he felt from the confusions, i.e., from his transference fantasies.

The following excerpt is from the patient's written evaluation that is mentioned above [Sect. 9.3.2].

I started from a simple assumption, which in principle I still adhere to. You showed me how I had adopted the

attitudes of the older figures, had identified with them in a deleterious manner. At first I was mad at myself for having been so dumb. I have to add that I am convinced that the suitability and willingness to identify is expressed to very different degrees in different people; I consider myself to be one of those initially more dependent on it and inclined to do it. This mood soon changed, making room for some hope which has remained until this day. I then came to understand the features I had adopted as being a great chance to identify with suitable role models and to gain definite self-esteem. I expected you to react correspondingly, which took a long time coming. The absence of opportunities for identification led me to call my condition a deficit. In this context I am sure I usually spoke about wanting to be loved and not being loved; what I meant, naturally, was not a momentary desire, but the old one from childhood. Not being loved was the focal point for my identification with my mother. I kept describing this starting point in my attempt to find some way out. It has become clear now that I don't need "love." The problem was "another solution." Deficits cannot be overcome by simply describing them. The separation from old figures, the liberation from them, does not put anything in their place. My goals in life out there are very varied. I profit immeasurably more if, with your support, these real goals gain in value. I don't understand why the discussion of my goals should be in the least bit less important momentarily or why the meaning I let you assign to it should be a trace less immediate than "direct verbal expressions." None of the intensity is lost, and the interview is not less personal as a result. Your options are unlimited; aggression and sexuality can be easily included without it being necessary to resort to some padding, artificial interpretations, and awkward intermediate steps. If it is possible to reach "agreement" at this level, it's always clear what and who is meant. Giving me a generally positive attitude does not in itself have a "mutative" effect. To me it seems to be necessary for you to take a stand. Just a little sign is enough; I think that just indicating a tendency is helpful in itself, if certain conditions are satisfied. You only relate warmth, tolerance, and a positive attitude to the presence of sexuality, aggression etc. in the patient, and of course empathy at their being the way they are. Massive changes in the patient are facilitated if the analyst, in addition to understanding, can also show an iota or minimal dose of identification with the patient—which of course is not supposed to alter the doctor. The old is discarded, and the new takes its place. Sympathy alone doesn't help me much; you stay "extinguished." What's decisive is a tiny bit of "life." The liberation from the old figures is thus a process that is largely free of mourning, because their positions are not empty but pleasurably filled. Even leaving from you is easy after the goal has been reached. The difficulties are somewhere else. People are what they are not only on the basis of predisposition, but also as a result of their interaction with their environment. Because of my lack of experience I have regularly felt that I am crippled, underdeveloped, and stunted, and have described myself in these terms. I have not had a suitable interaction with my environment. It is most difficult to make progress in analysis if there are "blind spots in my soul." The precondition is then that the analyst intervene and construct in a special sense, which probably contradicts the traditional conception of therapy. I have not really managed to convince you of the necessity of changes in this direction. On the other hand, I admit that I have come a long way and have probably reached quite a bit with your assistance. It hardly needs mentioning that I am grateful to you, especially for your flexible stance to this quite demanding and occasionally very trying patient.

Commentary. We would like to make a few comments here because of the fundamental significance of Christian Y's comments about transcripts from the termination phase of his treatment. We want to refer to the technical mistakes he complained about. The analyst always managed to make good for his mistakes, at least to the extent that a severely ill young man who had not been able to leave the hospital and had been nearly immobile both intellectually and physically had become able during treatment to reach both his personal and professional goals. Christian Y's criticism stems from the last phase of psychoanalysis, when patients frequently take stock. It thus seems logical for a patient who, despite numerous

satisfactions, suffered from a deficit—seemingly and paradoxically because of his excess of maternal love—to conclude at the end of treatment where he came up short. This argument provokes another, and in no time we would be embroiled in a very far-reaching discussion, which could only be conducted and grounded in an empirical case study that takes the form of a combined study of the course of treatment and of its outcome, such as is being undertaken by Leuzinger-Bohleber (1988). So let us return to the analyst in this case and accept his judgment that his technical mistakes were not only due to diagnostic error and to some aspect of his personal equation. In the analyst's words,

> I began the psychoanalysis of Christian Y in accordance with the understanding of the psychoanalytic technique I had at the time, i.e., of the theory and practice of transference, countertransference, resistance, and regression. With regard to the subjects discussed in these two segments, I learned very much from Christian Y and from other patients with similar disturbances, and I believe this has been of great significance for my current conception of the psychoanalytic technique. In the course of time I have become convinced that philosophical and social psychological theories about the role that confirmation plays in the interpersonal development of self-esteem can be productive for the psychoanalytic technique. Düsing (1986) has evaluated the works of Fichte, Hegel, Mead, and Schütz with regard to these problems. Although she did not establish any connections to the theory of psychoanalytic technique, it is obvious from her study that different psychoanalytic conceptions about the development of self-esteem and the role of confirmation have their roots deep in intellectual history. This philosophical knowledge of man is now supplemented by empirical results on the existence of intersubjectivity between mother and child from birth on. [We pointed to the convergence with the interactional conception of transference and countertransference in Vol.1.]
>
> Of course we cannot simply make, for example, Hegel's famous interpretation of the relationship between master and slave or his philosophical discussion of the mortal struggle for confirmation the subject of therapeutic interventions. Similarly, we cannot simply incorporate Mead's social psychological interpretation of the role that the significant other plays in the constitution of self-esteem into therapeutic technique [on this issue see Cheshire and Thomä 1987]. There are far too many ways that humans look for acknowledgment, which in turn has a wide range of implications. For instance, Christian Y looked precisely for confirmation other than that mediated by the glance in the mother's (or analyst's) eye, to refer to Kohut's metaphor for narcissistic mirroring. With the aid of an eccentric position he wanted exactly the opposite, namely to overcome the confusion in order to find himself in his own different nature. Christian Y sought mutual confirmation, which is avoided in the customary psychoanalytic neutrality. My positive comments about the patient's criticism during the termination phase and even earlier were based in my conviction, which fortunately also acquired a therapeutic function. The dialogues reproduced here represent great moments inasmuch as they point beyond the individual case and can contribute to the resolution of fundamental problems in psychoanalytic technique. The polished language and level of abstraction should not distract from the fact that both emotionally and existentially there are extremely important values at stake. Christian Y managed to verbalize this and thus, together with my agreement, to delimit his world and his self. It could have probably happened much earlier, yet at the beginning of therapy I did not know better.

9.4 Depression

Dorothea X, a 50-year-old female patient who suffered from depression accompanied by states of anxiety,

had undergone unsuccessful pharmacotherapy for years. Her symptoms grew out of her mourning the death of her husband, who had died after a brief illness. She developed hypochondriac anxieties about dying just as her husband had, from a carcinoma that was discovered too late. The unconscious identification with her idealized late husband and the continuation of her internalized ambivalent relationship to him in the form of self-accusations followed the pattern typical of depressive reactions. Dorothea X lived withdrawn and hidden, in a literal sense—she pretended to have oversensitive eyes to justify wearing sunglasses and hiding behind them. Although she believed she had to take care of two of her grandchildren one day because of a daughter-in-law's chronic illness, she was afraid that her own illness made her incapable of doing so. This concern increased her suffering, yet also made her feel obliged to stay alive and not to succumb to her thoughts about committing suicide.

9.4.1 The Psychoanalyst as Transference Object

Working through the patient's depressive identification with her late husband had led to some symptomatic improvement and reestablished her capacity to relate to people, initially to me as her psychoanalyst, i.e., her transference object.

In transference Dorothea X tended to mother me in a friendly manner. At the same time she idealized my equanimity, as when she said "You are as calm as I've always wanted to be." The point at which her previously mild positive transference suddenly changed occurred accidentally. At a late afternoon session, which was not her customary time, she encountered a tired and exhausted analyst. An comment she made about my being tired, which I confirmed, precipitated agitation motivated by her irrational concerns. She suspected a serious illness was the reason for my exhaustion and felt that I could not be burdened with any further stress. The previously benign mothering took on exaggerated forms. Her symptoms disappeared almost completely, yet this was connected with her self-reproach that she would never be able to stop the treatment because she then would not have the opportunity to constantly convince herself that nothing serious had happened to me. She felt she at least had to be constantly ready to provide me some form of compensation. At the same time she accused herself of burdening me by continuing the treatment; she once again made herself guilty at the very time she was discovering old feelings of guilt.

Dorothea X's irrational concern about me as a transference figure facilitated the process of working through her unconscious ambivalence, which derived from the idea that she had been the cause of her mother's severe hypochondria. The loss of blood at her birth had been almost fatal for the mother, and for years this had been taken to be the reason for all of her mother's complaints. This background must be taken into consideration in order to understand the fantasies about death and rescue that were the central ideas in the patient's childhood.

While we, under the protection of a positive transference, succeeded in clarifying the negative and aggressive aspects of her thought and behavior, the defensive character of her idealizations became increasingly evident. It became apparent that the maternal role, which she too had fulfilled toward her late husband, who had been dependent on her, was ideally suited to hide her sexual needs and to satisfy them in a regressive manner. In mothering her husband she had been the one who, under her skirt, had worn the pants in the family, which provided additional satisfaction. She had also made a substantial contribution to his successful career.

I looked for a fitting opportunity to focus on the very human side of her transference figure. This was in vain because although the patient realized intellectually that I must have weak spots too, she did not really want to be aware of this fact.

There was a typical form of the interaction between idealization and disparagement. The patient acknowledged on the one hand a comment to the effect that I used my knowledge with her own good in mind, and on the other disparaged my remarks as narcissistic self-confirmation. The patient had to close this line of thought with a comment excusing me, which she did by tracing this "lack of concern" to some presumed terrible experiences I had had. For a long time, however, these disparaging thoughts remained as inaccessible to interpretation as her idealizations were.

9.4.2. Deidealization and Perception of the Real Person

A second turning point in this treatment occurred after Dorothea X had seen me race past her in my car. Her description of the circumstances, location, and time removed all doubt about the accuracy of her observation. Yet she attempted to suppress this knowledge and avoided verifying her observation by

closing her eyes as she walked passed my parked car. For her, the large horsepower of my sports car did not fit her image of the calm and apparently undynamic psychoanalyst.

Her accurate observation on the street led to a lasting disruption of her idealization. After intense inner struggles about whether she dared find out for certain, i.e., whether she dared look at the car or not, Dorothea X finally decided to eliminate all doubt. She realized that her analyst was one of those men who was guided by irrational thoughts when choosing a car. Her attempts to find a justification and explanation for my behavior only led to temporary compromise relief. The aspect of reality introduced by the car took on numerous meanings: it represented and symbolized everything from power and dynamism to carelessness and waste. Finally the car became a true sexual symbol. The patient's agitation increased to the degree to which she recognized her idealization of her transference figure. In her transference figure she sought not just the satisfaction of her own needs, but especially *herself* , i.e., her own dynamism, which had been submerged by her idealization and mothering.

The primary goal of my interpretive work was to show Dorothea X that she had delegated significant parts of herself to me and the car. The return of her vitality was initially linked with great distress since she had had to learn to control her temperament in many regards during her long marriage. She managed to win back her energy and activity and integrate them as a consequence of the progress we made in working through the "delegation" idea. While working through the unconscious meanings, the course of the treatment was uncomplicated.

Both of the turning points in this therapy were precipitated by realistic observations that Dorothea X had made about me. My confirmation of her observations lent substance and conviction to my interpretations. In the first episode we traced her exaggerated concern about my tiredness back to aggressive components of transference. It is questionable whether an interpretation of the unconscious fantasies contained in the observations would have had the same effect. Would such an interpretation not instead have contributed to raising doubts about the patient's capacity for perception, as if the analyst had not been tired at all and was therefore vulnerable?

In the second episode it was another realistic observation that offered her the chance to overcome the polarization of idealization and disparagement and that led her to approve my having—the

previously denied—masculine qualities and to integrate her projected parts into her self-conception.

9.4.3 Epicrisis

Some three years after the termination of therapy Dorothea X wrote in a supplement to a questionnaire specifically designed to examine the consequences of interruptions during therapy:

> I answered all the questions immediately after receiving the questionnaire, for me a sure sign of how much I still felt a close tie to psychotherapy and to my psychotherapist. The greater the distance to the last session, the more benefit I can derive from the treatment. For example, I've just now come to understand many of the therapist's ideas from that period and know how to handle them. I am thankful for every session of therapy in which I learned to live a bit more light-heartedly and happier.
>
> Some time before the termination of my psychotherapy I rehearsed, laughing and crying, all by myself for the hour of separation. This game became so unbearable for me that I requested that the therapist announce the last session as quickly as possible. And I also clearly felt that the time was ripe. Afterwards I felt free--not happy and not sad—just waiting. I continued to live as before and had many mental conversations with my ex-therapist. I have never considered returning to therapy. The circle had closed. I knew that it was a good and productive period for me. In therapy and from the therapist I studied how to live better and more freely and rehearsed it. I then had the firm will and fairly secure feeling of being able to master life outside.

9.5 Anorexia Nervosa

9.5.1 Reconstructing Its Genesis

We have taken the following reconstruction of the origin of anorexia nervosa from a case history that has already been published in full (see Thomä 1967a, 1981). Although it is not a trivial matter that this reconstruction of a psychogenesis still retains such vitality after almost 30 years and that the problems posed by identification and identity in anorexia nervosa which are the focus of this reconstruction have in the meantime been acknowledged by all the schools of psychotherapy, we would like to emphasize something else. We want to familiarize the reader with the termination phase of a psychoanalysis, because in the eighth and ninth phases of this treatment there are hidden signs that in hindsight turned out to be significant regarding symptom substitution.

Henriette X's symptoms first appeared when she was 16. Her premorbid body weight of 50-52 kg (110-115 lb) fell to about 40 kg (88 lb). At the beginning of psychoanalysis three years later she weighed 46.3 kg (102 lb). Amenorrhea and obstipation had been present since the beginning of the illness.

During the psychoanalysis, a total of 289 sessions in two years, the patient's weight increased to 55 kg (121 lb), her period returned spontaneously after an absence of nearly four years, and her obstipation improved.

In order to provide insight into several important psychodynamic processes in this case we proceed from the precipitating situation, which is intimately related to an asceticism of puberty as it has been described by A. Freud (1937).

Henriette X used to blush when boys looked at her or when a subject related in any way with love was mentioned at school. The developing erythrophobia was a symptom that tormented her. She had had the feeling that she was the master of the house (see Freud 1916/17, p. 285) until something happened that was beyond her control. She discovered that she could make her blushing anxiety disappear by fasting in the morning. The blushing ceased with her loss of weight. In the course of the psychoanalysis this process was reversed. Her recovery of her ability to blush was accompanied by the old conflicts that had previously led to her asceticism and by the fact that she recognized them and was able to overcome most of them.

It turned out that Henriette X blushed because she was embarrassed when someone looked at her as a girl. This summary focuses on the anxiety that accompanied this involuntary act and her ego's defense mechanisms. The important question is why her erythrophobia was so intense that it caused her to limit her nutrition for years and to reject her body, which was accompanied by isolation. In the following we give the analyst's attempt to provide a survey of this patient's psychodynamics.

1. The description that the patient had felt like the master in the house prior to the blushing refers to a peculiarly structured ego ideal. She wanted to be a boy, not be looked at as a girl. This desire to be a boy had been anchored in her particularly firmly by elements of her environment. She had grown up without a father, an only child, together with her mother. Her mother was a widow who projected her image of her husband onto her daughter, who was intellectually precocious and acted as an advisor and partner to her mother. In other words, the patient was forced into a "masculine" role. The family circumstances strengthened those features in the patient that are not inherently masculine or feminine but are primarily exhibited in Western society by men, such as independence, firmness, and vigor. She set the tone and was accustomed to her mother doing as she wanted. This circumstance was partially responsible for the fact that the

patient hung on to the misapprehension of an "omnipotence of ideas" (Freud 1916/17, p. 285).

The patient was also the active person in her long friendship with another girl. As long as she could play the role of the boy and succeeded in everything—she was an excellent athlete and pupil without having to work hard—her ego ideal was unimpaired. Her inner balance was disturbed until she reached puberty.

2. In the conflict between *not being able* to be a boy and *not wanting* to be a girl (in accordance with her ego ideal that was by now anchored in her unconscious), she reestablished a sense of security by adopting an asexual ideal. This is an example of the undifferentiated, primitive animosity between ego and libido or instinctual nature that A. Freud referred to in connection with the asceticism of puberty. The consequences of this patient's general rejection of libidinal wishes can be seen in her behavioral modifications in general and her disturbed eating behavior in particular. The patient achieved an anxiety-free ego by denying dangerous aspects of external reality and repressing her own libidinal nature.

3. Hunger became the prototype of her bodily needs, and asceticism helped her to overcome her anxiety about the intensity of her drives.

4. Upon closer consideration, I differentiated this anxiety into its unconscious components, whose repression disturbed and inhibited the patient's thoughts and behavior. This led to, first, a limitation of the patient's capacity to enter interpersonal relations, second a disturbance of her capacity to work and concentrate and, third, functional disturbances. These consequences resulted from the different fates of the affect and mental representations of her unconscious impulses. The repressions were secured by means of anticathexes and alterations of her ego, as could be discerned in her behavior.

5. The following psychogenetic processes can be distinguished:

   a. The avoidance of real satisfaction, retreat of the drive from the object, and satisfaction of desires in fantasy (daydreams about eating). This is already an attempt to avoid a danger that would be posed given an unrestricted and real satisfaction of drives.

   b. It turned out that the patient's amazon behavior in general and the anorexia in particular were the result of the receptivity she warded off ("something comes in me") because food was unconsciously linked with fertilization. Revulsion and vomiting were related to sexual defense.

   c. Oral gratification was unconsciously linked with destruction and killing. Her

experiencing of eating was therefore restricted or burdened with guilt.

6. Her anxiety that the borders might be destroyed points to a longing for a relationship that is all-encompassing or transcends all differences. Since she felt anxiety about her ambivalence and destructive oral claim to totality, she repressed this longing and satisfied it in a regressive manner. From an economic perspective, the tension from the restricted nutritional intake was discharged in her urge to be active (excessive walks). The urge to move and be active also helped to purify her body and were thus a part of her defense.

Biography

Henriette X grew up as an only child and without a father. Two much older siblings had almost left home when she was born at the beginning of the war, in which her father died. It should be emphasized that a very close tie developed between her and her mother; her mother loved her more than anything else and let her sleep in her bed because the child otherwise fell into states of anxiety at night. From the perspective of the mother and other family members (a distant uncle who had a large family of his own took on an idealized father role), Henriette was a completely normal, happy, yet often difficult child who preferred to play outside than with dolls. She was intelligent and had a vivid fantasy. From early childhood she and Gusti were close friends, each of them playing a gamut of different roles. Of course, Henriette was not only the more inventive, but also frequently the active one, playing the "masculine" role.

School continued to pose no difficulty to her, and she continued to be one of the best in her class. Everything seemed to come easily for her. She was an excellent athlete, played piano well, and was gifted in learning languages. She was also one of the boyish leaders in her coed class, setting a tomboyish tone. She found complete satisfaction in her friendship with Gusti, which protected her against having to keep closer contact with the others in her class. Her relationship to the others consisted almost solely of competing in gym class. Henriette frantically attempted to maintain this constellation and detested her periods, which forced her to abstain from competition for days.

With the changes that took place in the class during puberty she gradually lost her position of leadership and changed her behavior, becoming quiet, fragile of character, and losing her desire to roam around. In contrast to earlier, when she enjoyed eating, just like Gusti, she now reduced her food intake

and occasionally vomited. Her declining athletic prowess kept her from taking part in competition. At the age of 16 she had to change schools, taking a bus to one further away. This meant a separation from Gusti. The physical and psychopathological manifestations of her illness, which arose when she was 15, did not change during the following two years at the new school, at which point she came for treatment.

9.5.2 The Terminal Phase of Therapy

Eighth Phase of Treatment: Sessions 215-254

It was with some concern and also pleasure that Henriette X commented that the increase in her weight that she had achieved some time ago was accompanied by a change in her body feeling, adding that her muscles had become softer. Her concern resulted from sensations from her body, such as the pressure on her stomach when she wore a narrow skirt or belt. We were unable to understand a number of other, peculiar body sensations, but they appeared to us to be of significance for understanding the relationship between function and form, i.e., her disturbed nutrition and body image. The remarkable fact that many anorexics can maintain their body weights constant for years with only minimal fluctuations leads one to assume that food intake is automatically regulated by unconsciously signaled bodily perceptions.

Henriette X was just as moved by agitation that drove her to eat as by her perception of her body forms. In her states of anxiety she feared being overcome both from inside, by unknown instinctual dangers, and from outside. The unification of inside and outside, such as during eating and sexual intercourse, was the subject of the following dreams.

In the 237th session Henriette X mentioned a dream in which she had at first sought protection with her mother and then lay in bed with her analyst. There was a struggle, an injury, and bleeding. The important dream element in this context was that Henriette X was suffocated by the heavy beams in the ceiling of the room, which in the dream were actually cookies. In further dreams (240th session) she once again had the sensation of suffocating, and in one of them had her period. Finally in the 245th session she dreamed about having had her period, which was partly white. In the dream the blood from her period, including the white parts, were mixed with food that she ate. Later in the dream she lay under a particularly beautiful girl and had intercourse with her. She did not have a sensation of a penis, but did feel the girl's beautiful body and see her well formed breasts.

Now it became clearer what the phrase "being married with food" meant; Henriette X occasionally used these words to describe her current condition. Her dream about the white color of some of her period and the mixture of her menstrual blood with her food depicted an unconscious fantasy that refers to self-sufficiency, parthenogenesis, and oral fertilization. The analyst interpreted the dream at two levels and—to be brief—in the psychic context viewed the white component in the one case as semen and in the other as milk. It was now also possible to better comprehend an earlier dream, in which a baby sucked at her genitals; she had unconsciously equated her excrements with food. The analyst referred to the narcissistic nature of the dream, in the sense that "I am strong and can do everything, both procreate and live from my own substance."

This autocracy refers on the one hand to an anxiety about loss and death (nothing should be lost), and on the other to an attempt to overcome this anxiety. If this process is not restricted to the dream level but also governs behavior, then a situation develops that is apparently characteristic of many of those who refuse to eat. As a result of the maximal isolation caused by defense processes, nothing changes any more and the patient—even to the extreme of losing her life—retains her belief in her immortality, in a delusional manner. This paradox can be described by the following set phrases: "I live from my own inexhaustible substance and am thus not exposed to all of the dangers of an exchange that ultimately lead to death. I am from nothing, and therefore not threatened by death." This denial enables the anorexic to be free of a fear of death. (Unconsciously, the person's own substance is identical with her mother's, so that the unconscious symbiosis appears eternalized in death.)

Fortunately Henriette X did not live in such autocracy in reality, and with the help of other dreams we are also able to understand why she had been thrown back to its narcissistic nature. She had to ward off dangerous relationships, such as being overcome orally by cookies (displacement from bottom to top) and homosexual contacts, and the accompanying instinctual impulses. The object displacement of the dream image—e. g., the suffocating on the cookies—also corresponded to a peculiar body perception during association. Henriette X had the sensation that her tongue was swollen, and she reproduced the feeling of suffocation she experienced in the dream. The analyst took the swelling of her tongue to represent a displacement of excitation, and Henriette X feared that she might not be able to speak normally any more and would stutter. This fear disappeared immediately after the analyst interpreted the displacement as libidinal tendencies related to the mouth an the organ of articulation; in this regard

he referred among other things to a homosexual dream. The patient commented that at this point she would have broken off the treatment if the analyst had been a woman because she would have been unable to speak with a woman about her needs for tenderness.

It is amazing that Henriette X managed to comprehend the analyst's interpretations, to place her initially seemingly unmotivated states of anxiety in the context of her experiencing, and to integrate them. She was particularly tormented by her aggression directed against her mother, which on the one hand helped her to ward off her desires to lean on somebody, and on the other was the result of frustration. Her feelings of guilt occasionally led her to be careless and get into very dangerous situations in traffic; also involved in this was the aspect of testing her skill.

To her own surprise the quality of her work at school improved, even in the sciences, even though she had little endurance—but when, then with great intensity—and in comparison to the others in her class she still did not work enough. Her choice of a profession created more difficulties. She wanted to keep all her options open and, moreover, as she ultimately realized, find a profession that would serve as a substitute for marriage and family. At a job counseling session she was characterized as being of above average intelligence overall. She made good for her lack of persistence with her great agility. She herself had already considered becoming an interpreter, and with her continued progress this choice of a career seemed to come naturally.

Ninth Phase: Sessions 255-289

Henriette X wanted to take advantage of the Christmas holidays to study hard, but it did not work out that way. For the first time she had fun at a party that she had organized together with her girlfriend Gusti. She was relaxed, enjoyed herself, and did not need to control herself. She was successful, admired by the boys, and courted in a friendly manner. She was not tormented by impulses to kill. Yet she did not dare to go for a walk alone and occasionally had the feeling of suffocating.

Her relation to her mother had changed, and Henriette X regretted that she innerly was more separated from home. It was also obvious that she continued to ward off strong needs to lean on somebody, which had a peculiar effect on her dealings with children. Although she enjoyed playing with her nieces and nephew, she suffered from the impression of innerly not being free and uninhibited and

of not having any really contact to children. In her words, "I could have feelings toward children after all, now that I don't have any feelings toward my mother anymore." The only desire that seemed natural to her was to once have an intimate relationship, inconceivable in contrast the thought of bearing, feeding, and raising children. The analyst based his interpretations on the assumption that she could not have any feelings toward children because she would then partly identify with them, and precisely in identification with a child of her own she would experience infantile dependence. The interpretations were extended with reference to the above-mentioned dream about sucking and licking. The real problem expressed by both the patient's and the analyst's words was that of the interwoven nature of self- and object representation.

In the final phase of treatment Henriette X dreamed about suffocating her doctor. The dream contained some talk about love and lust. She associated a fantastic dream about a devil who waited for his victims before greedily devouring them. She also recalled that her 4-year-old nephew had once whispered to her while playing, "I want to tell you something very beautiful: I want to make you dead." The destructive force of her claim to love led the patient to ward off her desire to lean on somebody because in such a circumstance she would have been helpless against her own impulses.

Another fact that deserves mention is that on the weekend between the 258th and 259th sessions Henriette went dancing and fell intensely in love for the first time. A girlfriend commented, with satisfaction, "You're becoming normal."

The patient passed her final examinations at school without experiencing any anxiety or agitation. She also did not miss an opportunity to celebrate fasching (Mardi Gras). Her first intense love was replaced by a new fascination. One night she became enthusiastic about an "existentialist" boy, in whom she in many respects saw an image of herself. They discussed good and evil half the night, denying the existence of the latter. They also decided in favor of highly ascetic ideals and called every form of dependence on the body inhumane. These arguments did not, however, keep them from caressing passionately. During the brief period of sleep that followed, Henriette X dreamed about lying in bed with a young man and hiding him under the blankets from her mother. She subsequently had difficulty falling asleep, which resulted in part from the sexual arousal she felt every evening. Henriette then recalled that she had used to feel sexually aroused, but had rejected the feeling and had not masturbated.

The patient's experiences during fasching precipitated a dream which revealed one important root of her feelings of inferiority as a woman. Henriette X dreamed that a large number of small black bugs came out of her full and swollen breasts. This dream was motivated by her sensation of the boys' sexual arousal while dancing, which was autoplastically represented in the equation of breast and penis. The black bugs symbolized semen, making it something repulsive. The patient came to this interpretation practically on her own, especially since it now became clearer that she considered herself for ever unable to fulfill the role of a mother: breasts were supposed to procreate, not nurse.

The patient was excessively disturbed by a renewed difficulty to fall asleep that manifested itself during the final phase of treatment. Previously she would have resorted to a fantasy that worked promptly, but which was now ineffective. This was the idea of falling in a deep well. The explanation for this difficulty was that she experienced this "falling" to sleep both as something that overpowered her and as a regression into the security she longed for. It was characteristic that the patient now felt the anxiety about falling asleep during a session. That this letting herself fall was still burdened, via an unconscious linkage, with an aggressive and dangerous act was shown by a dream in which the patient fell over, paralyzed by a man's poison-filled pistol. A significant improvement in these symptoms was reached by a continued working through.

Henriette's treatment came to an end after she had finished school and was in good condition. Her period had come regularly for months. Her weight was 55 kg (121 lb) and the obstipation was significantly improved. Overall she showed a positive development. Yet with regard to her symptoms, it must be added that the patient still did not feel completely uninhibited while eating and took special pleasure in the last bite.

The analyst now felt justified to leave the rest to the vis medicatrix naturae, the healing power of nature, and to terminate the treatment. The patient wanted to pursue her education in another city. Arrangements were made for another 15 sessions, held some months later. Overall the patient's development had been positive.

9.5.3 The Problem of Symptom Substitution

Almost thirty years have passed since the termination of Henriette X's psychoanalysis, which provided important insights into the pathogenesis of anorexia nervosa. Her treatment produced lasting changes. We are completely justified in speaking about a cure because Henriette X has led a successful and full life, both privately and professionally, since completing treatment and because she has not exhibited any residual symptoms of anorexia nervosa. After graduating from college and starting a career that led her to spend some time abroad, Henriette X married the friend she had been living with for a long time.

Some twenty years ago she had a disturbing symptom, which led her to consult her analyst once again. She had rejected the intense desire that she and her husband had for children because of her neurotic anxiety that something might happen to their helpless children, and that she herself might do something to them. The patient, who had retained a vivid memory of her analyst, traced this symptom to the fact that in her psychoanalysis she had been separated from her mother too abruptly. Although she was completely happy with her husband and was grateful to psychoanalysis for her being at all able to establish a heterosexual relationship, among many other positive changes, she criticized the intensity of the treatment and the far-reaching changes, referring in particular to the abrupt resolution of her close relationship to her mother. She then went on to complain about another restriction of her otherwise active life—a light flight phobia—that she attributed to the changes caused by her treatment. In order to fly alone, she had to overcome her anxiety. She also blamed this inhibition on the analyst because he had contributed to her recognizing her dependence and thus losing the self-security she had had in her illness.

By acknowledging her complaints and thematizing them both at the relationship and transference levels, the analyst made it possible for the patient to undergo an intensive focal therapy, which for external reasons consisted of numerous sessions in a brief period of time. In the transference analysis the imaginative patient was able to relive her very aggressive feelings toward her mother and critically reflect on them. Since these aggressive feelings were manifested in a relationship she unconsciously experienced to be distinctly symbiotic, the patient could not be sure whether she was not referring to herself when she thought of her mother and any children she might have. She was anxious about the children she might have because the problems of a symbiotic relationship might be repeated for them. It

was not difficult for the analyst to include her anxiety about flying alone in the focus of treatment, especially since the transference aspect was quite obvious. She could not face empty space without feeling anxiety because she still had an old bill to pay; having great trust in someone also means being very dependent and experiencing the related disappointments. The wide spaces represented a transference object whose reliability was cast in doubt by her own unconscious aggressions.

The patient's longing for an omniscient and omnipotent mother inevitably led to disappointments and aggressions that undermined the security she sought. Ultimately it was the unconscious process by means of which the symptom motivated the anxiety—as can be regularly observed with such symptoms—and was perpetuated by "external" confirmation, which has the effect of reinforcement. The symptoms improved in a short time as a result of the intensity of her experiencing in transference and of her insight.

Henriette X is now the mother of several children and has written her analyst about her family several times.

Several interviews were conducted about ten years ago in the course of a follow-up survey conducted by the analyst. They helped the patient to cope with a momentary stress situation. She had a particularly close relationship to her children, which made it difficult for her to bear the steps they took toward autonomy before and during puberty.

The issue of symptom substitution is raised by the phobic symptoms mentioned above which appeared some twenty years after the termination of Henriette X's treatment. The stumbling block is a comment referred to above that might be related thematically with the patient's later symptom. At the time the patient had said that it might be possible for her to have some feelings for children since she did not have any feelings left for her mother, but that bearing, feeding, and raising children was inconceivable to her. Based on our knowledge of the later course, we can now state that an unconscious constellation had remained that later brought forth a thematically related symptom.

Such observations contributed to the formation of the theory of symptom substitution and symptom displacement, which Freud (1937c) discussed in his late work *Analysis Terminable and Interminable* . The issue of symptom change is connected with a controversy between the psychodynamic schools of

treatment and behavior therapy (Perrez and Otto 1978). Several comments about this are appropriate at this point in consideration of the course of Henriette X's illness. Taking into account the effects of so-called nonspecific factors in psychotherapy inevitably leads one to question the hypothesis that a treatment can be effective solely at the symptomatic level, because the motivations emitted by the symptom in a self-reinforcing manner remain linked with the earlier pathogenetic conditions. For this reason these conditions can be affected in some way even by treatment that is symptomatic and seemingly noncausal. Psychoanalysis has in practice neglected the dimension that consists of the course and secondary gain from illness, together with its repercussions on the underlying primary condition. It is not only with regard to the transference neurosis that the illness "is not something which has been rounded off and become rigid but that it is still growing and developing like a living organism" (Freud 1916/17, p. 444). A symptom displacement is only to be expected, on the basis of psychoanalytic theory, if important conditions of the origin of the symptom cannot be overcome by psychotherapy and continue to exert an influence. In the case of Henriette X an unconscious configuration survived, whose revival was precipitated in a particular situation and which became active again. A latent condition became manifest, precipitated by a thematically appropriate factor.

Since all neurotic symptoms are overdetermined, it is often sufficient to remove one of several conditions. The problem of symptom change thus amounts to the question of whether it is empirically possible to predict the conditions under which a configuration shifts from a latent to an active state, or to determine when the relevant links in a chain of conditions are actually interrupted.

The not insignificant difficulties involved in specifying the connections between latent dispositions and the probable future conditions of their manifestation seem to have contributed to the striving for a utopian solution, namely the destruction of all the pathogenic constellations that might become active in the future. Although Freud (1937c) demonstrated that such a goal is infinite, such utopias exert a great attraction. Paul Ehrlich's idea of one day developing a *therapia magna sterilisans* , i.e., a chemotherapy able to cure all infectious diseases with a single dose, corresponds to the utopia of resolving the disposition for psychopathological reactions by means of an interminable analysis.

We would now like to turn to the question of whether the *familial constellation* might have contributed to the origin of Henriette X's anorexia nervosa. This discussion will be exemplary in nature,

providing a basis for different practical applications.

We will now summarize several of the peculiarities in Henriette X's family that had an affect on the formation of her inner world. Above we mentioned that in a certain sense Henriette X took the place of her father at her mother's side. This resulted in a very close tie between mother and child, the mother being able in her loneliness to find consolation in her daughter's company, which must have given Henriette X the feeling that she was very important to her mother. In the literature on family dynamics, the term "parentification" is used to refer to a situation in which a child takes on such a parental role (Boszormenyi-Nagy 1965). This is a kind of reversal of roles in which the mother or father directs desires to the child that were not satisfied in their relations to their parents or partner. They demand too much of a "parentified" child, forcing it prematurely into an adult role. Henriette replaced her father. We have described the difficulties this caused her in finding her sexual identity.

When Henriette X felt the desire to have children, she developed a neurotic anxiety that was rooted deep in her symbiosis. Later she actually sensed how her children's autonomy was a burden on her. The therapeutic work at this juncture was directed at resolving the parentification of her own children. In her close relationship to her children she attempted to satisfy her own childhood desires to lean on somebody that she had not been able to satisfy with her mother. This had been thwarted by her efforts to find autonomy and by her precociousness.

As the analytic treatment helped Henriette X to increasingly separate herself from her mother and to recognize her longings for dependence, and as she became careless in traffic because of her feelings of guilt about her aggression, Henriette's mother turned to the analyst. She was concerned that her daughter might do something to herself. In terms of family dynamics, the therapist was assigned the role of the father, which visibly relieved the patient. Henriette could transfer her worries about her mother to the therapist. At the same time the analyst was able to work out with the mother how the patient unconsciously attempted to assure herself her mother's attention in order to control her own strong desires for autonomy.

The family dynamics must be taken into consideration especially if a circular process cannot be interrupted by a change made by the patient. However we do not share Petzold's (1979) view that

anorexia nervosa is the symptom of a family neurosis. The assumption that there are pathologic familial constellations which are specific for the origin of anorexia nervosa, other psychosomatic illnesses, schizophrenia, or cyclothymia may well prove just as illusory as the assumption of specific causes of psychosomatic illnesses (see Sect. 9.7). The adverse consequences of such a misjudgment are well known since the invention of the "schizophrenogenic" mother. Moreover, in an individual's experiencing the sense of cause is easily linked with guilt or at least with responsibility, which impedes or even obstructs any attempt to involve family members in the therapy because they feel misunderstood and perhaps withdraw completely.

The study of family diagnosis is still in its infancy. Research into the typology of psychosomatic, schizophrenic, and manic-depressive families (Wirsching and Stierlin 1982; Stierlin 1975; Stierlin et al. 1986) is burdened by so many methodological shortcomings that any assertion of causal relationships is dubious. Anderson (1986) has, for example, discussed such methodological problems with regard to the model of "psychotic family games" designed by Palazzoli Selvini (1986). We believe that a more modest goal is called for, also for reasons of theoretical plausibility; such a goal is for the family crisis precipitated by any chronic illness to be registered and included in the therapeutic scheme. Although Henriette X's family has to be considered incomplete, due to the death of her father, it still clearly demonstrates the "entanglement" between mother and child described by Minuchin (1977). This word refers to an extremely close and intensive form of interaction. Other descriptions of "typical families of anorexics" (Sperling and Massing 1972) also point to specific structural features in familial relations that appear to be typical. Meant are patterns of interaction that are identified *after* the manifestation of the illness. The approach of family therapy constitutes a supplement to individual treatment if it provides the patient the freedom to leave home and attain the necessary autonomy (Gurman et al. 1986).

It is misleading to act as if a child has no innate dispositions, space for individual freedom and decisions, or active participation. Despite a child's dependence, it does not simply react passively to its environment, but takes an active part in constructing it. This is particularly true of anorexics in puberty, who truly have a mind of their own.

9.6 Neurodermatitis

The repertoire of different types of somatic treatment for a chronic illness has usually been exhausted when a patient comes for psychotherapy. This fact, together with the study of changes during the analytic process, facilitates a *comparison of the case with itself* and thus the evaluation of the therapeutic efficacy of the new procedures, i.e., the psychotherapeutic ones. This constitutes a valid basis for single case study design, given that the only new factor is psychoanalytic therapy and that all the other conditions, particularly the patient's living conditions, are constant. This is a fruitful application of J.S. Mill's classical differential method in clinical research (see Eimer 1987).

First, it is necessary to name a few of the criteria that have to be taken into account in single case studies of this kind. The comparison of a case with itself is the most important basis for therapy research (Martini 1953; Schaumburg et al. 1974). Ideally, the therapeutic interventions should be varied according to the etiological assumptions, with the goal of most effectively eliminating the pathogenic factors and symptoms. It is, thus, important to observe the course over a long period of time and note the alterations treatment brings about in the symptoms as indications for assumed structural changes (Edelson 1985; Wallerstein 1986).

In evaluating the therapeutic efficacy of psychoanalysis in the case of the neurodermatitis patient we would now like to present, it is necessary to distinguish three phases:

1. At the initiation of analytic therapy the patient had already had the illness for eight years. During this period the patient was treated regularly by a dermatologist and was often unable to work. Inpatient treatment was necessary four times because of a worsening of the skin disease (the total length of hospitalization was about six months).

2. The patient's external living conditions were unchanged during the 2.5 year period of analysis. The local dermatological therapy was continued as previously. The new approach consisted in the specific "influence" of psychoanalysis. It was possible to correlate the changes, improvements, and setbacks occurring during psychoanalysis to psychic processes. The patient's attitude to life, not his external circumstances, underwent significant changes. Since all the other conditions stayed the same, the changes brought about by analytic means can be considered the cause of the patient's lasting improvement and cure.

3. This thesis is supported by the follow-up; the patient has been healthy for the nearly 30 years

that have elapsed since his analysis. He occasionally had light efflorescences, which did not require dermatological treatment.

9.6.1 Excerpts from the Case History

Over the years Bernhard Y's skin condition, which he called chronic eczema, had been the object of different diagnoses, including seborrheic dermatitis and atopical neurodermatitis. The patient had not told the doctors about his impotence and obsessive thoughts. The clinical records also made no mention of the events that precipitated the outbreaks of his illness. It was not until after ten years of treatment that the patient encountered a dermatologist who suspected a psychic factor and referred him for psychotherapy.

Course of the Illness

It is noteworthy that although the patient had suffered from rough and split skin since childhood and a rash near his mouth between the ages of 10 and 17, these symptoms disappeared after his initial separation from home when he served as a soldier. (His parents and siblings are healthy, and skin diseases and genetic predispositions are not present in the family.)

At the age of 20 Bernhard Y became ill (vomiting and loss of appetite), and the disappearance of this illness was immediately followed by an itching skin inflammation, which spread to his arms, breast, and back. The patient was unable to work and referred to a dermatology hospital for the first time in September 1948. A seborrheic dermatitis was diagnosed, and tests indicated that an oversensitivity to a particular brand of soap was the precipitating cause. The symptoms were improved by local therapy and radiotherapy to the extent that he could be released. Since then Bernhard Y had neurodermatitis; severe exacerbations made hospital care lasting numerous weeks necessary in 1950, 1951, and 1956. In the course of these clinical therapies detailed allergy tests were conducted, which demonstrated an oversensitivity to eggs. The patient had already detected this oversensitivity on the basis of adverse oral sensations.

Biography

Bernhard Y was raised according to strict Catholic tenets in a small town, where he attended elementary

school from 1934 to 1941. He was an above-average pupil. He gave up his first choice of a profession (baker) because the work appeared too strenuous. After attending vocational school until 1943, he began an apprenticeship in a commercial firm, where he has worked to this day except for a short interruption at the end of the war. The patient had always been an especially conscientious person and was given his rigid moral code by his mother. As far as he could recall and particularly since puberty the patient said he had been shy and inhibited and had suffered from severe feelings of guilt. His long friendship to his later wife was primarily during the period he was ill, which added to his isolation. Under the impact of his mother's maxims and her warnings about the possible consequences of intimate contacts, the patient was inhibited and insecure toward his girlfriend, both physically and otherwise. Because of his skin disease he postponed sexual contacts for the distant future and thought about never marrying. He also feared that his skin disease was hereditary. He resisted marriage until the last moment, not deciding to marry until his wife assured him that she herself did not want any children.

Although the patient was frequently absent from work and had to restrict his contact to customers and people in general because of his itching exanthema, his reliability made him a valued employee.

Precipitating Situation

The latest symptom formation was preceded by a conflict at work. His boss and earlier master was a man who was particularly inaccessible and strict, and who left his employees in the dark about planned raises and such things. A new pay scale had come out, but the boss had not informed the patient about the raise he could expect. One day, while attempting to find the new pay scale on his boss' desk after work, his boss surprised him. He quickly thought of an excuse, which was a half truth, namely he was looking for a letter that had to be mailed. From this day on the patient was not able to work for several weeks because of vomiting and loss of appetite, and later was tormented by doubts about whether his boss would ever trust him again. Finally the patient talked about the matter with his boss, but without reestablishing the old relationship. The patient considered the fact that his skin disorder did not heal to be the punishment for his curiosity. Prior to this moment he had been able to maintain social contacts despite his intense inhibitions and inner insecurity; now in contrast, he was fairly isolated, a secondary consequence of his illness. The patient contemplated applying for an early pension for invalids.

Initiating Treatment

At the beginning of treatment the patient was unusually inhibited, seemingly having become an *alexithymist* (see Sect. 9.9) after having been ill and receiving somatic treatment for 10 years. That the therapy did not immediately founder on the initial resistance, such as has been described by V. von Weizsäcker (1950), was connected with the fact that the patient, despite being skeptical, sought help because of his difficult circumstances, and on the other hand had trust both in the institution and in me, a favorable prognostic sign.

The analyst's therapeutic technique at the time of this therapy was distinctly nondirective. He provided indirect encouragement, which facilitated dreams, associations, and self-reflection. The style of the protocols, dictated after each session, reflects this nondirective technique, compiling almost exclusively the patient's own thoughts. References to the analyst's feelings of countertransference, his considerations, and interpretations are sparse. Both for clinical and scientific reasons this type of treatment and preparation of protocols proved inadequate. Over the course of time they have undergone significant modification (see Thomä 1967b, 1976; Kächele et al. 1973). Although we are not able at this point to discuss the numerous conscious and unconscious reasons that dictated this therapeutic technique, we would like to refer to several factors that are important for the evaluation of the segments of treatment described above. Aside from the analyst's own insecurity, he was concerned that his interpretations might have a "suggestive" influence on the patient. The analyst was still busy studying the misunderstanding regarding the differences between various forms of suggestion within the spectrum of psychotherapeutic and analytic techniques (see Thomä 1977).

A lengthy first phase of treatment served to establish a viable working alliance, which the patient experienced as dangerous because of his intense ambivalence and deep-seated anxiety about punishment. A deterioration of his symptoms made him unfit for work, and his family doctor reported him sick for some two months. The patient tested his analyst's reliability and tolerance for criticism and aggression by obtaining negative statements about psychoanalysis from doctors and homeopaths. His retreat to home and into an incapacity to work, however, itself had adverse effects. Although he avoided intense psychic stress at work, he had only exchanged this for an increase in tension in his marriage, which he in turn attempted to avoid by withdrawing further into the autoerotic and autodestructive

attention he paid his skin. The initially seemingly banal precipitating conflict situation attained, from the supplementary and corrective comments the patient made, a depth making his stress at work more comprehensible. At work the patient was constantly filled by the anxiety that his kleptomanic theft of penny sums would be discovered one day, a fear that strengthened his neurotic anxiety.

In his initial dream the patient had been held responsible for the loss of a key. It was not until much later that he was able to speak either about his thefts or about his impotence, which he initially had also not mentioned. It turned out that, contrary to his initial statement, his skin disease was not the reason that he had repeatedly postponed marrying or contemplated not getting married at all. After hesitating for a long time he finally spoke about his sexual problems, which he had not mentioned to any of the other doctors. As mentioned above, the patient did not decide to marry until his wife assured him that she herself did not want any children because she was too narrow and afraid that a cesarean section might prove necessary, as in the case of both of her sisters. They therefore agreed to lead a kind of platonic marriage. He feared he had so injured himself from masturbation that he had become infertile and impotent. Since his wife complained of pain, they could not have intercourse. After the patient learned to recognize his rationalizations of avoiding sexual contact with his wife, he experienced timidity, fear, and repulsion at the sight of his wife genitals as well as feelings of guilt and anxiety about his own aggression.

Overall it was clear that the patient suffered from severe hypochondriac ideas about physical defects and resorted to magic means in his regressive attempt to overcompensate his defects.

The initial worsening of his symptoms can be traced back to his disturbing admissions in analysis. Even before treatment the patient himself had ascertained that changes in his symptoms had little to do with his somatic therapy, but much with whether he was left in peace and quiet. He felt he would have been best able to find quiet at home in early retirement if he had only stayed a bachelor and were not subject to tensions in his relationship to his wife.

His severe neurosis was accompanied by fantasies in which he had intercourse with a much older woman. For a long time his associations were too sparse to make the oedipal roots of both his inhibitions and his displaced desires visible. In his few dreams, of which he had only a fragmentary recollection, he

saw himself, for example, walking arm in arm with a strange woman. In reality he was preoccupied with obsessive thoughts while walking on the street, especially with a compulsive counting of the passing cars and trucks. Whenever he went out onto the street, the patient decided which cars he would count on that day and how to evaluate the result. Through skilled manipulations he almost always arrived at a favorable number, even when he had previously chosen another; for example, if he had assumed that an odd number was adverse for a rapid cure of his skin disease, he manipulated the numbers until he could alter the adverse result. He usually consulted the number regarding the rapid cure of his exanthema or financial benefits, such as the amount of his future pension, unexpected income and so forth.

His magic way with numbers made him dream of financial benefits enabling him to lead the life of a pensioner and to be pampered by his wife. As long as his mother had survived, he had used this secondary gain from illness to be spared work at home, to be given preferential treatment versus his brothers and father, and to get their attention.

Skin Care as Regression

The patient spent several hours every day preoccupied with his skin; during this time he did not want to be disturbed. Although he did not say anything if his wife entered the bathroom, it irritated him and his criticism was displaced onto some other object, for instance that his shirt was not ready to wear.

The treatment sessions were also filled with his fairly monotonous and repetitive descriptions of his skin's condition. The patient had developed a rich vocabulary with which to describe his skin's different qualities. He even noted small differences—sometimes his skin was more chapped, once redder, occasionally scalier—that an expert would hardly have been able to detect.

He withdrew from his wife, retreating, as he himself said, back to his skin. His symptoms were one aspect of his interpersonal disputes, which expressed themselves in different ways and at different levels. He spoke about the "outrageous idea" that his wife might be the cause of his illness—his more severe skin disturbances had never actually disappeared since he had married and at times, e. g., during a vacation, he had observed that his skin became fairly good until the day his wife arrived. He wondered whether she emitted something poisonous or something that caused pimples, thinking of her vaginal secretion. His skin was, in general, the object of all of his moods; it was, so to speak, the organ of choice.

When he was mad, he scratched himself; yet on the other hand he cared for his skin as if it were a object he loved.

These comments indicate Bernhard Y's regression to his body ego. The concentration on this theme in this case came almost automatically because of this patient's interweaving of subject and object and its significance for his therapy. His self-observations made it clear that his skin's condition—both its improvements and its aggravations—was very closely connected to the rubbing and scratching that, unnoticed and almost reflex-like, accompanied his hours of caring for his skin. The analysis of his retreat into the bathroom, especially in the evening, was at the focus of the entire therapy.

The description of this case can be organized around the questions the patient had to avoid for unconscious reasons—why he, having become impotent, had to avoid sexual gratification and what he was seeking in his autoerotic withdrawal. The patient gradually became aware that his behavior damaged his skin, yet he was unable to interrupt this vicious circle.

Viewing scratching simply as autoaggression is inadequate for both theoretical and technical reasons. Schur (1974; see Thomä 1981, p. 421), in particular, has pointed this out, showing that by acting this way a patient is seeking unconscious objects in himself with which he has maintained a link. In such regressions the self-reinforcing circular behavior strengthens the primary identifications and weakens the subject-object boundaries. In the course of the working through in this patient's analysis, his skin took on divergent object qualities or, more specifically, their representation (including of the transference relationship). Since to conscious perception these unconscious object images were sinister and a cause of extreme anxiety, the patient was able to achieve greater self-control by withdrawing, i.e., by loving and hating the object via his body, at the same time as avoiding any real contact, i.e., a real but extremely disturbing merging.

The patient was quite aware that the reason he withdrew from his wife into the bathroom, especially in the evening, was his anxiety about sex, a symptomatic manifestation of which was his impotence. Based on knowledge of his biography and the nature of the symptoms, it seemed reasonable for the analyst to assume that the oedipal situation was a barrier that led to regression.

The analysis alternated between focusing on the regression and on the oedipal factors that

precipitated it. A first significant improvement in the patient's symptoms occurred when he overcame his impotence after reducing his oedipal feelings of guilt and partially overcoming his castration anxieties; at this point his strong anal fixation manifested itself again. He was aware of his feelings of guilt, which he traced back to the masturbation he continued practicing until he had overcome his impotence. His self-accusations were so strong that he wished he had died as a soldier.

During puberty he had been frequently disturbed by incestuous fantasies, and for many years struggled, ultimately successfully, to overcome his sadistic impulses. An immense castration anxiety had led him to hide his genitals under a protective cover. Even after he had overcome his impotence he was very frightened when his wife made sexual advances. He developed fantasies about how he could compensate for the loss of semen and the psychic damage he experienced. To cite from the protocol of one session:

The patient spoke about his oversensitivity. Despite everything, he still had reservations about whether everything would really turn out alright. An egg is life, man's semen, punishment for masturbation; eggs are the testes; peculiar thought that the skin could be irritated by one's own testes; he fantasized about swallowing his own semen, to keep from losing it or his strength. He had actually already thought about trying to do this, but was prevented by his revulsion. Another of his fantasies was to squeeze his sebaceous glands and to use the secretion to treat his skin. Now he would have preferred to cover up his genitals and had an immense anxiety about losing them. He felt that looks alone meant that an attack, an intervention, would come. His body was supposed to belong to him and him alone.

In a long transitional period he described the unbearable tension he felt when he was unable to wash at the right time or take care of his skin. If it were impossible for him to withdraw, his agitation became so intense that it was not uncommon for him to think about suicide.

P: Although I'm able to postpone my skin care for a while, perhaps for 1-2 hours, the tension in me then becomes so great that most of all I would like to kill myself. Excessive skin care is like an addiction, and then I'm able to make the rudest accusations against my wife, and I really have.

After the emotions and fantasies that had previously been tied to symptoms were unleashed, his various anxieties took on concrete forms that were accessible to interpretation. His magical thoughts and the compulsive anal rituals assumed a phallic meaning. One purpose of his phallic narcissism was to ward off castration anxiety, such as was exemplified by the following dream:

P: I was at the sports festival, taking part in both the high jump and the long jump, where I managed 7.80 meters. Uwe Seeler [a famous soccer player] was on the loudspeaker, and the women in the stadium were completely enchanted by his voice alone. A woman next to me moved as if in intercourse; just his voice made her have an orgasm.

In his associations, he thought it would be great if it were possible without intercourse, solely as a result of words. He wanted to be a famous athlete and jump so far that he would never touch the ground again. Having an immense penis, he said, would be the greatest of riches, being a male whore and injuring women. In his youth he had trained himself to suppress his sexuality, but also to realize his fantasies of omnipotence, in order to be like Uwe Seeler in his dream and fascinate women with his words. Then the patient became agitated and developed a momentary anxiety about being poisoned, which he immediately related to his skin infection—vaginal secretion could poison him.

Incidentally, in another phase of treatment this patient had expressed the desire to hear his voice once from the tape recorder in my office. He had never heard his own voice before. (Today I would presumably record the treatment, with the patient's approval, and surely not deny him his wish.)

His insight into the fact that he used his skin in place of objects and that his many nuances of pinching and scratching were his attempt to accommodate object-related feelings was facilitated by a dream that repeated itself in altered forms. In this impressive dream, the subject and object were exchanged—the one scratching and the one being scratched, the one applying the salve and the one being salved. He himself was the patient, but then he was not, after all; the features of the other person were not clear. In the transference I also had a part in this fantasized role playing in which the subject and object were exchanged. Regarding the origin, he remembered homosexual contacts and goings-on with his brothers. The longest period of time was filled by the fantasized exchange of ambivalent actions related to his skin. In another dream his damaged, eczematous skin was transposed onto a woman's breast. This transformation temporarily strengthened his anxiety about poisonous secretions from his wife. The anxiety decreased after he had retracted the projection of his own aggression, which had transformed the object into an evil object.

That projections of this kind are "only an element of a total identification with the object" is a fact that Marty (1974, p. 421) has described and given an anthropological foundation: "This intensive movement of total identification that allergy patients have with their objects is actually only a unalterable fixation, which is alive in each of us to a certain degree: the desire to be the other" (p. 445). It is definitely wrong to consider this process typical for allergy patients. Yet I do consider it possible that—*given* an allergy—the specific manner in which this patient cared for his skin and also his withdrawal, as it was caused by his illness, reinforced his unconscious confusion of subject and object. This was thus a retrograde revival of the undifferentiated phase that Freud described in the following way:

> The antithesis between subjective and objective does not exist from the first. It only comes into being from the fact that thinking possesses the capacity to bring before the mind once more something that has once been perceived, by reproducing it as a presentation without the external object having still to be there. (Freud 1925h, p. 237)

In this context it is possible to describe the development of the patient's oversensitivity to egg white. Although he was already aware that he had an allergy, even before he began analysis, he had noticed that the effects of the allergen on the target organ were very dependent on other factors. (He himself had noted that when he avoided all egg white he was able to detect even minute traces of them that accidentally got into a dish, by means of the taste sensations they stimulated, specifically a burning sensation in his mouth.) As already indicated, the patient had developed his own psychosomatic theory of his oversensitivity, in which some substances his wife secreted or transpired played a central role. Foodstuffs thus came to join the body substances he thought caused his disturbance.

The patient described, for example, his repugnance at having physical contact with his wife. He claimed she sometimes had a slight mouth odor, and he then used his skin as a pretext for not having closer contact. He said that he had a real anxiety about mouth odor; he would hold his breath when he passed by someone, or stay in back or pass by very quickly, to be sure to avoid the smell because exhaled air might be contagious.

His paranoid anxieties decreased and ultimately disappeared entirely, according to his degree of success in tracing his projections back to his own unconscious impulses. In this process, the dream in which he confused the subject and object took on a guiding function. In this context the patient had the following association: "Infect people with my disease, yes, that's what I want, first to wound them and then to infect them." His anxieties about injuring objects and himself were filled with contents from the oral, anal, urethral, and phallic phases of development. Initially the different contents were mixed together in his unconscious experiencing, which led to agitation and a worsening of his symptoms; then he became aware of the mixture, which made it possible for him to differentiate them and overcome his anxieties.

He wanted to gain sexual prowess by eating, using some powder, or taking one of various substances, e.g., a hormone or something for his testicles, but then was afraid that it might aggravate his skin. "I could annihilate all chickens to keep egg white from getting into food." Here his revulsion and

hate were directed at eggs. He continued by associating about his fear that his testicles might get damaged. He became enraged by just thinking about his wife acting affectionately toward him and possibly making a sudden and unexpected movement—"touch my genitals." "It's an anxiety that almost has the same effect as pain." Incidentally, the patient's oversensitivity to eggs first developed in 1949, about 2 years after the onset of his illness, and he did not notice the burning sensation in his mouth after eating eggs until later. The allergy tests were conducted in 1950.

Whatever the conditions were that let the patient's latent disposition become manifest in this case, it can be seen in the course of treatment and in the case history that the patient's oversensitivity only played a subordinate role in the development of his chronic neurodermatitis. Much more serious were the meanings he attributed to certain "objects," such as his wife, as a result of which he developed an oversensitivity to them that continued until he succeeded in retracing his repulsion back to the indirect satisfaction concealed in it, recognizing it as pleasurable, and integrating it. It was then possible for him to give up his multifaceted withdrawal in favor of a less constrained relationship with his wife and his surroundings. In the last phase, exacerbations of his neurodermatitis became increasingly infrequent, to the same degree that his skin lost its character of being an autoerotic and autodestructive substitute object.

Epicritical Comments

The analyst's thematic concentration on regression raises various questions. Although the patient's daily routine was filled by such forms of experiencing and behavior, certain areas are underrepresented in this selective description and in the therapy. The analyst oriented himself on the psychodynamic processes, which exhibited a particularly close *situative* connection to the changes in symptoms. Since the issue was not to reconstruct the specific conditions of the regression and trace them back to fixations, the analyst emphasized the circumstances in the situations that governed the daily course of the disease. In repetition compulsion there are, of course, conserved causes at work, i.e., causes that have existed for a longer period of time, and from a therapeutic perspective special attention must be paid to circular self-reinforcement and the consequences it has on the primary conditions of symptom formation. Very different anxieties and (oedipal) guilt feelings—which, precisely because of the patient's skin symptoms, could be precipitated by situational factors at any time—intensified the regression and contributed

indirectly to the aggravation of his symptoms.

If regressive processes of this kind exist long enough—and this patient had undergone unsuccessful dermatological treatment for eight years—then it is possible for externally directed intentions to become unconscious and affect the body feeling. At the risk of being misunderstood, we can describe this with the brief statement: This patient's life was limited to his skin. This simplification makes comprehensible the reasons that various psychoanalytic and psychotherapeutic theses about neurodermatitis and other dermatoses are accurate and can be useful in treatment. Regressions manifest the weak spots that—depending on the terminology in fashion and the technical and theoretical developments—belong to the psychodynamics of neurodermatitis and have a *nonspecific correlation* to it. This has been shown in the case of aggression (Thomä 1981), regardless of whether we refer to the sadomasochistic and exhibitionist features that Alexander emphasized, or to other averbal unconscious fantasies.

The guiding perspective in the presentation of this case resulted from the focusing on one form of regression. Yet guiding perspectives conceal dangers because they can be misunderstood as the special or even specific mechanisms of the particular symptoms. Such a thesis is not supported by the therapeutic experience with this patient. The following observations about the course of the illness during the analysis are relevant in this regard.

For both clinical and scientific reasons and in accordance with A. Mitscherlich's working hypothesis, it is important to pay special attention to the course of the symptoms as they correlate with psychodynamic events and changes in them (see Thomä 1978). For this patient, everything became a strain because of his withdrawal, anxieties, and feelings of guilt, and his skin was almost always also affected. The isolation of those conflicts accessible to therapy led to a reduction in the number and quality of "precipitants." The sequence in which conflicts open to resolution are worked out follows rules that differ from those determining pathogenetic significance. Because of this difficulty and because of the inadequate nature of the protocols of this case, it is impossible in retrospect to evaluate the clinical correlation more precisely.

The motives that had driven the patient into regression had been overcome when treatment was

terminated. His symptoms had either disappeared or improved significantly. His relationship to his wife was and has remained satisfactory to each of them. For the first time the patient had confidence in his capacity of being able to structure his life in a meaningful manner. The neurodermatitis has not remanifested itself during the subsequent period of almost 30 years. Noteworthy is, however, that the patient has retained his oversensitivity to eggs, yet without his skin being affected.

Epicrisis

The clinical and scientific significance of the comparison of the case with itself is obvious. It reaffirms the causal significance of the psychogenesis without raising the claim that this patient's biographical data or that the insights gained in analysis into his conscious and unconscious experiencing are typical for neurodermatitis in general. The case history contains a description of several important preconditions of his symptoms. It was logical for the analyst to proceed from the regression linked to the symptoms and to focus on the effects of the rubbing and scratching that had become chronic in the self-reinforcing circle of events. The case history also demonstrates that significant causes of the neurodermatitis were overcome. It has never required any dermatological or other treatment.

On other hand, some five years after the termination of treatment the patient underwent an operation for a cataract on his right eye (his left lens was not affected). Since the lenses, just like the skin, stem from the ectoderm, the appearance of a cataract is an indication of a possible somatic source of his neurodermatitis. Finally, the patient underwent a successful plastic operation a few years ago for a clot in his right femoral artery.

The patient's private and professional life developed favorably and to his satisfaction. The couple had a son, and the patient went on to have a successful career. The patient attributed the curing of his neurodermatitis and the positive turn in his life to analysis, which freed him of severe guilt feelings and the anxieties that had restricted his life.

9.7 Nonspecificity

The psychosomatic research inspired by psychoanalysis, which was given a methodological foundation in the 1930s by Alexander's pioneering studies, was characterized by the *specificity*

hypothesis . The results of decades of scientific effort support the following view: Regardless of the importance that psychosocial factors have for the genesis and course of somatic illnesses, it is rather improbable that there is a specific causality. The alternative hypothesis—the assumption that psychic factors play a nonspecific role in the multifactoral constellation of conditions that cause illnesses—can, in contrast, be shown to agree with the available findings.

Related to the concept of specificity is a theory of causality that originated from our understanding of infections. A specific morphological change in tissue corresponds to a specific pathogen, e. g., the diphtheria pathogen, the typhus pathogen, or the tubercle bacillus. Substances that are effective in countering pathogens are also referred to as specific. Thus the concept of specificity is double edged, referring both to the cause and the effects. Disposition, however, must also be taken into consideration, even in the case of infectious illnesses, in order to adequately comprehend the constellation of conditions. As we described in Sect. 1.1, Freud adopted in psychoanalysis the explanatory scheme that in principle is still valid in medicine, and in his theory of complemental series adapted it to the particular circumstances of mental diseases.

From today's perspective it was mistaken to mingle the scientific discrimination of necessary and sufficient causes with the concept of specificity. By the same token, the somatopsychic consequences, which in turn also have a causal effect on one's psychic state, were given inadequate consideration. Yet although it was a mistake to burden clinical research with the search for a typology of *specific* conflicts underlying somatic illnesses, this methodological approach has historical merits, as shown by its unbroken relevance. The multivariate approach that Alexander favored has remained part and parcel of psychosomatic medicine despite all the shifts in emphasis with regard to the variables studied. In Alexander's school it was postulated that the genesis and course of illnesses are governed by three groups of variables. One group of variables consists in a psychodynamic configuration that, together with the corresponding defense processes, is formed in childhood. The second group of variables refers to the precipitating situation in life, whether as a lived experience or a series of events immediately preceding the outbreak of the illness, that has a special emotional significance for the patient and in addition is suited to activating his central unconscious conflict. Finally, the third group of variables includes all of the somatic conditions, which Alexander took to mean a constitutionally or dispositionally determined "somatic compliance" (Freud) or "organ inferiority" (Adler). By renaming the "vulnerability" of the

appropriate organ or organ system factor X, it has stayed too much in the dark, especially since precisely the pathophysiological and morphologic processes might be the ones that are responsible for the "choice of the symptoms."

Alexander et al. (1968) summarized their working hypothesis in a retrospective publication in the following manner. A patient in whom a specific organ or organ system is vulnerable and a characteristic psychodynamic configuration is present develops a corresponding illness if the circumstances in his life mobilize an earlier, unresolved, central conflict and if the resulting strains lead to a collapse of his primary defences. The correlation studies conducted on the basis of this working hypothesis showed that blind diagnoses and symptoms corresponded relatively well solely on the basis of knowledge about the psychodynamic variables. The studies conducted by Alexander and his students appeared to provide confirmation that forms of experiencing and behavior that can be traced back to endopsychic core conflicts are manifested more frequently than would occur by coincidence and that these frequencies differed for the seven illnesses that were studied. Alexander and his followers chose bronchial asthma, rheumatic arthritis, ulcerative colitis, essential hypertension, hyperthyroidism, stomach ulcer, and neurodermatitis as paradigms in their studies. These illnesses, referred to as the "Chicago seven," have a place of honor in the history of psychosomatic medicine and attracted so much attention that many physicians believed for a long time that both psychosomatic medicine and Alexander's approach were limited to these seven illnesses.

Psychic influences are conceivable and possible in all human illnesses, and for this reason psychosomatic medicine has never been limited to studying the seven illnesses named above. Initially the specificity hypothesis was applied and tested on these seven illnesses for several reasons, not least of all because of methodological and practical restrictions. Although we are today more inclined to assume that the relevant conflict constellations in these illnesses are nonspecific or variable, the seven have remained important paradigms in psychosomatic medicine, at least as far as it attempts to demonstrate correlations serving as the basis for further hypotheses and theories. Moreover, Alexander's specificity hypothesis never specified which side of the three-part model is the specifically determinative cause of pathogenetic conditions. The three groups actually consist of a multitude of individual features, which makes it necessary to employ a multivariate model and a corresponding methodology. One factor would only acquire "specific" weight in a very rare case, which is not to be expected in practice. Which of the

postulated variables is decisive in selecting the organ that is affected remains an open question. It might well be factor X, the specific organ vulnerability (Pollock 1977).

Thus, improbable as it is that the specific cause of somatic illnesses can be found in certain conflict constellations or in Lacey's stimulus specificity (see Schonecke and Herrmann 1986), the fact that psychosomatic research was initially limited to a few illnesses has nevertheless proved to be productive in the history of psychosomatic medicine. Weiner (1977), for example, compiled a brilliant survey covering the six illnesses (without neurodermatitis) originally studied in Chicago, in which he described in exemplary fashion the problems that were of clinical importance and of relevance to research strategy in the 1980s. In retrospect it can be said that the research inaugurated by Alexander basically has a multivariate approach that can only satisfactorily describe the multifactorial etiological events if all the important variables are taken into consideration. A methodological consequence of the use of this general psychosomatic approach as a principle guiding physicians' actions is that the psychosocial factors influencing the genesis and course of somatic illnesses must be examined as thoroughly as possible and the patients be given psychotherapeutic treatment especially with regard to the consequences of these factors. As can be seen in Weiner's (1977) critical survey or in von Uexküll's (1986) encyclopedic textbook, the impact of psychosocial factors on the course of an illness can today be best assessed for those illnesses that previously served as paradigms. Despite all the complaints about body-mind dualism, psychosomatic medicine is also bound to a pluralistic methodology, which is frequently ontologized by materialistic or spiritualistic monisms and raised to an ideology (Groddeck 1977). For them, dualism is the evil factor (Meyer 1987).

Examples of such monism are, on the one side, Groddeck's all-encompassing spiritualism and, on the other, a materialism that identifies the neurophysiological substrate with mental and psychic processes. The autonomy of physical laws was overlooked in Groddeck's speculations, and in some areas of today's psychosomatic medicine psychic phenomena and their psychodynamics appear to dissolve into physiology. The history of the influence of the concept "conversion" shows how large the confusion can be. For instance, Lipowski (1976, pp. 11-12, emphasis added), in his influential survey of the state of psychosomatic medicine, advocated the view that "this area of research"—specifically that on "the interrelated neurophysiological, endocrine, and immunological processes and pathways whereby *symbolic* stimuli may affect any or all somatic functions"—that this area "has showed spectacular

advances in the past decade or so, and it is now possible to bridge the so-called leap from the mind to the body." Lipowski added, "Without clear understanding of these processes, we are left with nothing more than correlation between specific events and *psychological* traits of the individuals exposed to them, on the one hand, and a given *bodily* dysfunction or disease, on the other."

Every physician who thinks in terms of psychosomatic categories emphasizes the qualitative autonomy of symbolic processes when confronting monists who equate psychic phenomena with the cerebral substrate. It is conceivable that the range of symbolic human activities that are tied to cerebral structures and functions influence all the processes in the organism down to individual cells. Yet to want to go from the recognition of physiological transmitter processes to psychic experiencing and symbol formation is a serious fallacy that is based on a fundamental confusion of different epistemological categories.

From a psychotherapeutic perspective, the studies by Alexander and his school have proven to be unusually productive. It is no coincidence that it was French (1952), a member of the Chicago research group, who was the first to introduce the concept of focus into the theory of technique. The significance of the here-and-now relationship was also made the center of attention there. Because of the different consequences of individual illnesses, it seems obvious that, for example, patients with a dermatological problem are more inclined to speak about themes dealing with exhibitionism. The fact that premorbid latent dispositions are activated and manifest ones are reinforced is, after all, an experience made in everyday clinical work. Furthermore, different realms of experiencing are associated with skin than with orality or with motility and restrictions of it. We emphasize the course of the illness and its circular consequences—in the sense of a self-reinforcing vicious circle—because it is here that psychoanalytic efforts can and must be focused. It is then possible to go from the somatopsychic consequences to the patient's experiencing without the manifestation of the particular resistances that appear to justify the assumption of specific "psychosomatic structures" (see Sect. 9.9). If the physician confronts the physically ill patient primarily by trying to discover psychic conflicts, i.e., in a broad sense to discover the psychogenesis of the complaints, then he triggers the reaction attributed to a patient suffering from a stomach ulcer: "But, Doc, my problem's in my stomach, not in my head." If the doctor proceeds from the physical complaints and pays serious consideration to both the somatic side of the body and the psychoanalytic discoveries about body image (see von Uexküll 1985), then he can effortlessly discover

how patients cope with their illnesses. This is a means of accessing the psychosocial factors influencing the development of physical illnesses. It is always advisable to dwell on the momentary course of the illness for a long time, as we have described in Chap. 5 with regard to a case of wry neck. Psychoanalytic interviews seldom fail if the analyst orients himself on the fact that the physical complaints lead at least to a secondary complication of the unconscious fantasies associated with them. For example, heart anxiety restricts one's freedom of movement, and all complaints regarding the digestive tract lead to a sensibilization of orality, regardless of the significance of its role in the genesis of the disorder. In establishing a therapeutic relationship to patients whose complaints are somatic in nature, it is decisive that the analyst acknowledge the primacy of the body insofar as this is compatible with his methodological restriction to body image and with the fact that it is impossible for him at the same time to pay adequate consideration to the body in somatic terms. We of course agree with von Uexküll (1985, p. 100) that the psychoanalytic method, to the extent it can also move into the unconscious sphere of the body ego, can always only reach the different images or representations of the body and "does not catch sight of the body in its deeper dimensions that are in principle unconscious and that can never become the

object of consciousness." Connected with this is the therapeutic range of psychoanalysis with regard to physical illnesses, i.e., the problem of the degree to which the therapeutic efforts regarding subjectively experienced body image have an affect on the somatic functions. The psychoanalytic observations that Rangell has summarized are relevant at least to an individual's subjective condition:

> Thus there is no extensive psychoanalytic clinical report of an ulcer patient without observations about the oral meaning of the gastric contractions or tensions, nor of a case of ulcerative colitis without an abundant reference to the incessant struggles around anality expressed in physical terms, nor of an asthmatic, or a neurodermatitis, without similar reconstructions of the symbolic distortions at various levels inherent in the multitude of physical and functional alterations . . . In most cases, therefore, the resultant psychosomatic syndromes would be a combination of the organ-neurotic and the conversion processes. (Rangell 1959, p. 647)

In our opinion it is not just a coincidence that Rangell only referred to the kinds of cases whose symptoms can be linked in some manner to the suffering, acting, feeling, and thinking person. The skin and body orifices are, for example, associated with experiences that can be correlated with functions. The task that remains is to grasp the genesis of symptoms from the correlation with conflicts. Thus, Alexander did not assign a "meaning" to the morphological alteration itself, but he did assume there was a very close "emotional syllogism" between functions and experiencing. Even in his first studies (Alexander 1935)

on psychosomatic illnesses of the digestive tract, it is possible to locate the conflict configurations in the "giving" and "taking" that were later designated "specific." Alexander observed that an ambitious person with an ulcer unconsciously identifies his repressed longing for love and help with the need for nutrition ("emotional syllogism"). This identification sets his stomach moving, which reacts as if nutrition were to be consumed or as if it were time for a meal. The conflicts of dependency that Alexander emphasized are repressed. Yet the ulcer itself does not express any symbolic meaning. Although Kubie's (1953) criticism of the specificity hypothesis has gained acceptance, the significance of Alexander's observations is not diminished if "specific" is replaced by "typical." The typical conflict constellations in Alexander's scheme did not constitute the specific factor in the sense of our understanding of infections because other etiological factors, such as the organ disposition, were also referred to as "specific." In the critical survey mentioned above, Weiner discussed a present-day pathophysiological classification of the dispositions in the illnesses studied by Alexander. The success of the multivariate approach was demonstrated particularly convincingly with regard to the etiology of ulcers of the stomach and duodenum (Schüffel and von Uexküll 1986).

From a psychotherapeutic perspective the distance between a focus—the theme of the interview—and the physical illness is initially unimportant. Decisive is rather that the patient gain confidence in the interview, i.e., that he accept it as being a means of therapy. The question regarding which bodily changes might at least in part have originated from psychic factors and might be reversed is completely open. Anyone who actually tries to reverse chronic somatic symptoms by means of psychotherapy will not lose touch with the real problems, which are due to the primary or secondary autonomy of physical symptoms.

9.8 Regression

In Vol.1 we discussed regression in connection with Balint's concept of a new beginning. Regression also played a prominent role in the conceptualization of the therapy for the patient suffering from neurodermatis. Precisely for this reason it is important to us to draw attention to the fact that we reject using an unlimited extension of the theory of regression as a pattern for explaining psychic, physical, and psychosomatic illnesses.

Even a brief consideration of the processes of regression indicates that the term refers primarily to a descriptive generalization. The concept of regression in its general sense means "a return from a higher to a lower stage of development—then repression too can be subsumed under the concept of regression, for it too can be described as a return to an earlier and deeper stage in the development of a psychical act" (Freud 1916/17, p. 342). In *The Interpretation of Dreams* Freud had already distinguished between topical, temporal, and formal aspects of regression. Freud first introduced Jackson's teachings about evolution and dissolution into his research on aphasia, and later put Jackson's views on functional degeneration to productive use in psychopathology. He later assumed "that particular regressions are characteristic of particular forms of illness" (Freud 1933a, p. 100). The concept of regression then goes beyond a descriptive generalization within the *explanatory theory* of psychoanalysis, obtaining an explanatory significance in connection with the concepts of precipitating conflict and fixation. In our opinion, this must be understood as an acquired disposition in the sense of an unconsciously anchored disposition (Thomä and Kächele 1973). Of note is the fact that the concept of regression refers exclusively to the explanation of *psychic processes* .

If, in contrast, fixation and regression are understood in terms of fictive *psychophysiological* categories, then the return to an earlier, unconscious level seems to be able to explain the development of both psychic and somatic illnesses. In fact, many theories in psychosomatic medicine since Groddeck's work have followed this assumption, even if this is not apparent at first sight.

It is not difficult for someone familiar with the subject to recognize a few patterns in this unlimited extension of the concept of regression. The common element stems from the psychoanalytic theory of defense, from which two theses about etiology can be derived. According to the first assertion, physical illnesses occur when Reich's character armor is reinforced and manifests itself somatically. Mitscherlich's two-phase repression goes back to the assumption of an existing character neurosis that is reinforced, so to speak, in the psychosomatic pathogenesis. Long ago one of us (Thomä 1953/54) published, very naively, a model case based on this idea without considering the fact that defense processes must be understood as *processes* and that even Freud, referring to repression, spoke of *after-pressure* .

The second widespread idea that has been derived for psychosomatic medicine from psychoanalytic theory is oriented on regression. Prototypical for it is Schur's (1955) conception that

psychosomatic disturbances are connected with maturation and regression processes; he grasped the development of a healthy child as a process of "desomatization." According to Schur, a more conscious and psychic form of reaction develops through maturation, out of the undifferentiated and undeveloped structure of the newborn, in whom psychic and somatic elements are indivisibly linked with one another and who reacts primarily physically and unconsciously at this stage of development. Somatic forms of reaction diminish, and the child learns to react cognitively and psychically instead of somatically, i.e., through states of physical excitation. Schur associated this process of desomatization with the neutralization of instinctual energies by the ego. In the case of a psychosomatic illness, the ego is no longer able to cope with conflict situations by utilizing freely available, neutralized energy. Because of the anxiety associated with this, there is regression to the level of earlier patterns of behavior, i.e., to the level of the somatic form of reaction (psychophysiological or psychosomatic regression). Energies that had previously been tied down by the defense process of neutralization are released by the particular collapse of the ego and are expressed in an undifferentiated somatic manner corresponding to the stage of the regression. The particular shape of the resomatization, i.e., the choice of organ and the extent of the range of somatic reactions, depends on the infantile traumatic experiences and the consecutive fixations on the body's functional processes. Schur proceeded from the assumption that, in the course of ego differentiation during the process of physiological maturation, uncoordinated somatic processes are integrated cognitively and psychically, replacing the somatic reactions in the primary process with mental actions at the level of secondary processes. He viewed psychosomatic regression as a step backward, toward the original level at which the mind and body were a reaction unit that tended to discharge tension somatically.

The fundamental conception of this prototypical explanatory approach, which can also be found in the works of Mitscherlich (1967, 1983) and other authors, is the analogy or identification of infantile somatic-psychic forms of reacting with the psychosomatic form of reaction. Schur followed the psychological approach to neuroses inasfar as he viewed regression as the primary mode of the development of the illness and additionally included physical processes. The regression model is thus simply extended past the psychic level onto that of physiology. The specificity postulate is supposed to be satisfied by the familiar fixation hypothesis. It is typical for the theories formulated by many schools of psychoanalytically oriented psychosomatic medicine that the range of the particular approach is tested

less from methodological perspectives than simply asserted with the help of dating the causes back into earliest childhood. If we do not let ourselves be deceived by the ingenuity with which new terms are created, then we soon recognize the uniform pattern in the assertion of the early (preoedipal) origin of psychosomatic illnesses, in which physiological laws are disregarded. It is amazing how false assumptions, with or without a dubious sense of reality, can continue to survive when authors avidly cite one another, or how secondary, terminological modifications can feign new knowledge. For example, Kutter (1981) raised Balint's *basic fault* , which was dubious even with regard to the etiology of neuroses, to the *basic conflict* of psychosomatic illnesses and contrasted them to neuroses. This makes patients suffering, for example, from one of the seven illnesses mentioned above into seriously ill borderline cases, which is compatible with neither the results obtained by Alexander nor our present-day knowledge. Kutter and others reduce the psychosomatic theory of illness to one fundamental condition, whose etiological primacy is even improbable in the theory of neuroses. The etiological theory that Freud created with his model of the complemental series has in the meantime assumed a complex form because of the multiplicity of psychic and somatic processes involved in the origin and course of every illness. It is out of the question that the basic fault constitutes the necessary condition for neuroses, i.e., that the latter develop out of it with the necessity of a law of nature, like an egg after insemination. This is also the reason for our criticism of Balint's conception of a new beginning, which we have summarized in Vol.1 (Sect. 8.3.4).

With the help of the assumption of a "psychophysiological or psychosomatic regression" and of the additional speculation that early traumatic experiences affect the psyche-soma unit, it appears to be possible to explain every severe somatic or psychic illness, from cancer to schizophrenia, from one vantage point. It seems to be possible to derive everything from the "psychosomatic structure." Bahnson, for instance, asserted in his *complementarity hypothesis* that

> In the somatic sphere the processes taking place resemble those in psychic regression (during neuroses and psychoses). If repression must assume the primary burden of the defense processes, instead of projection, then there is a shift of instinctual energy into the somatic sphere. Then we find a sequence of increasingly deeper somatic regression, from conversion hysteria to the deepest regression in the sphere of cell mitoses. (1986, p. 894)

Bahnson assigns the origin of malignancies to the deepest point of regression due to repression and, complementarily, that of psychoses to the deepest point of regression due to projection.

It is surprising how much fascination is exerted by the idea of psychophysiological regression, which was propagated by Margolin (1953) and which especially McDougall (1974, 1987) recently applied as the all-encompassing explanatory principle of psychic and somatic illnesses. The concept of psychophysiological regression, or at least the essence of the idea—although long ago shown to be untenable by Mendelson et al. (1956)—seems to be just as timeless as the hope for eternal life, and may even have its source in the latter. The search for meaning governs human life much more than scientific truths do, and part of it is the search for the interchangeability of body and mind, together with the idea of a concealed meaning of somatic illness that has been derived from psychoanalysis. On the basis of these assumptions one arrives at V. von Weizsäcker's principle of equivalence and the interchangeability of organic and psychic symptoms, which also amounts to a panpsychism in the thesis, "Nothing organic has no meaning." C.F. von Weizsäcker, in a discussion commemorating the 100th anniversary of the birth of Victor von Weizsäcker, the founder of anthropological medicine, stated unambiguously that one could not "assign each physical illness a psychic interpretation, which then takes on a scientific function in the interaction between physician and patient" (1987, p. 109). At that symposium, von Rad (1987, p. 163) drew attention to the panpsychism of anthropological medicine in the ideas of the interchangeability of body and mind and the security each finds in the other, and warned about the dangers associated with them. V. von Weizsäcker's philosophical ideas about human nature are, as von Rad documented by referring to several quotations from von Weizsäcker's writings (e. g., 1950, p. 259, 1951, p. 110), in fact dominated by the idea of a panpsychism, which from the very beginning has been a burden on the introduction of the subject into medicine. The scientific methodology of anthropological medicine is also in its beginnings. If bipersonality is taken seriously in therapy and scientific research, then all the problems characterizing the psychoanalytic paradigm are confronted. Clinical psychology has also been confronted by a paradigm change since the "cognitive revolution" of behavioralism (Bruner 1986). The contemporary attempts at integration, such as those presented by Wyss (1982, 1985), do not do justice to the comprehensive clinical knowledge that has been accumulated in psychoanalysis in this century.

To use the idea of psychosomatic regression—in whichever of its various but only apparently very different versions—as a basis for a comprehensive explanation of somatic illnesses leads to incorrect diagnoses and obstructs the development of more tenable theories.

The analogy of infantile psycho-somatic forms of reaction that are integrative in nature with somatic

disturbances does not bear fruit, as we have demonstrated in Chap. 5 with regard to the example of wry neck. The physiology of the newborn is substantially different, as Meyer emphasized, from that of the adult:

> I would like to recall just one of the numerous differences, namely that of less functioning homeostasis. At the slightest infection newborns and infants have a body temperature of 39 °or 40 °C, they vomit at the slightest stress, they become exsiccated within hours. The only thing we do not find in the infant is an outright asthmalike or colitislike deviation that an adult might regress to. On the other hand, psychosomatic fever is unusual—the two cases that I have observed in 30 years did not result from physiological regression, but were residual stress consequences of herpes. (Meyer 1985, p. 54)

The infantile discharge of tension takes place through the body-mind unit because of the lack of cognitive forms of coping. In such integrative reactions characterized by the features of the primary process, the infant or newborn is in an animalistic phase of maturation. It is noteworthy that a psychosomatic illness does not occur in animals in the wild, only developing through artificially set conditions. In contrast to the infantile stage of development, events do not take place integratively in psychosomatic patients, i.e., not in the form of a body-mind unit; the characteristic feature of this form of disturbance is the complete lack of such a connection. Conceiving of psychosomatic decompensation as regression, understood as a reversion to infantile forms of the somatic discharge of tension, cannot explain the destructive aspect of physical illnesses.

The inclination of many psychoanalysts "to psychologize the physiological" (Schneider 1976) and their complementary inclination to disregard physiological laws when considering psychosomatic disturbances has led to a fatal stagnation. There is no mention of a differentiation between individual illnesses, rather the continued assertion of a seemingly holistic explanatory claim for "*the* psychosomatic illness." And there is no talk of a differentiation between acute and chronic illnesses, since many of the psychic features described in the course of chronic illnesses, such as the helplessness-hopelessness complex described by Engel and Schmale (1969), could after all be reactions of the sick individual to the somatic aspects of his illness!

9.9 Alexithymia

We made a reference to alexithymia when we said that the neurodermatitis patient behaved as if he were an alexithymist (p. 482). The term refers to the incapacity to "read," perceive, or express one's

feelings.

The idea of psychophysiological regression, which was foreign to Freud's methodological manner of thinking, was also the moving force behind the description and explanation of alexithymia. This idea unites the countless fantasies that shift the source of somatic and psychic illnesses—ranging from cancer to psychosis—back to early infancy, i.e., to the time prior to the differentiation into psyche and body. At this age individuals allegedly develop with a so-called *psychosomatic structure* characterized by the particular absence of fantasies and mechanized thought (*pensée opératoire* or alexithymia).

Although considered a school, the authors counted among the "French school" of psychosomatic medicine have by no means a homogeneous understanding of the concept "pensée opératoire." The processes of regression and fixation do, however, constitute the fix points in their ideas. De M'Uzan (1977) saw the lack of an opportunity to satisfy hallucinatory needs in childhood as being an important cause of the deficitary nature of psychic structure he believes characterizes the psychosomatically ill; Fain (1966) postulated a regression to a primitive defensive system of the ego as being the motor for the formation of somatic symptoms in psychosomatic illnesses; and Marty (1968) conceived of specific regressive processes (e. g., progressive disorganization, and partial and global regression). Marty (1969) traced the formation of somatic symptoms corresponding to these different forms of regression back to fixations originating from pathological humoral interactions between the fetus and mother, i.e., in the intrauterine phase. For these authors, this is the source of the clinical phenomena they describe. Operative thought is the "expression of an overcathexis of the most material, concrete, and practical elements in reality" (de M'Uzan 1977), which does not permit the patient any access to affective or fantasy levels, only creating images of the time and space relationship and thus a "bland relationship" to one's partner in conversation. They consider this the form of relationship characteristic of the psychosomatically ill. These French authors describe a tendency of such individuals to superficially identify with an object's features, a phenomenon they refer to as "reduplication." The patient thus makes an infinitely reproducible person out of himself; he grasps the other person only on the basis of his own model and has no comprehension of the other's individual personality.

Although Marty initially based his ideas on the assumption of intrauterine fixations, he later introduced a conception in which the origin of the primary fixation mechanisms responsible for the

development of a psychosomatic disturbance was understood as being the result of the pathological interplay of death instinct and evolutionary process. Marty (1968) attempted with this idea to correlate the observed features of operative thought with the psychophysiological development of the individual. For him, human development is evolution that takes place under the influence of the life and death instincts. The proximity of these thoughts to Schur's concept of desomatization is obvious even though they are bound in a different theoretical framework. According to these authors, antievolutionary influences (caused by thanatos, the death instinct) disrupt the biological economy during the infantile development of the psychosomatic individual (evolutionary process, influenced by eros); although the pathological dysfunction is then eliminated, nothing can prevent these phases of development from continuing to be points of psychosomatic fixation.

It can be demonstrated for these French authors that they combine fragments of theories without integrating them and that they make no attempt to overcome the contradictions immanent in their theories in order to achieve a somewhat consistent theoretical model that is open to verification. For example, they assign operative thought to the sphere of the primary process, while they also discuss it as being a modality of the secondary process, with emphasis on orientation to reality, causality, logic, and continuity of thought processes (Marty and de M'Uzan 1963). This raises the question of how psychosomatic individuals then customarily demonstrate such a conspicuously high degree of social integration in spite of their functioning at the level of the primary process. The concept of reduplication has also not be refined sufficiently for it to be consistently related to the often mentioned observations of behavioral normalcy.

A new specificity assumption also guided the American authors who coined the term "alexithymia." They postulated a specific personality structure for psychosomatic individuals that—in contrast to that of neurotics—is characterized by alexithymia, the incapacity to express one's feelings appropriately in words. Sifneos (1973) has compiled a summary of the features he considers characteristic of psychosomatic patients: impoverished fantasy life with a sequential, functional manner of thinking, a tendency to avoid conflict constellations by acting out, a restricted capacity to experience feelings, and the difficulty to find the appropriate words to describe one's own feelings in individual situations. Although these authors (Nemiah and Sifneos 1970) initially proposed parallel psychodynamic, underdevelopment, and neurophysiological hypotheses, they later explicitly favored an idea borrowed

from MacLean (1977), which is based on the assumption of a neuronal link between the limbic system (as the seat of libidinal and emotional processes) and the neocortex. It was thus possible for excitations to be directly discharged into the somatic realm via the hypothalamic-autonomic system.

These ideas stimulated intense empirical research, whose results however have been negative. Of 17 empirical studies to identify alexithymia as a personality feature, there were no indications for the presence of such a specific personality feature in psychosomatic patients except in the study by Sifneos himself and in two others by one other group of authors. The features measured by the other clinical groups and also demonstrated for control groups were, in contrast, verifiable (Ahrens and Deffner 1985). The retention of the idea of a specific psychosomatic personality structure, regardless of its particular form, has obstructed the further scientific development of a psychoanalytically oriented psychodynamic approach (Ahrens 1987). The intention of finding a uniform personality structure for the complex and diverse nature of psychosomatic disturbances constitutes a constriction contradicting clinical experience. The latter suggests the assumption that there are heterogeneous conflict constellations even for *one* psychosomatic symptom, which has also been shown in empirical studies (Overbeck 1977).

The most probable explanation is that all the important features of the so-called psychosomatic structure to which mechanized thought (*pensée opératoire*) and alexithymia are attributed are situative in origin. They are more likely to be the result of a specific manner of interviewing and the assumptions it is based on, than constant and etiologically relevant personality features, not to mention their alleged origin in the first year of life. Cremerius justifiably asked whether the verbal behavior that strongly inhibited the fantasies of patients—who, as mentioned in the published examples to document the diagnosis of lack of fantasy, confronted by a lecture hall in an unmediated manner and without any preparation in the guidance of the psychoanalytic interview—may itself not have been induced by this setting. His reference to the similarity of this style of speaking to the language spoken by members of the lower social classes also deserves notice. Ahrens (1986a,b) used a technique of content analysis to examine a sequence from an initial interview published by Sifneos and Nemiah in 1970, which they had employed as an example of alexithymia in psychosomatic patients. Over half the sentences the patient spoke in this sequence contained aggressive connotations that, however, the interviewer did not recognize or make the object of discussion and that, on the contrary, acquired a hidden resonance in the

course of the interview. The authors thus projected the "problem of communication" mentioned in the title of their study into the patient and gave it the name "alexithymia," while bracketing out the problem of transference and countertransference. Other studies that compared groups of neurotic and somatically ill patients, using a differentiated methodological approach, came to results that contradict the idea of a specific psychosomatic personality structure since no differences between the two groups of patients could be determined (Ahrens 1986a,b). These results have been given little consideration; there is a very skewed ratio between the efforts to validate assertions in verifiable studies and the production of all-encompassing etiological fantasies.

It is quite obvious that we are challenging prejudices that can hardly be resolved or even weakened by the rational means of scientific validation. This raises the psychoanalytic question as to the motives that make such back-dating of the causes to a common matrix so fascinating and that protect them from reality testing—or actually provide this form of fantasizing a general immunity against scientific arguments.

Marty's hypothesis regarding the death instinct may serve as an example. An explanatory model is erected on hypothetical constructs that are inaccessible to empirical verification or even to the test of plausibility based on clinical experience. On the one hand, such speculation—in contrast to ideas and fantasies that can serve as a basis for scientific study and research—is bottomless; on the other, it governs therapeutic action without being able to provide a justification. Many psychoanalysts believe they can justify their speculation by referring to Freud's *drive mythology*. Freud's famous ironic and philosophical comment was,

> The theory of the instincts is so to say our mythology. Instincts are mythical entities, magnificent in their indefiniteness. In our work we cannot for a moment disregard them, yet we are never sure that we are seeing them clearly. (Freud 1933a, p. 95)

We attribute several different meanings to these sentences. Drives cannot be seen clearly because they are hidden in the biological unconscious. According to Freud, only their derivatives can be experienced psychically, namely inasmuch as they, as ideational or affect representatives, become conscious or can be deduced in a preconscious stage on the basis of symptoms. Drives share their greatness with mythical beings in the sense that they, just as the heroes in the personification of humans or gods in mythology, have effects. It is the latter that according to Freud's theory of drives must be identified scientifically. For

instance, unconscious oedipal desires can thus be indirectly demonstrated clinically, at least in the sense of a relevant connection (Grünbaum 1984; Kettner 1987). In this Freud followed Mach's postulate about the theory of science; Mach did not deal with drive the question of what the essence of causative force, e. g., a drive, was, demanding instead that the causal connections be demonstrated by means of a systematic cause-and-effect analysis (Cheshire and Thomä 1991).

This theory of drives, just like many other theories, is imbued with the mythology of the natural philosophy going back to the early Greek philosophers, as Freud explicitly emphasized. This natural philosophy contains, in its dualistic views of love and hate, profound human knowledge giving meaning even to otherwise empirically false conceptions. There can hardly be any dispute about the fact that the goal Freud, an advocate of the enlightenment, pursued was not to promote a remythologization in the guise of false causal theories. Patients have a right, after all, to be treated on the basis of verifiable theories. There are two aspects to the view that the mythological mode of thinking must be replaced by theoretical explanation. First, the mythological element in subjective theories about illnesses must be clarified scientifically by means of causal explanations. Second, the liberation of scientific theory from mythological components is an accepted sign of progress. Once the distinction between theory and mythology is accepted, then there can be no objections to a recourse to a mythological mode of expression for the sake of a more vivid description. Freud made liberal use of it. If, however, the distinction between mythology and theory is ignored and the ontological language and naive realism of metapsychology are taken literally, then Freud's ideas are reversed into the opposite. Freud referred to metapsychology, which is supposed to provide the overall frame for explanation in order to incorporate magic, legends, fairy tails, mythology, and religion in a scientific *theory* , as a witch, and it is more than disturbing that this metapsychology has remained true to its traditional, witchlike nature.

The issue in Freud's model of causal explanation is of course not the mythical nature of drives, whatever they may be, but the demonstration of cause-and-effect connections (Kerz 1987). It is another matter that Freud's instinctual theory contains elements of a natural philosophy that has (re)turned into mythology.

Interpreting somatic illnesses satisfies man's longing for meaning, which grows in the face of incurable and fatal illnesses. The problem of death has, accordingly, become a starting point for private

and social ideologies. Similarly, in animism, as Freud described in *Totem and Taboo* (1912/13), man attributes a soul to inanimate nature, creating for himself at the same time the belief in life after death.

This results not only in a universal tendency for man to take himself to be the measure of all things. Narcissism can become so intimately linked with a scientific method or a therapy that the latter seems to become universally applicable. Thus to trace the development of serious or fatal illnesses—such as mental illnesses or cancer—back to the beginning of life means to adopt the intellectual method of animism. In Freud's words, "It does not merely give an explanation of a particular phenomenon, but allows us to grasp the whole universe as a single unity from a single point of view" (1912/13, p. 77).

The division of medicine into separate fields and the inevitable, ever increasing specialization has created the opportunity for progress to be made in diagnosis and therapy in every field. Yet to the degree the specialization increases and as a consequence of the numerous threats to and complications of life, our longing for a unity and a whole also increases. Paradise is sought by fantasizing back: the loss of the whole after the Fall of Man brought time and death as well as knowledge.

9.10 The Body and the Psychoanalytic Method

The body is directly accessible to the psychoanalytic method via *bodily experience* without in this way becoming an object of medical examination. This means that it is important for psychoanalysts who have been trained as physicians, especially those active in psychosomatic medicine, to maintain their capacity to diagnose and treat somatic illnesses. Every specialist confronts the problem of how to maintain his general or specialized medical knowledge when he stops using it continuously.

In their capacity as specialists, psychoanalysts are confronted by the same general problems as all specialists are. General practitioners have, as their title indicates, a wide range of knowledge, yet insufficient in any one field for them to act as specialists, while specialists, in contrast, lack the overview of general medicine that the general practitioner must have. A consequence of specialization and subspecialization is that experts constantly learn more and more about less and less. Yet this scornful remark is accurate only if the fact is disregarded that, regardless of how detailed intensive scientific study may be, connections continue to exist to major, fundamental problems that go far beyond the scope

of a single discipline and require interdisciplinary collaboration. As we explained in Sect. 1.1, psychoanalysis is particularly reliant on an exchange of information with the other sciences studying human beings. Of course, this does not alter the fact that its method, insofar as it finds application as therapeutic technique, deals with the patient's psychic experiencing, not with his body. The comparison of methods need not be limited to the phenomena each leaves out of consideration; such comparisons must not lose sight of the fact that the individual is a unit. This results in diverse tensions, the consequence of which, in addition to of the methodological restrictions, is that the analyst only reacts adequately to the patient's holistic needs in his office in special moments. Tensions originate in the deficits between the desired, holistic, mind-body attention and reality. This thesis is based on the anthropological assumption that the human being is a unit that becomes immediate in holistic expectations, which he anticipates in conscious and unconscious fantasies and for which he constantly counts the deficit. This deficitary nature of man has long led philosophical anthropology to conceptualize man as a two-faced being who at one and the same time is characterized by an excess of fantasy. Dissatisfaction is consequently inherent, and is particularly great everywhere methodology brackets out phenomena or, because of man's obvious imperfectness, techniques are deficient.

Very intense and original holistic expectations are evoked in patients in psychoanalysts' offices; they point both to the past-as the lost paradise that existed prior to separation, trauma, or conscious awareness—and to the future—as a utopia. In our experience we can claim that "limitation proves the master," i.e., that the psychoanalyst earns respect if he is competent in employing the restricted scope of his method, despite the related problems this raises. At no time did this scope end at the frontier to the body, inasmuch as this is represented in conscious and unconscious experiencing as the *body image* . We refer the reader to Sect. 9.2.1 on "Conversion and Body Image" and emphasize that the origin of body image is one of the domains of psychoanalysis and that body image plays a decisive role in therapy. Psychoanalysts recognize numerous facets of body image by taking a patient's body feeling seriously. Yet this body image, including the unconscious and conscious ideational representatives united or in conflict in it, is obviously different from the *body* of modern medicine.

Psychosomatic phenomena affect the individual's subjective feeling, which in the form of body feeling is closely linked to body image. By proceeding from this domain of psychoanalysis, it is possible to recognize and possibly decrease the psychic effects on bodily phenomena. Difficult issues requiring the

attention of different specialists raise problems as to integration and responsibility. We argue that the analyst should show a strong interest in his patients receiving the same care for intermittent or chronic somatic illnesses as he would want for himself or his family, because this adage leads to the best possible medicine. The role a medically trained psychoanalyst can play in an individual case depends both on methodological criteria and the analyst's evaluation of his competence. Taking somatic illnesses seriously, instead of psychologizing them in the irresponsible manner of panpsycholigism, and working through the patient's subjective theory of his illness provide the psychoanalytic method great room for action. The care the analyst provides for somatic illnesses can go much further if he proceeds from the patient's subjective condition and body image than would be permitted by a wrongly understood principle of abstinence and neutrality.

It is in treating severe anxiety illnesses, borderline cases, and psychoses that analysts are most frequently confronted with the question of whether to prescribe psychopharmaceuticals. Even analysts experienced in pharmacotherapy hesitate to prescribe beta blockers or benzodiazepines for patients with anxiety neurosis. Their fear that the prescription might make it impossible to analyze the transference disregards the fact that a rejection might have even worse and lasting adverse side effects. Splitting medical functions among different persons can cause additional problems for some patients, particularly those already suffering from splitting processes. In a publication that has received little attention, Ostow made the following correct observations:

> But while such uniformity is desirable, it is essential only that all transactions with the patient be deliberate and controlled so that fantasy may be contrasted with reality. For example, no analyst will hesitate to offer a seriously depressed patient more assurance, more time, or more affection than he ordinarily does. Third, the administration of medication to a patient has unconscious meanings which can be analyzed as readily as the unconscious meanings of all the other contrived and fortuitous features of the therapeutic contact, such as disposition of the office furniture, the analyst's name, arrangements for payment of fees, an illness, an so on. (Ostow 1962, pp. 3-4)

This flexibility enables an analyst to treat very severely ill patients, even though Ostow's economic speculations about the mechanism of action of psychopharmaceuticals are untenable. Psychopharmaceutic medication must of course be viewed in the framework of analytic treatment, with special attention being paid to the problem of addiction. Many representatives of the biochemical school of psychiatry prescribe psychopharmaceuticals without paying attention to the genuine psychic source of anxiety (see Sect. 9.1). The lack of controlled studies makes it impossible to make a general

recommendation as to who should prescribe medication in a joint treatment (see Klerman et al. 1984).

The tension between the holistic expectations of the patient, on the one hand, and the incompleteness, as manifested by specialized methods, on the other, can be put to productive use. The exclusion of the body, in contrast, seems to be taking its revenge on psychoanalysis, just as are excluded family members who seek an advocate among the family therapists. Yet for which body are body therapists the advocate?

The renaissance of the body in body therapy refers to *body image* , as can been seen in the informative book by Brähler (1988). Body image is also the object in Moser's (1987) enthusiasm for body therapies; a factor that has definitely promoted the spread of such therapies is the *exclusion* of the body in a particular form of psychoanalytic abstinence, which unfortunately is more than a caricature invented by Moser. We share his criticism, yet without drawing the consequences he does, for several reasons.

According to the experience of Benedetti (1980), Schneider (1977), Wolff (1977), and Ahrens (1988), and our own studies, patients with somatic symptoms develop an affective resonance and active fantasy after a period of treatment that are qualitatively and quantitatively comparable with those developing in the treatment of neurosis. The problems of therapeutic technique described by McDougall (1985, 1987) and Moser can therefore not be traced back to alexithymia. Of course, it would be logical to make at least an attempt at body therapy if there were a deficit in the preverbal phase of development that could be compensated. As Moser (1987) and Müller-Braunschweig (1988) have indicated, analysts should at any rate not let themselves be put off by the abstinence taboo, the rigid application of which was partly a sign of the times.

Theoretical considerations limit our willingness to expand our flexibility beyond certain limits. The success, or lack of it, of an analysis depends on so many conditions that it is impossible to blame the failure of the standard technique in patients with a "psychosomatic structure" on a hypothetical infantile disturbance. There is not even a consensus at the phenomenological level of diagnosis that goes beyond the agreement of an individual with himself, not to mention the differences of opinion regarding the reconstruction of the causal conditions. Moreover, our personal stance prohibits us from choosing a therapeutic step if we are convinced that the theory justifying it is misleading. Yet some helpful

therapeutic steps stem from false theories. For example, it is conceivable that the action of a body therapist might work wonders if a patient has undergone severe frustration for years. This has little or nothing to do with traumas experienced in the first year of life or their compensation in such a fictive new beginning. What this proves is that it is damaging to frustrate a patient instead of providing him with the opportunity to cope with what he has been through. Regardless of whatever constitutes the curative effect, both the formation of deficits or defects in the self-feeling anchored in the body and their experiencing are a very complex matter. Finally, it is disturbing that the body therapist acts at an as-if level while allegedly at the appropriate moment doing paternal or maternal things to which he attributes a particularly realistic meaning. How does one go from the as-if level to deeper reality? Important are not solely the empirical contacts, among other things, but their significance as a sensory perception. To be specific, the issue is the body image, not the body (i.e., the object of scientific medicine), in the sense that only a wonder can help the latter by postponing death for a finite period of time if pathophysiological or malignant processes are present.

Where are the limits on the translation of body language into spoken language? "Symptom as Talk: Talk as Symptom" is a noteworthy heading in Forrester's (1980) book on language and psychoanalysis. Of course, *symptoms* and *talk* can have a dynamic all their own, independent of each other. Forrester thus correctly added, "Symptom as Symptom: Talk as Talk." He referred to the far-reaching ambiguity that has been an element of psychoanalytic theory from the beginning. We cannot consider both languages, that of symptoms and that of therapy, to be identical even though Freud discovered that a symptom can be an equivalent and take the place of a thought. The equivalence must be determined methodologically with reference to their interchangeability, which is excellently suited for determining in practice the therapeutic range of the psychoanalytic method—whose limits are where somatic symptoms defy *translation* . Although the symptoms of malignant disease can be described in words, they are *explained* with the aid of scientific concepts in the context of causal theories. For them, just as for many other somatic symptoms, translation cannot be employed to make them part of conscious experiencing in the sense that the symptoms might then be explained psychodynamically. Such somatic *symptoms* are not *symbols* for something else although the individual may attribute some *meaning* to his life, suffering, or death.

The following points of view should be observed in the diagnosis and psychoanalytic therapy of

patients suffering from somatic symptoms. Patient and analyst often discover that somatic symptoms are involved in connection with, for example, situations of stress. The healthy individual then has a holistic experience. The manifestations of pleasure, sadness, and pain, to mention just a few examples, that are observable or accessible to introspection demand a circular description not specifying the starting point. The manifestation of physical pain at the same time a separation from someone dearly beloved is experienced does not in itself justify a statement about cause and effect. Correlations do not specify which side of a relationship is the dependent or independent variable or whether both are dependent. Of course, the demonstration of *correlations* is a precondition for clarifying the *causal relationship* of somatogenic and psychogenic conditions. We thus join Fahrenberg (1979, 1981) in pleading for a double consideration that is methodologically adequate to the emergence of the psychic manifestation (see Rager 1988; Hastedt 1988).

> Higher life processes, i.e., the psychophysical processes linked to man's brain activity, can be described and analyzed in two different and nonconvertible (incommensurable and irreducible) reference systems. The one is not a secondary phenomenon, equivalent, function, or epiphenomenon of the other, but indispensable for the adequate description and complete understanding of the other. This complementary model of categorical structures shifts the ontological question to the sphere of the method of categorical analysis and excludes ideas about psychophysical isomorphism, simple reflective or dictionary functions, energetic interaction (psychic causality, psychogenesis, the assumption of mental influence on synapses or modules), and physicalistic-materialistic reductions. (Fahrenberg 1979, p. 161)

The *causal analysis* of the correlations between experiencing, behavior, and physiological functions make it possible to intervene systematically in causal relationships by distinguishing the different variables. It is in this context that the *psychogenesis* must be empirically shown, as in a *causal* connection, without reverting to energetic interactions such as are associated with conversion theory.

In diagnostic procedures the correlation between somatic symptoms and experiencing is usually dealt with in a one-sided manner. Since all somatic symptoms can have somatic causes, the diagnostic procedures to exclude potential causes are taking up increasing space in medicine. And since there are many potential causes, for instance, of pain in the groin that radiates toward the genitals or of pain in the upper abdomen, and they are investigated in different specialities, many specialists are involved. Frequently only minor deviations from normal are detected, which the patient, doctor, or both, dwell on and overemphasize. Since these attempts to find an explanation can be accompanied by advice as to therapy, it is not unusual for a vicious circle of hope and new disappointments to develop. Before this

happens, as a consequence of a one-sided somatopsychic reading of the correlations, it is time to return to a holistic perspective, at least to approximate one. That we speak of an approximate return to holism might disturb the reader, yet the multitude of languages associated with methodological pluralism cannot transformed into *one* generally valid semiotic without a great loss of information on all sides. This is no more possible than a reduction of the psychoanalytic method to physiology or vice versa. It is therefore decisive that we at least approximately satisfy the insatiable longing for holism by making an *integrating evaluation* of the observations and results.

The involvement of somatic symptoms secondary to experiencing must be grounded *positively* , not just verified by excluding the other potential causes. The body language Freud discovered in hysterical patients was a hidden, unconscious form of expression that appeared to be independent of consciousness and take its course both blindly and arbitrarily. The grammar of feelings and affect, in particular, which can only be artificially separated from cognitive processes, follows rules whose discovery was a consequence of the psychoanalytic method. Freud's theory of a dynamic understanding of psychic life, which went beyond descriptive phenomenology, is characterized by its capacity to put symbolically expressed intentions into context and give them meaning. Even more important is the link of this theory to the *methodologically* grounded assertion that the experiencing and recognition of unconscious desires and intentions makes the symptoms disappear. As early as in his *Studies on Hysteria* , Freud wrote:

> To begin with, the work becomes more obscure and difficult, as a rule, the deeper we penetrate into the stratified psychical structure which I have described above. But once we have worked our way as far as the nucleus, light dawns and we need not fear that the patient's general condition will be subject to any severe periods of gloom. But the reward of our labours, the cessation of the symptoms, can only be expected when we have accomplished the complete analysis of every individual symptom; and indeed, if the individual symptoms are interconnected at numerous nodal points, we shall not even be encouraged during the work by partial successes. Thanks to the abundant causal connections, every pathogenic idea which has not yet been got rid of operates as a motive for the whole of the products of the neurosis, and it is only with the last word of the analysis that the whole clinical picture vanishes, just as happens with memories that are reproduced individually. (Freud 1895d, pp. 298-299)

The opposite is also true; just because of these interconnections—in which the pathogenic ideas are not isolated from another but instead mutually reinforce and support each other—the therapeutic work on one node or focus can radiate over the entire complex of the causal constellation. The therapeutic effect of the psychoanalytic dialogue thus spreads through the network of connections between the unconscious

motives without it being necessary for each specific wish to be named individually or for each node to be resolved. We thus have a pragmatic guide at our disposal: the scope of the psychoanalytic method with regard to bodily phenomena does not end with its language because the therapeutic dialogue also realizes a nonverbal component.

The somatopsychic consequences of fatal illnesses have become an aspect of a psychoanalyst's experience since psychoanalysts have been confronted with therapeutic tasks while working as consultants in intensive care units and in psychooncology (Gaus and Köhle 1986; Köhle et al. 1986; Meerwein 1987; Sellschopp 1988). Of relevance here is also the body experience under the special circumstances of knowing or having a premonition about the nearing of death. With regard to the questions as to meaning that a patient poses the analyst at the end of his life, we recommend making a distinction. It is an obvious fact that psychoanalytic theory and its latent anthropology call for death to be acknowledged and are unable to provide consolation in the form of hope for fulfillment in the hereafter. The changes accompanying fatal illnesses contribute to the dissolution of spatiotemporal borders, which probably can only be expressed via allegories, a form of language that both within and outside psychoanalysis employs metaphors of a return.

Such allegories provide the patient indirect consolation, for example by providing the subjective experience of security that makes the awareness of physical decline more tolerable (Eissler 1969; Haegglund 1978). The analyst, as every doctor, must respond as an individual who himself must confront the ultimate questions about the meaning of life and death. It seems very dubious to us whether analysts can provide better answers to these questions within the theoretical framework of the life and death instincts or that of object relations. We presume that analysts, as others, base their contact with patients in the throes of death on their personal attitudes about life and the world and use psychoanalytic theory, including its metapsychology, metaphorically and as a structure providing support.

9.11 Results

The starting point of the discussion about the outcome of psychoanalytic treatment was Freud's case histories. Fenichel (1930) reported the first systematic study of therapeutic results, performed by the

Berlin Psychoanalytic Institute. This institute was conceived according to the idea, which Freud (1919j) also advocated, that health care, research, and teaching constituted a unit. Later the activities of most institutes became restricted almost exclusively to training. The studies Dührssen (1962) performed at the Berlin Central Institute for Psychogenic Illnesses had a far-reaching impact in Germany, specifically on the inclusion of psychodynamic and analytic treatment among the forms of therapy covered by health insurance (see Vol.1, Sect. 6.6); in practice, however, the systematic case history never gained widespread acceptance. In the meantime, research into the results of psychotherapy (see Kächele 1981; Lambert et al. 1986) has produced methodologically viable empirical studies about cases of intensive psychoanalysis (Bachrach et al. 1985; Bräutigam et al. 1980; Weber et al. 1966; Kernberg et al. 1972; Wallerstein 1986; Zerssen et al. 1986).

Many analysts defer research to institutions. Psychoanalysis had its origin, however, in practice, and Freud claimed there was an inseparable bond between research and treatment (see Vol.1, Chap. 10). In fact, therapist and researcher pursue different interests. The therapist requires security because his faith in his comments is an important element of any psychotherapeutic intervention (Kächele 1988a). It is his task to maximize positive evidence in order to maintain his capacity to act in the clinical situation. The scientist, however, is guided by a different interest. His task is to maximize negative evidence, i.e., to constantly question the results and their explanation, as Bowlby has emphasized:

> In his day to day work it is necessary for a scientist to exercise a high degree of criticism and self-criticism: and in the world he inhabits neither the data nor the theories of a leader, however admired personally he may be, are exempt from challenge and criticism. There is no place for authority.
>
> The same is not true in the practice of a profession. If he is to be effective a practitioner must be prepared to act as though certain principles and certain theories were valid; and in deciding which to adopt he is likely to be guided by those with experience from whom he learns. Since, moreover, there is a tendency in all of us to be impressed whenever the application of a theory appears to have been successful, practitioners are at special risk of placing greater confidence in a theory than the evidence available may justify. (Bowlby 1979, p. 4)

Many analysts appear to want to retain their security after the conclusion of a treatment since, as Schlessinger and Robbins (1983, p. 7) emphasized, there is an obvious deficit of follow-up studies among the wealth of psychoanalytic literature. They believe that a significant role is played by the defensive attitude of most analysts, such as knowing in advance what the result of a psychoanalysis should be, which obscures their perception for processes that do not agree with their traditional view.

We believe it is therefore important for a critical textbook of psychoanalytic practice to include comments about the nature of follow-up that is appropriate to clinical work. A critical examination of the consequences of an analyst's therapeutic technique is in the interest of his own expertise, the purpose of which is to promote the patient's well-being. This takes place during treatment, at the conclusion of treatment, and at one or more later points in time. Every analyst summarizes the severity of the symptoms at the beginning of therapy and makes conditional prognoses based on the patient's underlying psychodynamics (Sargent et al. 1968). These prognoses contain hypotheses about causal connections, and the conditional prognoses are corrected and extended in the course of therapy. Such an evaluation oriented on the oscillations during treatment enables the analyst to adjust his goals and strategies to the particular patient. At some point the analyst attempts to draw a realistic balance about the investment and return. This sober, economic perspective reminds one of the limitations on the modifications that psychoanalysis attempts to achieve.

Each participant, of course, attempts to take stock of the effects of treatment. The possible modalities are each for himself, both together, and by third parties (e. g., relatives). Since the issue of change is central during therapy, whether directly or indirectly, it is logical to jointly take stock during the final phase of analysis. In a favorable case, the analyst will hear that the patient is satisfied with the outcome, that the symptoms that led him to seek treatment have disappeared (if they have not been momentarily revived as part of the problem of separation), or that he feels like a new person because it was possible to achieve a substantial change of his character. Although patients seldom mention the capacity for self-analysis, which we discussed in Vol.1 (Sect. 8.9.4), they do describe the particular manner in which they internalized the analyst's functions, which are then partially continued in self-analysis. Genuine analytic use of this capacity is probably made by those patients who draw advantages for their profession from the treatment.

As a rule psychoanalytic treatment constitutes a large investment in time and money. The number of patients a practicing analyst can treat in some 20-30 years of work is limited in comparison to other fields of medicine. For this reason our knowledge of the later consequences of analytic interventions constitutes an important corrective for the psychoanalytic community, as described by Schlessinger and Robbins (1983).

Many analysts are reluctant to undertake follow-up studies of their patients because they fear a revival of the transference they believe has been dissolved. This concern is unjustified, for several reasons. It is known, since Pfeiffer's (1959, 1961, 1963) studies, which have been continued by Schlessinger and Robbins (1983; see also Nedelmann 1980), that the transference continues to exist in the patient's positive memories of the helping alliance, which are revived by follow-up interviews. If the course is favorable, those aspects of transference are resolved that can be segregated off as neurotic. Furthermore, the analyst continues to be a significant person for the patient, occupying a favored place in his experiencing. It is therefore easy for expatients to quickly find their way back to old modes of relationship and to reflect on this reactivation in follow-up interviews, whether with a third party or with the analyst. Although the idea of a complete dissolution of the transference has thus been refuted, it has not died out, but has led to a regular increase in the length of analyses, particularly of training analyses, since the late 1940s. Balint (1948) called them superanalyses. In our opinion they are linked with the thought that an intensive and lengthy analysis will resolve the transference especially thoroughly. In fact, however, the opposite effect, a vicious circle, seems to have resulted because the superanalyses have increased dependence precisely in analysts in training, reinforcing the neurotic elements of transference. In these analyses the idealization of the training analyst and the avoidance of realistic evaluations is particularly pronounced on both sides, causing each to go through a process of disillusionment after termination that continues for years and constitutes a not insubstantial burden on the professional community. The fact that this problem was recently the object of a detailed discussion must therefore be seen as a great advance (Cooper 1985; Thomä 1991).

We have to expect that follow-up studies will cause us to make substantial corrections to the conception that we acquired during the treatment itself. These corrections are of great value for the psychoanalytic theory of treatment because they can be either positive or negative (Kordy and Senf 1985).

9.11.1 Patients' Retrospection

Since we take the views of our patients about the consequences of our therapeutic actions particularly seriously, we have given a number of our patients the reports written about them and asked for their opinions. We have also received retrospective evaluations.

The following response is from Friedrich Y, about whom we reported in Sect. 2.3.1. He described his symptoms and impressions about the events in therapy. We have altered only those items necessary to ensure anonymity.

Looking Back at My Psychoanalysis

Symptoms

I was repeatedly confronted by my anxieties, by the energy it took to drive with the brakes on. Suffering: I could not openly express my anger and rage at colleagues or close associates, but only created a burden for my wife and myself. I avoided disagreeable meetings and parties, dances, and recreational events. I postponed difficult calls and visits. At work I often lost control of myself, went wild, became abusive, and once beat my wife. I often fled into the forest or into demanding too much of myself. I was unable to relax, calm down, or play with the children. I justified myself through what I achieved, putting my family second. I often had problems with my digestion and headaches, sore throat, and backache. My suffering grew. A friend of mine encouraged me to visit a therapist, someone he had also already consulted.

First Interview

I went: with the fear of being sent away, with complete frankness, almost self-exposure, aware that it was now or never, and with the strong desire: I want to ease the brakes inside me. I want more life. I want, finally, my life.

He took me. I get along with him. I want to get somewhere with him. He listened, very patiently. I said a lot, threw ballast overboard. He had something alive, experienced, generous, seductive. He wasn't pushy.

First Phase

With him I could let out my hate for my mother. She denied me so much life, beat me, oppressed me, forced me into being good. She ruined my father and misused me as his substitute. She used my bad conscience and religion to suppress my aggression and make me a weakling and cripple. At the same time I recognized that she perhaps did not have a choice, as the oldest daughter, having lost her father very early, having had a strong and energetic mother, and having been responsible for her sisters. She first suppressed her own life, especially after the death of my father. She had to struggle, be strong. And, she turned old, went from being the strong one to the weak one, from being the dominant one to the victim. Shameful time in her last two years; she was afraid of those near her, wanted to kill herself, and was a difficult patient for the family taking care of her.

In the last few years I was able to do something good for her, give something back to her. I could see what she had sacrificed for me. I saw, regretted, and was amazed by her struggle; I could help her in her weakness, helplessness, and occasionally unjustified anger. She died forty years after the end of Hitler's rule. (How had she lived then? We were never able to speak about it in peace. She

always blocked it off, justified herself, gave excuses!)

Second Phase

What kind of a father did I lose, and what did I lose with him? He increasingly appeared in therapy behind my mother. I was never actually a son, boy, more a girl like my sisters. I did not have a male role model in my struggles, conflicts, self-assertion. Now I can work on my aggression.

I could stand up better at work, restrain myself, let myself be angry. I stopped hiding in groups, took responsibility, stood up to conflict. I stopped taking things or people as easy as I used to, and being so afraid of being hurt or hurting others. I've stopped hiding and am no longer ashamed about my being attracted to other women; I can handle it. I could more clearly feel where my wife suffered from me, felt overwhelmed or neglected by me. I became better able to accept conflict with her, coming closer to her in the process. I became better able to bear it if she were despaired. I could go to the limits and consciously restrain myself, of my own will, not because of a bad conscience or pressure. For example, my wife is more important to me than others are. Family is often more important than profession. Accepting something is sometimes more important than conflict "at any price." My sexual freedom together with my wife, in letting myself have something, is growing, also to the degree that my wife could do something for me. I became able to accept that my wife did something for herself, that she still needed time to get freer, to free herself from the burden that I had placed on her for such a long time. Even that she got mad after talking with me and the analyst. I was better able to accept my wife being weak and to accept that I have weaknesses too.

Third Phase: Termination of the Analysis

What I still wanted to work on: On the connection between the psychic and the body. Where do headaches come from, backache? How do I overcome illnesses? How could I work preventively on the causes? One weekend something changed. For weeks I had had a sore throat after analysis, problems with my voice, difficulties singing, at work, speaking. I publicly stood up to my analysis, told others about it, and encouraged others to work on their problems. I stopped sweeping conflicts with close colleagues under the carpet, started defending myself, even being provocative. It was exhausting, to take the resistance and animosity. I got stronger, uncompromising in helping others, the oppressed, for example in letters against apartheid and racists. I didn't simply become enraged but actively fought, despite the risks, against "evil spirits" such as addiction, racism, fascism. I increasingly asked others, "Do you want to be healthy? If not, then I will tell you what your illness is, keep my distance, and not let myself get involved, especially in your neurosis." I would have rather cut out the rotten apple, cut through false appearances, cut open the festering ulcer—as the accomplice of the illness, the repression, the resignation.

How I Experienced My Therapist

He was usually patient. He could take silence. He could also be tough, not let loose. He often asked critical questions about "little" things, which helped me, things like gestures, greetings, forgetting a session, and saying goodbye. He made cautious reference to my dreams and often opened my eyes about their meaning. He initiated the separation, the end of therapy quite early (not too early

fortunately, as I was once tempted). And even after therapy was over, he kept his door open for me. He encouraged me not to show him too much consideration (sometimes I wanted to "spare" him something, but he can take care of himself.)

When I managed to overcome my frugal habits, with his help, and to act more self-confidently, the price of the therapy wasn't a problem any more. I consciously decided to afford therapy (which was no big deal since most of it was refunded by the health insurance!), and am glad to have become so healthy, both psychically and physically.

This retrospective description was written a year after the end of the analysis. Subsequent events confirm that the patient had learned in his therapy how to make a decisive change in his life.

Therapeutic institutions desiring to follow-up a larger number of patients without resorting to an excessively complex methodology can employ a questionnaire devised by Strupp et al. (1964). Such a procedure makes it possible for the patient to make a retrospective evaluation of the success of therapy from various points of view.

In an examination of our own (Kächele et al. 1985b) we chose this approach to question a group of 91 patients who had undergone different types of treatment. On a scale from 1 to 6 (best to worst), the average grade for "the feeling of complete satisfaction with the therapeutic success" was 2.2. The obviously contrasting question of "Do you have the feeling that another treatment is necessary?" was given 3.1 and there were a wide range of answers, indicating a clear ambivalence. Although 36% of the patients were very satisfied and 27% satisfied—corresponding to the two-thirds rate found in many follow-up studies—a not insignificant number of patients were the view that they needed another treatment. In our opinion these apparently contradictory evaluations express a very differentiated view, namely that not all their goals have been achieved, but that everything was not possible. This idea clearly had an impact on the answers about the relationship between the cost and effect of the treatment, which were very favorable at 1.7. The capacity to admit the personal significance of one's own therapy in public is emphasized by the fact that 72% of the patients said that they would recommend that a close friend seek psychotherapeutic treatment if in need.

Of great practical significance is the outcome that the patient's evaluation of the therapist for the dimensions "empathy and acceptance" and "trust and esteem" make it possible to make a retrodictive prediction of the patient's satisfaction with the treatment. Even without elaborate research into the results of psychoanalysis, such a study confirms that the positive structuring of the therapeutic

relationship is a necessary condition, although not a sufficient one, for the satisfaction with the outcome that both patient and analyst desire. The previously widespread and cynical argument that this esteem was only the consequence of the patient's financial sacrifice, which motivated him to believe idealizing self-deceptions, has fortunately been disproved by the introduction of health insurance coverage for psychodynamic treatment. We therefore proceed from the assumption that patients provide realistic information.

Aside from patients' attitudes, in whichever form they are obtained, is the question that every therapist must ask himself: Am I satisfied? This is a crucial question because it confronts the professional ego-ideal. The patient's subjective experiencing alone cannot suffice to satisfy the analyst; he also has to examine whether there is a tangible connection between the course and outcome of therapy, on the one hand, and, on the other, the nature of the genesis and resolution of symptoms and character traits according to the theory he adheres to. In his final reflections he will have to ask what his goals were at the beginning of therapy and which of them he managed to achieve. This perspective does not exclude the fact that the patient continues to be responsible for himself. The analyst, however, has to justify his methods and the outcome to himself and the professional group he identifies with.

The basis of the analyst's evaluation should be a comparison of his notes from the beginning of the treatment with those made at the end. Substantial modifications of the implicit and explicit goals of therapy are found particularly in therapies of long duration. We assume with good reason that it is inconceivable for an analysis to be conducted without some goal, and that psychoanalytic practice facilitates the view that the goal is a product of the process. It is a serious mistake to believe that analysts can maintain a distance to concrete goals linked with specific values (see Vol.1, Sect. 7.1). Bräutigam (1984) has presented a critical discussion of the modifications that goals have undergone in the course of the history of psychoanalysis, correctly referring to the fact that therapy-immanent goals—e. g., expansion of consciousness, affective discharge, regression—have increasingly gained in importance. In an effort to acquire the appearance of value neutrality, the expression "Where id was, there ego shall be" has been used to describe analytic work because it apparently provides an etiological, pathogenetic grounding for the therapeutic process. In the framework of the structural model this means that the ego gains better control of the id, which originally in the topographic theory was expressed as freer access to the unconscious. The psychoanalytic goal of structural change was linked to this movement from id to

ego.

Since Wallerstein's (1986) profound reflections on the implications of the results of the Menninger Psychotherapy Project, the question of how "structural" change can be distinguished from behavioral change is fraught with problems, especially with methodological ones. The view cannot be maintained that it is exclusively the psychoanalytic technique that affords insight and achieves structural change. According to the definition that Rapaport (1967 [1957], p. 701) also supported, these structures are psychic processes that undergo change at a slow rate and that we hypostatize but that we can only detect in behavior and experiencing. We cite the following summary comments from Wallerstein's comprehensive clinical review, probably the most comprehensive process study in the history of psychoanalysis:

> The treatment results, with patients selected either as suitable for trials at psychoanalysis or as appropriate for varying mixes of expressive-supportive psychotherapeutic approaches, tended with this population sample to converge rather than to diverge in outcome. Across the whole spectrum of treatment courses . . . the treatment carried more supportive elements than originally intended, and these supportive elements accounted for more of the changes achieved than had been originally anticipated. The nature of supportive therapy—or, better, the supportive aspects of all psychotherapy, as conceptualized within a psychoanalytic theoretical framework—deserves far more respectful specification in all its forms and variants than has usually been accorded in the psychodynamic literature . . . . The kinds of changes reached by this cohort of patients—those reached primarily on the basis of the opposed covering-up varieties of supportive techniques—often seemed quite indistinguishable from each other in terms of being so-called "real" or "structural" changes in personality functioning, as least by the usually deployed indicators. (Wallerstein 1986, p. 730)

We prefer Freud's formulation in *Analysis Terminable and Interminable* (1937c, p. 250) in which he clearly described the operational goal of every treatment: "The business of the analysis is to secure the best possible psychological conditions for the functions of the ego; with that it has discharged its task." This makes sufficiently clear that the analyst should not lose sight of the distinction between goals in life and treatment goals, which Ticho (1972) has referred to.

Until now analysts have presumably done little to fulfill their tasks of discussing the goals of the treatment with patients at the very beginning. Many seem to fear the danger that the patient will then raise excessively goal-related demands that the analyst keep his promise.

9.11.2 Changes

Well, what are the goals of treatment and how do they differ from those in life? We would like to clarify this issue by discussing in detail the changes that one patient, Amalie X, achieved in psychoanalysis. We have evaluated these changes in numerous ways, since this case was studied particularly intensively in various projects within the framework of the study "Psychoanalytic Processes" supported by the German Research Council (Hohage and Kübler 1987; Neudert et al. 1987; Leuzinger 1988).

Since the patient accorded her hirsutism a prominent position in her subjective understanding of the causes of her neurosis, we begin by considering the status of this somatic disturbance, from which we derive the specific changes that constituted the goal. Hirsutism probably had a double significance to the patient. On the one hand it impeded her feminine identification, which was problematic anyway, by constantly revitalizing her unconscious desires to be a man. For her, femininity was not positively considered but rather associated with illness (her mother's) and discrimination (versus her brothers). Her increased hair growth occurred in puberty, a period when sexual identity is labile anyway. The appearance of masculinity provided by her body hair strengthened the developmental revival of oedipal penis envy. Of course, the latter must have already been at the focus of unresolved conflicts, because it would otherwise not have attained this significance. Signs of this can be seen in the patient's relationship to her two brothers, whom she admired and envied, although she often felt discriminated against. As long as the patient could fantasize that her penis desire was fulfilled, her hair growth corresponded to her body schema. Yet the fantasized wish fulfillment only offered relief as long as the patient managed to maintain it, which was impossible long term because virile hair growth does not make a man out of a woman. This raised the problem of sexual identity once again. It was on this basis that all cognitive processes connected with feminine self-representations became a source of conflict for the patient, causing distress and eliciting defense reactions.

On the other hand, her hirsutism secondarily acquired something of the quality of a presenting symptom, providing the patient with an excuse for generally avoiding sexually enticing situations. She was not consciously aware of this function of her physical disturbance.

Two demands can be derived from these thoughts that can serve as goals for a successful treatment.

The patient would not be able to accept social and sexual contact until she, first, had attained a sufficiently secure sexual identity and overcome her self-insecurity, and second, had given up her feelings of guilt about her desires. Both points of this prognosis were confirmed. Amalie X significantly increased her capacity to establish relationships, and has lived with her partner for a longer period of time without being restricted by any symptoms. Her conscientiousness, which initially was often extreme, has mellowed, although the demands she placed on herself and those around her have continued to be very high. In discussions she has become livelier, showing more humor and apparently getting more pleasure from life. Can these changes be traced back to the fact that both of the causal conditions have demonstrably lost their effects as a consequence of her psychoanalytic treatment? We answer this decisive question in the affirmative although space prevents us from discussing the reasons in detail. The proof of structural changes requires detailed descriptions of the psychoanalytic process. We can say, in conclusion, that despite her virile hair growth Amalie X has found a feminine identification and freed herself of her religious scruples and feelings of guilt toward her sexuality, in accordance with the prognosis.

The results of the psychological tests, performed as a check on success at the beginning and after the termination of treatment and also as part of a follow-up two years later, confirmed the clinical evaluation of her analyst that the treatment was successful. A comparison of the profiles in the Freiburg Personality Inventory (similar to the Minnesota Multiphasic Personality Inventory) showed that the values at the end of treatment were more frequently in the normal area and less frequently at the extremes than at the beginning of treatment. This tendency had become more pronounced on follow-up.

> Especially on the scales on which the patient had shown herself to be extremely (= standard value 1) irritated and hesitant (scale 6), very (= standard value 2) yielding and moderate (scale 7), very inhibited and tense (scale 8), and extremely emotionally fragile (scale N), the values returned to the normal area.
>
> On a few scales the patient diverged positively from normal after treatment. Amalie X described herself as psychosomatically less disturbed (scale 1), more satisfied and self-secure (scale 3), more sociable and active (scale 5), and more extroverted (scale E). The standard value of 8 on scale 2 at the end of treatment deserves special attention because it expressed that the patient experiences herself as being spontaneously very aggressive and emotionally immature. At this point in time she may still have been anxious about her aggressive impulses, which she did not have such strong control over as at the beginning of treatment. On follow-up this value had returned to normal. The patient seems to have gained the security in the meantime that she no longer need fear an aggressive outburst. Conspicuous is also the extreme value on scale 3 on follow-up; Amalie X, whose desire for treatment was the result especially of depressive moods, described herself here as extremely satisfied and self-secure.

The values on the Giessen Test for the patient's self-image were within normal on all three testings. Beckmann and Richter, who developed this procedure, have commented about it that: "At its conception great weight was placed on experiencing how a proband describes himself in psychoanalytically relevant categories" (1972, p. 12). For Amalie X:

> The more extreme values diverging from the normal range simply demonstrate the initial self-description to be relatively depressed (scale HM vs. DE) and the concluding one to be rather dominant (scale DO vs. GE). The profiles demonstrate especially a shift showing that the patient experienced herself after treatment to be more dominant, less compulsive, less depressive, and more permeable (opener, more capable of contact). On follow-up the profile of her self-image was completely inconspicuous.

Of note regarding the image that the analyst had of the patient at the beginning of treatment (Giessen Test of Imputed Image of Others) was that the analyst considered her to be more disturbed than she did. In his eyes she was significantly more compulsive, depressive, retentive, and socially restricted. In these dimensions the image attributed to others was outside the normal range. According to Zenz et al. (1975) such a clear discrepancy is frequently observed after the initial interview. This discrepancy disappeared at the end of treatment, when the analyst considered her to be just as healthy as she did. Somewhat larger differences persisted on only two scales, the analyst viewing her to be more appealing and desirable as well as more compulsive that she did.

The results of the psychological tests supported the analyst's evaluation, and those on follow-up confirmed the continued positive development in the postanalytic phase.

Process changes are also of great interest for a psychoanalytic theory of change; these are changes in how a patient can structure the psychoanalytic process (Luborsky and Schimek 1964). This question was studied for this patient within a project in which specific psychoanalytic criteria of change were registered with regard to the patient's reactions to dreams (Leuzinger 1988). To supplement the psychological tests, a theoretically informed content analysis was performed on verbatim protocols from the initial and concluding phases to determine how the patient's cognitive processes had changed during her confrontation with dreams. The wealth of individual results on the changes in cognitive processes confirmed the clinical and test evaluations.

The case study of how the patient suffered from herself and from her environment shows a course that is clinically instructive.

> The patient's relationships were relatively constant in the first half of treatment. In analysis she was primarily concerned with herself and her inner world, as clearly demonstrated by the nature of the symptoms she described in the sessions. Erythrophobia, dependence on her parents, and sexual inhibitions keep the patient from actively confronting her environment. This phase of treatment seemed to be concluded around the 250th session; her suffering declined significantly. In the second half of treatment her suffering increased again. The treatment was molded by the intensive disputes with partners of the opposite sex, which was also particularly visible in the transference relationship. (Neudert et al. 1987)

The examination using "emotional insight" as a criterion of change also confirmed the positive outcome of this treatment:

> If the first eight sessions of this analysis are compared with the last eight, then it can be seen that the patient's comments reflect her livelier experiencing. In contrast to the beginning, where she very frequently intellectually distanced herself from her current experiencing and fell into brooding, in the final sessions the patient submerged into her experiencing without losing the capacity for critical reflection. The conditions for a productive "emotional insight" were thus much better fulfilled at the end of treatment. (Hohage and Kübler 1987)

In the case of Amalie X we were able to demonstrate a large correspondence between change as described in clinical terms and as measured by psychological tests. Yet it is also important to realize that change is multidimensional and that its course is not always congruent in the different dimensions.

9.11.3 Separation

As we emphasized in the Introduction, the termination of analysis does not always take place according to a standard pattern. It is not unusual for therapy to lead to changes in lifestyle, which in turn lead to the termination. It would be a mistake to play external and internal reasons for termination off against one another and to equate the external factors with terminable analysis and inner ones with interminable analysis. On the other hand, a deep longing for the interminable seems to lead to the utopia of being able to achieve it. This mutual fantasy is expressed in the unrealistic conception of a normatively conceived phase of termination.

Kurt Y, a 32-year-old scientist, who was awkward, inconspicuous looking, friendly, and obsequious, sought treatment because of his impotence, which was a great strain on him. He had previously tried behavior therapy oriented on that of Masters and Johnson, which brought only short-term benefit. Even in the initial interview the patient himself traced his deficit in spontaneity, especially in sexual matters, back to his strict upbringing. For the first time he had established a firm friendship to a woman he wanted to marry and who, according to his description, went well with him.

In his work he was valued as a skilled experimenter and had an important position in the firm as a factotum; however, he had generally helped others to achieve successful careers while only attaining limited benefits for himself.

> In the Freiburg Personality Inventory divergences from mean values were apparent especially on the scales for aggression (standard value 7), agitation (standard value 3), calmness (standard value 1), striving for domination (standard value 7), inhibition (standard value 7), and frankness (standard value 3). At the end of treatment his profile differed from the initial findings only on the scales for aggression (standard value 8), striving for domination (standard value 6), and inhibition (standard value 5). Of these, only the last amounted to a clinically significant change of two standard values.
>
> On the Giessen Test, however, two scales indicated change in the patient. On the scale "uncontrolled-compulsive" he changed from a T value of 56 at the compulsive end to a T value of 39 at the uncontrolled end. A second impressive change was on the scale "retentive-permeable," where the patient moved from a T value of 58 to a T value of 42 in the direction of more permeable. Conspicuous was, however, that a distinctly negative self-esteem of T 30 only improved to a T value of 32.

The Rorschach test also showed only a minimal change at the end of therapy. The following statement is from the final report of the test supervisor:

> The patient responds quickly to emotional stimuli, showing different kinds of reactions to emotional situations. He can submit to partly primitive and elementary emotional stirring, while under other conditions he can put them to positive use by means of his intellectual controls and an increased awareness of reality. The compromises required by the latter prevent him from making full productive use of his high intelligence.
>
> If the affect controls mentioned above are inadequate, infantile spite and a disguised aggressive attitude appear that in a sense become independent. The numerous modes of emotional expression only become important when the situation has been clarified and does not appear dangerous. This clarification takes place primarily through a withdrawal to customary behavior and an intellectual, rational manner of coping. His coping with his often violent emotions is, despite everything, always linked with effort and frequently with anxiety and insecurity.
>
> He has great difficulty admitting to himself that he has needs for affection. He has a tendency to distance himself from other people, expecting only disappointments from them. The few opportunities for affective contact are alloyed with aggression, giving him the character of a fighter.

It is not difficult to discern from this summary evaluation of the Rorschach test that in comparison with the initial findings only the beginnings of structural change in the four years of psychoanalysis were detected on the tests. We would now like to list some of the clinically observed changes that we feel justify speaking of a substantial improvement in the overall picture of this patient's schizoid-compulsive personality. The fact that a man has his first intimate relationship at the age of 32 almost speaks for itself. It is not amazing that his sexual impotence was the consequence of a strict superego molded by archaic norms. His partial professional impotence must be seen parallel to this, consisting primarily in the fact

that he can only be fully productive for others. At the time treatment was initiated, he had worked for years on his dissertation, which he managed to complete after working through the unconscious aggressive and grandiose fantasies associated with it. The latter were related in his preconscious with his fear that his boss might be usurped; this was unconsciously linked with his triumph over the modest achievements of his father, who had only advanced to be a medium-level civil servant in the post office. His sexual impotence was primarily caused by maternal introjections, which dictated a close tie between filth and sex. For long periods in therapy an unattainable goal for him was to submit to his pleasure as a precondition for having satisfying intercourse. It was only in the last year of his treatment that the patient permitted himself the desire to spend more than just weekends with his wife, seeking the everyday security and relaxed atmosphere that facilitated sexual pleasure.

Although the capacity to love and to work are the two pillars of the discussion of psychoanalytic goals, we should not overlook the fact that in consequence of the above-mentioned changes this patient experienced a number of seemingly minor enrichments in his life, such as being able to go to the cinema or to read something besides scientific texts before going to sleep. He was enthusiastic reading Stefan Zweig's *Sternstunden der Menschheit* one month before the end of therapy and compared himself to Goethe in old age, whose love as expressed in the *Marienbad Elegies* made it perfectly clear to the patient that "an old knotty tree can rejuvenate itself."

Measured against the ideal of the complete analysis, this treatment was painfully incomplete. The termination occurred primarily on the basis of the probably realistic estimate that Kurt Y would not go on for a career in science and would have difficulties at the age of 36 to find a suitable position. After a very long and tormenting search, an offer to become the director of a laboratory in a small town was the decisive factor in the decision to terminate the treatment.

In one of his last sessions Kurt Y talked about a question that was of importance to him, namely whether he would leave any marks on his current home town, specifically whether he had made a lasting impression on his analyst—a question he had carefully avoided until then.

He had always complained about his boss' favorites, the ones who knew how to ingratiate themselves, while he had only been able to formulate his love speechlessly, while sitting at the computer at night for endless hours. He concerned himself with the thought of whether it was not better for him to sacrifice such desires, since "it wasn't right to raise any unanswerable questions any more when

you're waiting at the train station." Having grown up a single child, he had avoided the role of "siblings," i.e., fellow analysands, throughout the entire period of treatment and rejected any comments I made.

In the penultimate session he spoke about his experience with the Rorschach test. He only had a vague recollection of the tester, but he experienced the cards in an entirely different manner than at the beginning. He no longer felt anxious expectation, but the satisfying experience of having control of it and of playing with the cards. The "funny devil" gave him the idea that he could start painting, that he would especially like to paint autumn leaves in all their wealth of color. He added, "Previously, everything seemed gray in gray to me, but now I see colors."

Let us give the patient the final say, quoting several passages from his evaluation of the outcome of treatment in the last session:

P: Yes, I somehow think it was—also as far as my experiencing was concerned—I'm taking something with me. The sessions here, it was, well, I wanted to say it elegantly, but I can't find the right word. [Pause] Yes, I would simply say it was an experience, a real experience. Yes, I don't know any more what all has happened. Of course, I didn't always like it, but apparently that's part of its value. [Pause]

A: This experience, what might it have been? What was different here that you haven't been able to find in this way anywhere else? [Pause]

P: Well, I believe it was almost real—that here—when I came here to you, then I had the impression that I could get out of the corner I had fallen into. Yes, perhaps that's how to describe it, that I didn't really need to feel ashamed here, to feel ashamed about the corner I had got myself into. And that was apparently enough to get out of the corner. [Pause] And what does shame mean, I think that's part of it, too, that I managed to speak about it. Because you don't speak about shame, but withdraw and hide. I managed to interrupt the hiding here. Yes, speaking about it and thinking about it, experiencing myself—that was, I think, always one aspect of this, on the basis of which I was—on the basis of which I managed to crawl out of my corner. That was, how should I describe it, the tool, the machine that I used. [Pause] Well, it's linked with, I think, this day; it reminds me of the treatment. More specifically, I can't really remember the rooms, places, and persons. It's more your voice that stimulates me, yes, I'd say that it was the tool for escaping from the prison. Yes, it was really an entanglement of escaping. [Pause] An entanglement—I can recall it myself—that was impossible to undo. [Pause] Yes, I believe the most important fact was that I was given space here, in a figurative sense, space that I had apparently been seeking but that I hesitated to accept. And this space is perhaps a sign for it, for being able to talk about something.

A: And it seems to be a space that you had lost or that you perhaps hadn't known, in the narrowness, in the protection, in the limitations under which you grew up.

P: Yes, yes, well, I had at least lost most of it, and I don't even know whether I knew of it before. And now I've found more space with my wife.

A: Well, perhaps because you've had the experience here that you can make claim to it.

P: Yes, yes, that was, let's say, a long and arduous, I'd like to say an arduous discovery, a genuine discovery where I've gradually experienced that, yes, that I can make claim to this space. Perhaps, now at the very end, I would say that I can claim it, or something of the sorts. Claim, a word that sounds to me, when I think of the position I'm going to assume, I've told myself I can claim it, I tell myself I can claim the space. And no longer have this uncertainty when I have to be concrete; I will demand that I be taken seriously, and if I'm not, then I will be mad. And then I'll take it, I'll fight for it. I can demand that I act in my way, that I act the way I want to. That's come just gradually, almost at the end, that I've told myself where I could get used to demanding something and that's the same as that I'm entitled to it. [Pause] Yes, it's appeared just gradually. Yes, on the scale where I compare the beginning and the end, I can now lay claim to experiencing so much here. I'm no puppet on a string, no I'm not.

The patient was very emphatic in his denial that he was, after four years of psychoanalysis, no longer a puppet on a string. To this expression of the comprehensive and radical change in his self-esteem, we would only like to add the thought that such changes are tied to a rediscovery of pleasure in physical and mental activity. The puppet on a string served the patient, after all, as a metaphor for an inanimate toy whose movements are set in motion by someone else and from the outside.