Psychoanalytic Practice: Clinical Studies

Resistance

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Table of Contents

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Introduction

In the corresponding chapter in Vol. 1 we described the classification of different forms of resistance; in this chapter, from the perspective of analytic technique, we focus on the *regulatory function* that resistance fulfills in the *relationship* .

The extension of the theory of transference that we described in Vol. 1 (Sect. 2.5), has obviously had a significant impact on the theory of resistance that corresponds to it. Although the differing views of well-known contemporary analysts remind us of the controversies between A. Freud, Fenichel, M. Klein, and Reich in the 1930s, at least in their wording, there are nevertheless numerous signs that resistance phenomena are today increasingly being viewed in terms of the relationship. This change was made explicit in a public discussion between Sandler and Rangell, held at the Madrid psychoanalytic congress in 1983. The following passage contains the essential points of Sandler's arguments:

> It seems clear that the introduction and description of these object-related processes, particularly the *object-related defences* , reflected a major *new dimension* in the analytic work and in the concept of transference. The analysis of the here-and-now of the analytic interaction began to take precedence, in terms of the timing of interpretations, over reconstruction of the infantile past. If the patient used defences within the analytic situation which involved both him and the analyst, this was seen as transference, and increasingly became a primary focus of attention for the analyst. The question "What is going on now?" came to be asked before the question "What does the patient's material reveal about his past?"
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> In other words, the analytic work became more and more focused, in Britain certainly, on the patient's use of the analyst in his unconscious wishful fantasies and thoughts as they appeared in the present—i.e. in the transference as it is explicitly or implicitly understood by most analysts, in spite of the limited official definition of the term. (Sandler 1983, p. 41, emphasis added)

Rangell commented on this passage by raising the critical question:

> Is it still resistance and defences first, as it has been with Freud, Anna Freud, Fenichel and others? Or have we moved to what is promulgated by many as transference first, or even transference only?

Everything seems to boil down to a new polarization: many psychoanalysts give the here and now precedence over reconstruction and insight. Rangell demanded that a decision be made:

> Ultimately we may have to decide between two different concepts of transference, intrapsychic versus interactional or transactional. The same choice may need to be made between the intrapsychic and interactional models of the therapeutic process. (Rangell 1984, p. 133)

In the long run the questions raised by Sandler and Rangell will be answered by research on the course and outcome of psychoanalytic treatment. We do not expect new polarizations to develop because it is impossible to establish a hierarchy of interpretations concerning resistance and transference in the manner that Reich and M. Klein claimed in their extreme positions. Reich systematized defense theory in terms of therapeutic technique in his rigorous analysis of resistance, which ultimately resulted in his strict theory of *character analysis* .

Reich made the rule of proceeding from the manifest a firm principle and applied it rigidly: "*No interpretation of meaning when a resistance interpretation is needed* " (Reich 1949, p. 27). By describing transference resistance specifically with regard to a patient's behavior, both in general and in particular actions, and to the way in which he follows the basic rule, Reich introduced a useful distinction between form and content. In his words:

> The character resistance expresses itself not in the content of the material, but in the formal aspects of the general behavior, the manner of talking, of the gait, facial expression and typical attitudes such as smiling, deriding, haughtiness, over-correctness, the *manner* of the politeness or of the aggression, etc. (Reich 1949, p. 47)

He used the terms "armor" and "character armor" to refer to neurotic character traits, regardless of how much they differed, in order to describe the fact that certain manners of

behavior function like compact defense mechanisms, which operate by regulating the distribution of libidinal energy between the outside and the interior.

The consequence of Reich's recommendations is that analysts should initially limit their interpretations to the resistance *to* transference and avoid interpretations of meaning, especially all deep-reaching, genetic interpretations. Reich formalized the following general rule: "*One cannot act too early in analyzing resistances, and one cannot be too reserved in the interpretation of the unconscious, apart from resistances*" (Reich 1949, p. 38).

Reich also forced the analysis of resistance in the here and now. In the first few sessions of a therapy Reich would establish a connection between resistance and transference by saying at some opportune moment that the patient had something against him but did not dare to mention it (Reich 1949, p. 55). Ferenczi (1950), taking up a similar suggestion that Rank had made, also recommended that each dream, gesture, parapraxis, and deterioration or improvement be considered first of all as an expression of transference and resistance. According to Ferenczi, Groddeck deserves the credit for this principle; at any sign of a deterioration in the patient's condition he asked the stereotype question, "What do you have against me? What have I done to you?" The similarity between Reich and Ferenczi in emphasizing that the here and now is a reaction to the phase of technique that Ferenczi and Rank (1924) criticized as *interpretation fanaticism* is just as significant as their differences with regard to technique (i.e., Reich's character and resistance analyses versus Ferenczi's technique). The term "interpretation fanaticism" was used to refer to interpretations that reconstructed events, making the patient an intellectual expert on the genesis of his illness yet without leading to any therapeutic gain.

Emphasizing the current significance of resistance and transference is thus nothing new. The here and now is the starting point in many otherwise very different psychoanalytic techniques, whose conceptions of it differ accordingly. Ferenczi's understanding of a resistance to transference was presumably very different from Reich's although both followed the same

rule and in their interpretations may have proceeded from manifest events.

The discussion between Sandler and Rangell may be considered a belated renewal of the earlier discussion about superficial and deep interpretations that was the basis of the controversies between the adherents of ego psychology and the Kleinian school. Fenichel's commentary on the earlier discussion, although written long ago, is still instructive:

> Taken correctly, this can only mean that it makes no sense to give "deep interpretations" (however correct they might be as to content) as long as superficial matters are in the way. For this reason one cannot, as Melanie Klein wants, "get into direct contact with the unconscious of the patient," because to analyze means precisely to come to terms with the patient's *ego*, to compel the patient's ego to face its own conflicts . . . . The defensive attitudes of the ego are *always* more superficial than the instinctual attitudes of the id. Therefore, before throwing the patient's instincts at his head we have first to interpret to him that he is afraid of them and is defending himself against them, and why he does so. (Fenichel 1953, p. 334)

By emphasizing the *object-related defenses*, Sandler is apparently situated between the traditional ego psychological analysis of resistance and the interpretive technique of the Kleinian school. We too proceed from the assumption that human beings strive toward objects and are characterized by a primary intentionality. One consequence of this assumption is that all unconscious fantasies are *object related*, which is the reason that the fundamental human anxieties manifest themselves on points of interpersonal contact. In Vol. 1 (Sect. 2.5), we emphasize the positive nature of the fact that M. Klein brought movement into the rigidified fronts of resistance analysis. Subsequently, however, new polarizations and one-sided positions arose once again. The connection between unconscious fantasies, anxiety, and defense became the focus of the typical Kleinian transference interpretations. Projection replaced repression as the prototype of defense mechanisms, and repression resistance lost its importance. In the Kleinian therapeutic technique, the analyst operates behind the back of the resistance, as it were, because the anxieties appear to offer a means of direct access to the presumed unconscious fantasies. For both theoretical and technical reasons it was therefore possible for the term "resistance" to

disappear from the terminology of the Kleinian school. In fact, the term "resistance" does not even appear as an entry in the indexes in representative books by Kleinian authors (M. Klein et al. 1952; M. Klein 1962; Segal 1964; Etchegoyen 1986), or there is only a note referring, for example, to the negative therapeutic reaction, as in Rosenfeld's (1987) book.

The atemporal nature of the Kleinian unconscious seems to let the here and now merge with the past. The Kleinian understanding of the relationship in the momentary analytic situation is thus completely different from Gill's although both attribute equal significance to the actuality of transference. By proceeding from ahistorical repetitions, which are manifest as object-related wishes and anxieties, a Kleinian analyst seems to acknowledge that everything of importance takes place in the therapeutic relationship, yet he nevertheless neglects the reality of the therapeutic relationship (i.e., the realistic aspects of the patient's relationship to the analyst). The analyst's contribution to the patient's resistance appears negligible from the point of view that unconscious fantasies and anxieties manifest themselves in transference almost independent of time. In contrast to the Kleinian school, Kohut (1977) emphasized the *dependence* of the resistance on the analyst's current *behavior* and especially on his lack of empathy. It is obvious that we, in this regard, are in complete agreement with Kohut.

It is now time to focus on the regulatory function of resistance in connection with the security principle. Misunderstandings are bound to occur in this regard since Groddeck, Ferenczi, Rank, and Reich all considered the forced linkages we have referred to above to constitute the analyst's contribution to resistance and transference. This type of intervention seems to be expressed by the questions "What about me?" and "Aren't you really talking about me?" In any case, Reed (1987) referred to an example of a female patient's initial interview with an analyst-in-training to indicate how this analyst directly related the patient's description of a traumatic tonsillectomy to himself by suggesting that she was really speaking about him. Although one objective of analysis is to discover similarities, this is only possible if dissimilarities are also recognized. Using the above-mentioned questions to force the creation of

transferences makes it nearly impossible to recognize the analyst's influence on the patient's resistance to experiencing transference, in the sense described by Gill. The erroneous use of the here and now, i.e., the actual genesis, is widespread. Such forced transference interpretations have a deterrent effect in the introductory phase, and can lead the patient to doubt the analyst's normality and to not begin treatment at all. In later phases this type of interpretation makes it more difficult to distinguish the different levels of the relationship and of the transference, i.e., the "realistic" and "new" versus the transferred, old aspects.

In contrast to this method of stimulating resistance or transference, we recommend, together with Gill, that the analyst thoroughly investigate and eventually interpret the *realistic* aspects of the patient's affective and cognitive processes in order to determine his own contribution to transference and resistance—in other words, that he examine the situational genesis of the resistance. This is the common denominator linking us in this regard with Gill, Klauber, Kohut, and Sandler.

The point is to gain the patient's confidence that he need *not* fear a repetition of his previous failures in the new relationship. He can then give up his habitual self-defenses, as Weiss and Sampson (1986) have convincingly shown. This approach is particularly helpful for dealing with superego resistance. If the analyst orients his actions toward the goal of increasing the patient's feeling of security, it is possible for him to test different kinds of interventions, taking advantage of the entire scope offered by a therapeutically helpful dialogue.

An illustration of the regulatory function of resistance is provided by the following passage from Cremerius' reflections about the correct technique for dealing with patients who cannot freely associate:

> The analyst only has to think what effort and struggle his patient had to go through in childhood to successfully manage to socialize his instincts while preserving portions of them, in order to be able to understand his behavior in therapy . . . . And when this point has become clear to him, then he will also understand that the patient cannot

> simply permit something to
>
> happen that his own survival may once have required him to repress. He understands that his patient has in the meantime made his arrangements and has become accustomed to living in this way, and he will therefore be able to empathize with what it means to expose oneself to a process whose goal is the return of what was repressed. (Cremerius 1984, p. 79)

Because of the ubiquity of the phenomena of resistance, the reader can find examples of it in every chapter of this book. We would like to emphasize the instances of resistance to transference; it is especially important therapeutically that this form of resistance be recognized as early as possible. In Sect. 4.6 we discuss identity resistance and its relationship to the security principle, which is beset by unusual technical difficulties.

The phase of an exaggerated focusing on the analysis of resistance (and the polarizations related to it) has been overcome. Our understanding of resistance is based on viewing the mechanisms of defense within an interpersonal matrix. In this sense we adhere to the idealist utopia that the limitations on experiencing and behavior caused by resistance are in principle accessible to analysis. We therefore recommend that the following examples be read from the primary perspective of this textbook, namely that the exchange between the patient and the analyst be examined with regard to what the latter contributes to the development and overcoming of repetition in the various forms of resistance and transference.

4.1 Disavowal of Affects

Nora X arrived late for her 413th session—an unusual event. During the 5 minutes I was waiting for her, I thought about her very intensely. On the one hand, I was worried; on the other, I detected a growing inner tension that was tinged with aggression. I was worried because the patient was inclined to inflict harm on herself, e. g., she was a reckless driver. When she finally arrived, I was surprised to see her smiling and beaming with happiness; upon entering the room, she looked at me longer than customary and in an inquisitive manner. Her happiness and my displeasure created a very discordant contrast.

P: I'm all out of breath, and I'm late too. [Short pause] But I can tell that somehow something is wrong. And I don't know right now if I'm happy because I'm late and made you wait, or because of what happened before.

She described how she had been together with her boyfriend. They had been sitting in a cafe and so engrossed in conversation that she had forgotten the time. At the end she had had to pay, and the patient recalled that this had also been the topic of the last few sessions. In the previous session she had been concerned with the fact that she frequently waited for longer periods of time before paying the bills for her analysis.

P: Yes, what really concerns me, I believe, was the last comment I made before I left, about paying, which was also the topic of the previous hour, and I thought it was simply indicative that precisely the same topic was the last point in my conversation with my friend, although we had talked about something entirely different.

She had talked with her boyfriend about the difficulties she was having with her superior. She felt that these conflicts were like the "back and forth in a ball game." She experienced the same back and forth with her boyfriend when, while paying for the coffee, they played a "funny game of give and take." For me, the aggressive aspect was in the forefront. With regard to her being late and my unease about it, I created an analogy between the outside situation and the one in analysis.

P: Now today . . . I play it where the point is to say what I think, hold it back, then with the bills and . . . I wonder whether there is a connection with my being late.

A: Hum, I think so.

P: You think so. Ok, I take some time away. But I actually divide it up differently, and my friend and I were together a little longer.

A: We recently spoke about you wanting to give it to your friend, and today it's my turn.

P: Yes, it's fun.

A: And that's why you were beaming when you came in.

I shared my impression with the patient to make it clear to her how much she enjoyed coming late and how much pleasure she had acting out aggressive impulses.

P: [Laughing] That honestly gives me a feeling of "illicit pleasure."

Affect and behavior were linked together in this illicit or forbidden pleasure; the patient's repelled aggression was expressed both in her pleasure and in the fact that her behavior was at the expense of the relationship.

A: Yes, that's clear, and you let yourself have this pleasure. But I'm not very sure whether you also see the consequences of your pleasure.

P: Yes, well, the question as to "What does it give me?" is one I haven't asked myself before. But when I raise it now, then I think that acting this way I gain your attention, because you might think "What's keeping her?" or something of the sort, and then I also think of how I react if someone else is late. It makes me pretty upset.

A: Hum, you're pretty sure of that.

P: That it makes me upset. But that it upsets others, I don't want to know that.

A: That is just the source of your pleasure, that you can make people upset in a seemingly unguilty manner.

This would have been an opportunity to refer to the patient's feelings of guilt as the reason that she felt compelled to ward off affects, but the moment did not seem ripe for this step, and the patient continued talking about being angry.

P: I recall that my boyfriend kept me waiting three times last weekend. The first time I didn't say anything, although he mentioned the subject. The second time I didn't say anything either, not until the third time. So I've just experienced what it is. And yet, just as I said

before, I recently let him have it . . . . Now what was the reason?

While in the act of speaking the patient forgot the way in which she had innerly turned away from her boyfriend. Although this momentary forgetting (see Luborsky 1967) was an interesting detail of the patient's distancing, in my next interpretation I reconstructed everything that had happened with regard to her being late in order to interpret the change she had undergone from being passive (as the victim of the tardiness of others) to active (by being late herself).

A: On the weekend you were the one who had to wait, and you were angry, specifically you were passive and the victim. Now you just did something that we've seen before a number of times, namely you turned the tables and let me wait. You tell yourself, "I don't want something to be done to me, so I'll do it to someone else." That is how you deal with being disturbed or hurt in this way. And so the real issues in your being late are provoking anger and being angered.

P: Hum. [Short pause] Maybe provoking anger and being angered are the point.

In the following passage the patient made it clear that she had indeed spoken with her boyfriend about his being late, but it had taken a long time before she had been able to overcome her inhibitions and express her feelings. After her reflection on how she acted to her boyfriend had made it clear to her how she dealt with aggressive impulses and how she transformed these impulses into acts, I directed her attention to her behavior during the analysis.

A: You've talked about giving and taking, but the subject is actually provoking anger and being angered. Of course they're closely related, because you know that you get angry when you don't get what you expect, whether it has to do with being on time or with money. And you assume that I react, think, and feel just the same way, namely that I get angry when I don't get what I expect. And your desire to provoke anger is reflected by your actions, and your laughing and the happy look on your face reveal what a forbidden pleasure you get from making me angry. And you can be so happy about it because you don't really perceive the

anger, just as you don't with your boyfriend either.

The patient responded to this interpretation by once again describing the interaction between her and her boyfriend, this time putting more emphasis on the aggressive character of the back and forth. At the same time her gaiety and laughing increased.

P: [Laughing, she quoted her friend] "Okay, before you say it again you're going to get it" [and she added very forcefully] smack!

A: But that sounds as if you slapped each other. The one goes smack, and then the other goes smack. [The patient confirmed this in a reserved way.] And I've also got my smack! [The patient laughed.] And you're happy about it.

P: Yes, even very much so. Somehow I don't want to let you take this pleasure away from me. It's a feeling as if it is finally out in the open and can come out.

After the patient had become aware of the previously preconscious pleasure she obtained from acting aggressively, both with regard to her most important current relationship outside of analysis and to her transference, the next step was to establish the connection to her main disturbance (breaking off relationships).

A: Yes, your pleasure comes from using the one person to give it to another. Today you used your discussion with your boyfriend to let me have it. It's hard for you to stay with one person and to tell that one person what's moving you. You look for a second person, who then gets what the other deserved. This is what characterizes your relationships; instead of concentrating on one person, you take your feelings and go to the next.

P: [Softly] Because it's fun.

A: Yes, it gives you pleasure, but it also makes you unhappy.

P: I have the feeling I've never found pleasure. That's why I said that it's also important that I finally let the laughing come out, because I hide it otherwise. I don't feel any pleasure

and happiness, I just always feel sad. Sadness is always there first, but it doesn't help me get any further.

A: Both are important. The pain is one thing, and it's closer to you; and your forbidden pleasure from this form of revenge or rage or anger wasn't a topic before.

In the following exchange I referred to the patient's earlier friendships. She had not been conscious of her own aggression in them, but had only perceived it mirrored in the behavior of others.

A: And we can now see how much pleasure you get, expressed in simple terms, from treating men badly. You treat me badly when you enjoy letting me wait, and you're overcome by laughter when it becomes apparent.

P: Yes, but that's something new. I used to always fall into sadness, and then it was over.

In the following sequence of comments I made a longer, summarizing interpretation in which I connected, on the one hand, the patient's development from her wishes to her disappointment and then to her transition from being passive to active as her means of warding off feared traumas and, on the other, the aggression that resulted. The individual links of this chain that were not discussed in this session were the result of prior work. I concluded this summarizing interpretation by referring to the aspect of transference in this behavior.

A: And to avoid this disappointment and the anticipated pain, you turn the whole story around and don't give me what you think I expect. In doing so you inflicted something on me that you feared would be painful to you.

P: Funny, I had to think about how the sessions end. My anger at the fact that you say, "Now our time is up."

A: Yes, I hurt you by doing that, and now you turn to counterattack. But the consequence is not that the situation gets better, but that the fact that you feel angry makes the hour even shorter. And this is the fatal aspect of this pattern—namely that your reaction does not

make the situation better, only worse.

P: Innerly I take more and more measures to make the time seem shorter, because even when I start to feel that the end of the session might be approaching I think: "When are you going to say it, when are you going to say it?" And recently I realized that my thoughts were already somewhere else. As if I wanted to simply ignore this pain. And now I just had the thought that in this way I at least have a little pleasure, namely in leaving mentally, and then it isn't as painful.

A: You become active, which on the one hand gives you the nice feeling that you are in control, but on the other has the disadvantage that you get even less.

P: Then I can't concentrate either, and I'm not intensely involved, and on the one hand it is pleasurable, leaving, but on the other hand it is also a loss because of the loss of intensity.

A: Right, and what we see here in miniature is a pattern of how you organize your relationships, because when your friendships could have become intense, you've always taken some action to end them prematurely. For the same reasons that you innerly prematurely end our sessions, namely out of fear of the pain that someone else could inflict on you by saying, "Now it's over." In doing so, you actively cause something to happen that might have happened sometime.

P: Yes, here for example, here I know that it's coming. And in a relationship I would always be afraid it would happen.

A: And that's your problem. It's hard for you to let it end either way; you always cause the separation when it starts to become intense.

P: A moment ago I wasn't actually thinking as much about the separation from my father, as about how my mother and I acted toward one another.

The patient provided details about this point for the rest of the session and related it to her mother's typical forms of behavior.

Triggered by the patient's late arrival, it was possible for us to clarify her masochistic reactions regarding rejection and separation and to elaborate on them in transference. The course of the session led from her desire to her disappointment to her transition from being passive to active, and ultimately to her defensive aggression. It was possible to trace this sequence of topics back biographically to her relationship to her mother.

If we, following Klauber (1966), formulate the guiding elements in the session in terms of anxiety, defense, and enactment, we can give the following summary. The patient's primary anxiety was that her affects could gain control of her. It was therefore necessary for her to deny them. Giving and taking, as part of this, were a pleasurable game, but also one that was invested with anxiety and that necessarily ended in pain for the patient because she had internalized the expectation that her wishes (e. g., for attention) would not be fulfilled. Her

primary defense was the disavowal of affects and acting out of aggressive impulses. In this way she enacted an anticipated disappointment, which she brought about in an unconscious yet active manner.

4.2 Pseudoautonomy

Although we would prefer to analyze patients who are independent, we are aware of the possible difficulties with those who desire to do everything alone.

> A marked tendency prevails to regard independence as something frankly positive and dependence as something frankly negative, from the point of view of psychological cure or evolution. The positive aspect of independence seems to lead one to overlook the negative one and thus is apt to mask neurotic ends. In the same way, the negative aspect of dependence seems to lead to a concealment of the positive one and the criticism of dependence may equally serve to cover pathological tendencies or defences. (Racker 1968, p. 181)

The issue of independence also has implications for how the analytic interview is handled. A very early feature of the clinical description of the forms of resistance was that the degree of deviation from an ideal dialogue was subsumed under the category of resistance; this was true regardless

of how the ideal form was determined and of the direction of the deviation. Cremerius has correctly emphasized that we must specify the criteria according to which we judge that a patient speaks too much:

> The answer is that this too much is not something quantitative, but rather something qualitative, namely that in this case speaking—and specifically, speaking too much—supports the defense and resistance. (Cremerius 1984, p. 58)

We would like to use the following example to illustrate how to deal in a calm and composed manner with a patient who talks too much. In doing so the analyst gives "the patient time to become more conversant with this resistance with which he has not become acquainted, to *work through* it, to overcome it . . ." (Freud 1914g, p. 155). The example is taken from a session of an advanced analysis of a 35-year-old man named Gustav Y, whose disturbed ability to work manifested itself as a transference resistance that took the form of stubborn silence (see also Moser 1962). After warded off aggressive impulses had been worked through, the patient developed the pseudoindependence described below, which manifested itself in statements that —although expressing reflection—were in fact monologues.

The patient first told me, in a comment phrased as a question, that he would have to end the session "a little early" in order to pick up his children on time. He explained this by referring to the heavy traffic and a dangerous encounter he had had while driving to that day's session.

P: While driving here I was in a pretty precarious situation. Someone was driving behind me, then passed me and pulled to the right . . . and then on the other lane someone else, a wide semi, was coming toward me, and I wouldn't have had a chance to get out of the way. And it would have been hard to brake because there were puddles of water on the road . . . and it was really just a matter of inches, he just managed to pull over in front of me, and well, I don't really want to risk anything. It's clear; if I drive and think that there isn't much time, then you just drive a little, a little faster than may be sensible.

The patient has a 35-40 minute drive. He requested that we stop 5 minutes early.

P: [After a pause] Yes, and there's something else, something that I read in the newspaper just before I left home today, that yesterday there was . . . I don't know, was it . . . just a . . . the B30 just before the . . . before the exit to this . . . the wider stretch of road over there . . . that there was a serious accident there yesterday, and a woman died at the hospital and there were three or four seriously injured . . . hum . . . so I thought about it as well, that's how it is on our roads today, they were even . . . dry, by and large, so that I somehow thought, "Now you can drive normal again" and although I had enough time I did drive pretty fast . . . I mean on that stretch later, where you can drive 80 mph, I mean I know that my speedometer is slow so I mean 90 . . . but just before I . . . when I realized I had to be where it had happened and looked out and didn't see anything, and then I realized then . . . and then the thought just passed through my mind what that just . . . . what kind of a feeling that has to be, isn't it, and it said that this . . . this car that caused the accident, that it's from Heilbronn, it traveled at a . . . it skidded in the corner, turned around and was standing broadside on the road, and the other one hit it from the side and the . . . well, the mother-in-law of that driver, she was injured so severely that she later . . . that she later died. And so I wondered, when I was driving past the spot, what kind of a feeling that had to be if you have an accident and somebody in your car, they're killed, or if I cause the accident myself and then other people, I mean, from a different car, are killed, yes.

The patient continued his "free associations" in this manner for quite a while. He remembered that while driving to the session yesterday he had become so tired that he had had to stop for a break.

P: I mean that this itself . . . I mean that really . . . here too, in our conversation just this . . . the question played a role, right, it . . . that just because of the road conditions there is a danger and I didn't really talk about it here.

A: Hum.

Commentary. The patient mentioned other associations to demonstrate the risks connected with his driving to treatment. Then the patient found a link to the previous session, in which the

indirect dangers of the treatment, i.e., from the analyst, had been a topic.

P: Maybe also because I then somehow immediately . . . this . . . somehow retreat into this role and something . . . well why not . . . I mean, I . . . or in the sense that this . . . this stress or other, I have to . . . simply to take it upon myself, right.

A: What do you avoid by bearing it all by yourself?

P: [After a pause] Yes, perhaps it is somehow the other side of these unpleasurable and . . . and . . . and burdensome . . . and definitely also a certain enjoyable side of the treatment, that I then namely have the feeling, hum, right here really being able to decide by myself what I want to do and whether I want to do something, that is, that I . . . uh . . . although it isn't quite right, isn't entirely clear, well, would like to avoid it, now somehow . . . let's say . . . that now . . . expressed a little pathetically . . . uh . . . somehow now, somehow like pity or something . . . for example, that you now show your understanding somehow that it simply is a difficult situation or is dangerous or so.

A: Hum.

Commentary. The patient was able to gain something from the analyst's reference to the purpose of his behavior, namely that he would like the analyst not to come too close by talking about the danger—as he had in the previous session.

P: And that is somehow . . . and somehow there is . . . I mean, but I . . . but it simply isn't . . . very clear yet what the . . . uh . . . primary thing is, if I . . . uh . . . if I don't really want it, if I just . . . if I really would like to do it alone or if it is also just this . . . this shyness toward any . . . well . . . any personal nearness or so that is somehow expressed. That is . . . uh . . . it just is not . . . not so clear . . . to, and I think that my [cleared his throat] now viewed from this aspect, the idea that I have is that I myself . . . that I would like to decide it myself, and also the other possibility, let's say, that I would not make up my mind now, would simply now say, "No, I won't do it, it's too risky for me" or so, yes, and this . . . and somehow I would then like to . . . hum . . . to make this decision by myself, without now . . . for

example . . . without somehow here . . . uh . . . getting permission. Yes, that's . . . that's also part of it.

A: Yes, that means that independence is something very important to you, and you yourself raise the question, "Is it really primary, or could it be that this independence is the consequence?" Perhaps you have given up expectations, and that the act of giving them up proved to be a gain in independence. You are independent of me now, regardless of whether I say something helpful, understanding, or not. You are—and this is an image that we have been following for a long time—you are now the hero who is mastering his dangerous path alone.

One of his frequent daydreams in this phase of treatment was about a Western hero, who comes to the aid of widows and orphans, only to reject the offer of a rescued woman at the end and travel on.

P: Yes, that actually . . . a few minutes ago that . . . let's say . . . entered my mind, and precisely now the . . . the way in which I . . . hum . . . how I act toward my wife right now, that I withdraw and only keep up a formal politeness.

He then described how his wife complained about his rejection of her wishes for nearness and intimacy.

P: But from my point of view, I really don't have any need for it, so that right now sexually . . . I actually don't miss anything and don't have any needs.

Gustav Y then formulated his wish that he would only like to sleep with his wife if she would not place any demands on his autocracy.

P: Not, and this is really the truth, that at the moment I'm particularly strong . . . hum . . . yes . . . how should I say it . . . I simply want to have my peace and quiet. People shouldn't bother me with with such things. And that's really how it is, perhaps I have arranged things that way, that I actually somehow feel quite well . . . hum . . . in the situation, or at least . . . or

perhaps have . . . by and large repressed my other wishes and needs . . . uh.

A: Hum.

Commentary. The concrete form that his heroic dream took in everyday life provided confirmation that the patient preferred to suppress his sexual wishes in order not to get in a position of uncomfortable nearness to his wife. Since his childhood had been overshadowed by the long absence of his father (who had been held a prisoner of war until Gustav was 10 years old), he—"the only surviving man in the family"—was spoiled and constrained by the dominant feminine environment. His childhood was constantly accompanied, understandably, by the worried complaints that nothing should happen to him. It was precisely this that he did not want to hear from the analyst. His understanding about the dangers on the street and about the dangers of pleasurable phallicism could only cover up accusations.

P: Not, and it's naturally the case now too, that when . . . not when I . . . when my wife then somehow makes . . . the . . . the accusations and . . . says to me that she hates me or whatever, really, then my reaction is, "Yes, alright then, yes, what do you want after all, it would be best if . . . uh . . . we restrict our contact to practical things and otherwise each of us can do what what we want."

A: The decisive point is contained in the feeling you express as "What's the point," that you shrug your shoulders and think to yourself, "What should I say about it, what's really the point?" Almost as if you put yourself into the situation you had in your fantasies about what happened the day before and then hit the gas pedal and then—what happens then—what is really expressed in your "What's the point?" You almost killed yourself. By letting somebody else do it, but it's also possible that you could have seen the other car . . . uh . . . just a few seconds earlier and then it would have been a little less dangerous.

P: [After a pause] Yes, yet . . . yes, of course, as far as the overall situation is concerned, yet I . . . yet I don't . . . yet it isn't entirely clear, I mean, what I just described about yesterday. I said it happened while driving here, naturally . . . but it therefore can't . . . hum . . . let's

say . . . have been a direct reaction to what we talked about.

Commentary. The patient was immediately unsettled by the interpretation the analyst offered, and he therefore had to, first of all, make a denial. In contrast to earlier phases of the analysis he was able, however, subsequently to permit himself to have a productive association.

P: Yes. Yes, but . . . it . . . now I can think of something that makes that even clearer. Such fantasies occur precisely at the moment when it's possible to dose them accordingly, right, that I could get out of everyday life in a small accident, but of course the stress at work also plays a role, right, to get put up in a hospital with some injury or other and there somehow get some peace and quiet to come to your senses. Right? It's therefore also . . . I mean that . . . this also indicates that some . . . uh . . . some wish or so played a role.

Commentary. In the course of treatment the patient was able to overcome the regressive idea of having a serious case of tuberculosis, at least to the extent that he could limit himself to a "small accident" in order to get himself "out of everyday life."

The patient then described an important observation he had made about himself, about how he had calmly accomplished a task he had been assigned, "with substantially less nervous energy than earlier," and that he was startled by his own generosity. There had always been a critical element in the patient's fictive conversations with others: "My God, when people read that, they'll think, `What a planner you are.'" Yet to some extent he was able to escape these expectations.

P: I said to myself, "Why burden yourself with such work. It doesn't matter after all, and if it doesn't work, then there isn't anybody around to fix it again," right, and so now I'm going to work with this kind of an attitude. I prepare even less than normal, but without punishing myself afterwards in such a terrible way.

A: You reject certain expectations that you've placed on yourself, and in doing so you have simplified your situation.

P: Well, yes, I mean, it's also contradictory, of course. If I really relativize it and tell myself that it doesn't matter, then on the other hand, this doesn't fit with the wish to avoid everything right now. At least I still see some contradiction in this at the moment, but I think that it naturally could also be that I just didn't immediately think that these problems at home might even play a bigger role, problems that I then wouldn't have to face, right?

A: You have to realize that a certain question was obviously implied when you talked about your additional tasks at work the first time, namely, "Why did the boss only give them to *me*, why me of all people?" And there was a small implication about whether he would really say it. It may really have been your expectation to be praised. And this "It doesn't matter" could be a reaction to your disappointment, a withdrawal into not caring, and analogously the "It doesn't matter" here could also be a reaction to a disappointment. In this way—by saying "it doesn't matter"—you make yourself independent.

Commentary. In the previous interpretation the analyst attempted to indicate to the patient one reason for his pseudoautonomy. The patient avoided disappointing the wish that he was looking for acknowledgment and instead only met concern. At home good grades at school had been a matter of course, because his mother had only had him to care for, but she had not fostered the development of his motor ability. In adolescence he had run his laps as a long-distance runner, where nobody watched; his daydreams, however, were about victories in the 100 meter dash that took place in front of the main grandstand.

A central aspect in this transference relationship was the patient's attempt to avoid his wish for confirmation of his dangerous journey through "life." In retrospect, this aspect does not seem to have become very clear. The analyst's interventions were directed at the resistance that concealed his desire for dependence.

4.3 Unpleasure As Id Resistance

To gain a better understanding of this section we recommend that the reader first turn to Sect. 9.3, where we summarize the case history of Christian Y and report about the external and

temporal circumstances of his analysis. After he had overcome his separation anxieties—in Sect. 9.3.1 we give an example of them from the 203rd session—it was possible for his treatment to be continued on an outpatient basis, starting with the 320th session. His unpleasure and incapacity reached their low point in the 503rd session. He was just barely able to walk to my office. Several fanciful activities did not provide him any satisfaction at all or increase his self-confidence.

In this phase of treatment his symptoms consisted in an extreme lack of vitality, which manifested itself in an incapacity to work and in laziness. For a long time his laziness, which at this point was a source of serious distress, was overlaid by severe attacks of anxiety that prevented him from being active and working.

From a descriptive point of view we attribute the patient's all-encompassing unpleasure to id resistance, which we however do not trace back to "inertia" or "sluggishness" of the libido (Freud 1918b, p. 116, 1940, p. 181; see also Vol.1, Sect. 4.4). In fact, there does not seem to be any movement in the two sessions reproduced here, which were typical for a longer period of treatment. The analyst despairingly attempted to make some sense of the patient's monotonous complaints about his complete lack of ability to accomplish anything. He viewed the patient's listlessness as the manifestation of an almost insurmountable resistance that contained concealed and completely unconscious satisfactions of anal spite and of the regressive self-assertion that accompanied it. Of course, the patient was far from recognizing the power of his passivity and from enjoying his triumph. His moods alternated from one extreme to the other, yet his anxiety signal was unchanged and independent of whether Christian Y openly expressed his rage or it receded behind his passivity or self-destructiveness. His anxiety also protected him, however, from breaking off the treatment or committing suicide. He secretly prepared circuit diagrams and programs, overshadowing his father, yet his visions of omnipotence were deflated when he took a realistic look at his achievements. The more he achieved in life step by step, the more obvious it became that his central problem in analysis was the discrepancy to his subjective view of himself.

As the following excerpt from the 503rd session shows, Christian Y insisted on the idea that he could only become a hard worker if the analyst made him one. He expected the analyst's interventions to provide him vitality or to result in activity.

P: I'm always afraid of getting on someone's nerves or of being too impudent. I'm usually already nervous when I get here, so I can't bear any additional stress, however minor. I can start with whatever I want, but you always lead me to spite. What are you trying to get at? I'm bored about talking about spite because I'm interested now in how to become hard working, and I can't see any connection between spite and laziness, and I don't think it's necessary to talk about spite because it includes rage, and rage is something different, it still doesn't go away. There must be some reason that you keep coming back to spite. What's wrong? Why don't you say anything?

A: [After a pause] One important aspect is to block direct pleasure and to incapacitate the other person. That was something you were able to follow yesterday.

P: No, I don't understand anything. Getting pleasure from spite isn't interesting, because I really don't want to slow things down. I try to talk about something. That I'm happy at those moments when you don't say anything, as if I had gained control, isn't interesting at all. What is important is being aware that I haven't drawn the conclusion that you can't help me. Otherwise there's nothing else to it. I think we've lost time again, and that makes me upset; I want to get ahead, for example, become a hard worker. Why isn't anything said about that, nothing at all? I don't want to exert myself; I'm afraid of doing something silly. Why don't you help me then? I can't have any thoughts of my own, have an opinion of my own; I've always been dependent on what others think. Why am I afraid of being criticized? In my opinion everything I do is full of crap. I talk, think, do something—crap, nothing else. I wonder why I wouldn't be satisfied with your approval. But it isn't any more important than getting the approval of other people. And besides, I don't want to do anything in order to get your approval in exchange, because that's precisely what I want to be independent of. It doesn't help me at all for you to give me your general consent; that's too watered down. It's no help to me; I'm still afraid that everything is full of crap, whatever

I do, however I walk and stand, whatever I touch, whatever I think; somehow whatever I do is really full of crap. I'm terribly afraid of making a mistake. Afraid of being laughed out, afraid of becoming angry. I'll always be making mistakes, and what I do will never be perfect, and I therefore always have to reckon with something unpleasant. Another thing is that I can never have a conflict with anyone, and it always makes me angry. I can only give in, agree, but I don't want to. If you don't help me to get over it, then things will just stay like they are.

A: So you're afraid that if I don't give you anything, any help, that you won't be able to do anything yourself.

Consideration. This was an attempt to show the patient that he could be independent, although it was very cautiously implied. This caution was connected in part with the fact that almost everything I could say, suggest, or do would be "wrong." On the other hand, from experience I knew that Christian Y could not bear a longer period of silence. He needed the reassurance of my reaction. This can also be seen in how he concluded his opening remarks in this session, "What's wrong? Why don't you say anything?" By remaining silent I might make his feeling of concern become intolerable. At the same time, what I might say exposed me to his biting criticism. For a while the patient had learned my comments by heart, and I had not realized that this provided him support.

P: Yes, that's how it is. I'm not afraid of it being that way; that's how it is. Or can you give me a different interpretation? If nothing were to come from you—if I stayed away, then what about my anxiety? What's the point of all this? I can't understand you. Listen, how can I get over my anxiety in everything I do? I come here afraid, you don't offer me anything, and then I'm unhappy again that I haven't got anything new. For instance, right now I'm really looking forward to my vacation because I won't have to be afraid every day of wasting my time coming here.

A: Yes, you're really looking forward to not having to come here for a while.

P: Just looking at it from the one side.

A: Real pleasure.

P: But there is also a kind of spite. I turn away from you, enraged, and accept the disadvantages.

A: Which is the precondition for the idea that if I don't offer anything, then you can't have anything either. Apparently my silence is turned into your experience that I don't have anything to offer. But why don't you have anything either?

Consideration. This question presumably expressed my helplessness. Indirect encouragements were insufficient, and all that was left was for me to bear the fact that I was doing something wrong.

P: Then let me try asking a question. How would you say that I have profited from today's session? Or how did I profit from yesterday's? Can you tell me that?

A: Yes, to know what a benefit is is a real question.

P: A benefit is when I'm better able to solve a problem, a benefit is when I'm less anxious.

A: Yes, then you would have benefited from today's session if you had learned that you have something that I haven't contributed to.

P: I don't have anything, I'm just afraid, too afraid.

A: You mean there's a connection between my being silent and your fear.

P: You haven't said anything for practically the entire session that is related to any of my fears. If I'm still afraid of making a fool of myself, then I haven't benefited at all.

A: What's taking place here is an example of the disturbance of your ability to work. If I don't immediately refer to something you've said or confirm it indirectly, then you jump to the

conclusion that everything that happens here is crap, that it isn't worth anything, and that it won't become anything until I make something out of it, until I've added my two bits to it.

Consideration. Christian Y was extremely dependent on confirmation from others. His mother had spoiled and loved him in excess, as he mentioned in another context, which resulted in a deficit that consisted in his still being incapable of being the person he wanted to be. I nevertheless felt that I could expect him to show initiative. His deficit was an atypical one, caused by too much good. In other words, the good turned into the false self. What the patient wanted to be remained a mysterious idea.

P: Yes, yes.

A: Until the two bits, my two bits, are added. The fact that you quickly become discouraged when you try something new is part of your disturbed ability to work.

P: I still can't agree with it. I haven't done anything else; I've only described some fears of mine. I haven't tried to solve anything because I know that I can't and because I don't have the faintest idea how, and I don't think it's possible to simply go from one to the other. I've raised questions and on the whole haven't found any answers. That's a disappointing experience because whether I continue to be so afraid or whether it decreases depends on the answers to these questions. I'm right, and it would be self-deceiving to act as if I weren't afraid, because I am. Just talking like this cannot be very valuable. I just don't see how I should have benefited from today's session. You haven't said anything about the anxieties I have, and at the one place you said that you had said something, it was a deception.

A: So if I don't say anything, you become afraid?

P: I'm afraid even before then.

A: Yes, I know, but what's important right now is, in simple terms, that you're afraid when I don't say anything.

P: At first I get angry, and maybe I get afraid then.

A: So being angry makes you more afraid?

P: We're losing time, and I don't understand what you're trying to get at.

A: If I don't do anything, then you think that you can't do anything either.

P: Yes, that's how it is; naturally not nothing, but far too little.

A: So if I don't have two bits, then you don't either.

P: Yes, that's how it is. I think that's how it is because it makes me feel so bad.

A: Yes, yes.

P: And as long as I feel bad, then I don't have two bits.

A: This must be taken very seriously. The connection is so close that what you have is only good if you have the same thing I do, when we can mix our bits together. If you do something alone, then it's—how should I say it—crap until I've added my two bits and it can all be put in one pot.

P: But I haven't found anything, so in my experience it's all crap. So I think I'm right, and if I seem stubborn, then maybe I'm just too dumb to grasp it; I can't understand you. I can solve the problem in another way, by not looking for anything here, but then I won't achieve anything in end effect. Where am I making a mistake? Where's the catch? I don't want to block myself in if you know something better and can give it to me.

A: The problem is that you have to have something in common to be able to do something yourself.

P: Yes, and if you don't say anything?

A: Right now we see that you are obviously still very afraid if we don't keep our bits in the same pot, that is, if you produce something yourself. That's why I said it would be a real pleasure for you not to have anything to do with me for a while. Although there is spite and rejection in it, it's also a demonstration of your independence.

Consideration. How could Christian Y overcome the dilemma that he detested being dependent and yet he didn't have the confidence to be independent? The patient's self-deprecation was so hard to bear that presumably I now attempted to emphasize his own ability.

In the following session things continued in the same vein.

P: I get scared shit when I feel the first signs of being tired. So now I'm at the subject of laziness again. You know, I'll never be healthy. I don't have any inclination to work. Doing something is completely alien to me; there's nothing I can do about it. Last Friday I was in despair again when I looked back at the week. There wasn't anything, nothing at all, that could stimulate me to want to work, nothing, and I reject work altogether. And I don't want to work; there's no point in your exerting yourself. Everything is so boring, life itself is a bore, empty and unexciting, and it won't get better, I'm convinced of that. Why should I get involved in such an unexciting, gray future, absurd . . . .

A: So, where the issue is that you should do something yourself, that's where my contribution is especially small, nothing or as good as nothing.

P: That's the topic.

A: Where you do something and I don't do anything. Where the point is that you develop more activity without me. So, is it your goal to do more without me?

P: Yes, but I can't because I'm lazy, for example.

A: What does your laziness get you? What do you want to achieve as a result of my intervening?

P: I don't know. Why should you intervene? I want to do it myself, but am afraid, as I've told you over and over, but you don't show any interest in why. I'm afraid to do anything. I'm afraid of tests. Last night I had a dream about something like that. I had to take a test and sat there and didn't know anything and got scared shit and was even punished by somebody. I'm scared. That's where we can get started. What do I want from you? Nothing! I don't want anything personal; I like to live impersonally. I want to be cool and keep my distance; that's nicer.

Commentary. Here the patient referred to his conflicting desires in one breath. The moment the patient wanted to do something himself his paralyzing fear manifested itself. Entirely aside from the fact that the analyst was too restrained in providing confirmation in specific situations, the patient was also ashamed of being dependent; it was therefore hard for him to accept help. His unhappy complaining about the lack of help was not only hard for the analyst to take but also caused the analyst to become concerned that the resulting feelings of guilt might have the effect of increasing the patient's fear.

A: Yes, that's what I mean. You want to do something all by yourself, something objective, and that's the problem. Why isn't it possible? Why?

P: For instance because I'm afraid that I will do something that somebody else will examine closely, for example, because I can't afford to have an opinion of my own, because I can't stand to have a conflict with anyone, what do I know. I'm so imprecise, so in a rush and unable to concentrate that when I do something I'm afraid of being rejected in some way. It's terrible for me when I do something wrong.

A: Yes, and as long as I take some of the burden off you, think for you, and become active, then you're out of the danger of having to do something yourself and I slide into the role of the critic.

P: I can't understand that.

A: As long as somebody else takes all your burdens off you, as long as you can be completely

passive and someone else acts for you, holds your opinions, and takes your place, that's how long you will feel secure.

Commentary. The analyst viewed the patient's inactivity in these sessions primarily as anal spite. Consequently, he looked for the pleasure concealed in his passive aggression and his spiteful self-assertiveness. In the session described here the focus of the interpretative strategy was the interactional side of the patient's spite, and the unconscious scheme of anality was discussed, if only by analogy. The analyst attempted to get the patient to understand the (transference) relationship as something in which the patient can openly pull the analyst along into the crap. The patient referred to himself as "somebody full of crap."

Even in this phase it was still possible to identify a component of castration anxiety in the patient's complaints about his physical inability. The roots of this component reach far into deeper levels, as these excerpts demonstrate.

The patient's idea that his "material defects" can only be healed if the analyst supplies him with materials results in a very serious problem of analytic technique. This problem is further increased by the fact that the patient was suspicious and experienced any true closeness as a severe humiliation. His recurrent mood of hopelessness, which was accompanied by his threats to break off analysis and commit suicide, was one consequence of this.

4.4 Stagnation and the Decision to Change Analysts

If stagnation or an impasse happens to occur in an analysis, the analyst can usually find very plausible reasons for it in the patient's psychodynamics. It is logical for him to think of a negative therapeutic reaction (Freud 1923b), and we have discussed the unconscious motives of such reactions in Vol.1, Sect. 4.4.1.

This attitude disregards, however, the analyst's contribution to the stagnation. If therapeutic change is missing, part of the responsibility probably lies in the analyst's personal

equation and technique. The results of research emphasize namely that an unsuccessful prior therapy does not necessarily justify a negative prediction about the outcome of a subsequent therapy. This result of statistical studies probably contradicts widely held clinical attitudes (see Kächele and Fiedler 1985).

Because of a protracted standstill in her therapy, Maria X consulted, by mutual agreement with her (female) therapist, another analyst, this one a man. Each side experienced the futility of the therapeutic work, yet drew different conclusions from it. The patient was absolutely against stopping, while the therapist recommended a break and left it to her discretion to later switch to a male analyst. This pessimistic point of view was the result of the fact that all of the analyst's efforts to communicate something good to the patient, who had diffuse anxieties and whose general mood was depressive, had apparently failed. The patient's chronic dissatisfaction with herself and the circumstances of her life, which was caused by a fundamental feeling that she was deficient, had remained inaccessible for a period of almost two years. Since the patient's response to each insight into unconscious conflicts led to a deterioration in her condition, the analyst diagnosed a negative therapeutic reaction.

In unsuccessful therapies analysts ask themselves critical questions, and such situations put them in the position of being the accused, as Wurmser emphasized:

> One defensive tactic that is especially popular if not typical of depressives consists in trying *to make the other person feel so guilty and humble* as they themselves feel. How is it achieved? By means of open and disguised accusations. It is a kind of turning the tables that includes the defenses of projection and the turning from passive into active and signifies a transition from the identification with the victim to identification with the prosecutor. This can also turn into a immensely strong kind of transference resistance. I think that a large portion of the *negative therapeutic reactions* can be attributed to precisely this turning the tables of prosecution. (1987, p. 149)

There are, of course, different ways of confronting such prosecution. Wurmser described in an impressive manner how he has learned to wage such onerous struggles for years with such patients, who seem to be beyond treatment. Among other things, he emphasized flexibility, which

under certain circumstances can include a change in therapists.

Maria X, a 37-year-old woman, complained bitterly in the consultation that, although she had always made an effort to cooperate during her nearly 2-year-long therapy, there had not been any change in her basic problem of being dissatisfied with herself or in her feeling that she was a failure. I inquired about the patient's view of the nature of the therapeutic relationship, and discovered that there were a large number of questions that the patient had not yet dared to ask, especially those that concerned her female analyst as a person. In summary, my impression was that the patient had not received enough encouragement to deal with her negative transference stemming from her relationship to her mother.

In our opinion a diagnosis of a negative therapeutic reaction one-sidedly made the patient responsible for the previous lack of success. The task should be, instead, to determine which interactional reinforcements have led to a situation in which the patient's difficulties can no longer be favorably dealt with. The goal of a renewed attempt at treatment in this case had to be to transform the patient's negativism into an open negative transference.

The procedure of first offering this patient a focal therapy in which the negative aspects of her relationship to the therapist that had previously not been dealt with are made the center of attention took the skepticism of the previous therapist into account in one regard. In another regard, however, the plan was designed to first tackle, as its predetermined goal, the problem of negative maternal transference that the first analyst had correctly described.

Maria X had originally been referred to a department of internal medicine for examination of her high blood pressure of unknown origin. She had suffered from high blood pressure for 11 years, and the somatic examinations revealed that the hypertension was the result of a stenosis of a renal artery. Surgical correction was not recommended. The patient's "dissatisfaction," as she herself referred to her symptom, had also existed for 11 years. She had furthermore suffered from anxiety since puberty; it manifested itself especially in stress situations or in conflicts with persons in positions of authority. A visit to a psychosomatically oriented consultant regarding

her hypertension had led to the initiation of regular analytic psychotherapy. The patient had feared that they might have a negative impact on her relationship to her friend.

The analyst's application for the approval of insurance coverage emphasized, with regard to the psychodynamics of the conflict, the tension that existed between her being closely tied to her mother and the insufficient separation from her, which was accompanied by corresponding reactions of rage and disappointment. Attempts to achieve a separation had led to reactions that were externally inadequate and that in turn were associated with strong feelings of guilt. The patient and therapist agreed upon an analysis of unlimited duration. According to the application, "The fundamental issue of separation and the massive aggressive conflict connected with it make me expect substantial resistance."

After this introductory sketch of the problem we will now reproduce several passages from the therapy in which the behavior that the younger (female) therapist had described manifested itself again, and will try to demonstrate a productive method of dealing with it.

After we had agreed that she would continue treatment with me, I gave her the application form for an extension of insurance payments. The moment the patient picked up the form, she sighed--not loudly, but perceptibly. I drew her attention to this expression of discontent, and she reluctantly answered that she didn't want to fill out such things.

I was impressed by this first demonstration of the behavior that the patient's previous analyst had told me about. In accordance with my understanding of the situation I gave the following interpretation:

A: In your subjective experience it's even too much to fill out a questionnaire you're familiar with. It won't take two minutes, and it's in your own interest; it's worth 6000 marks. The relationship between the real benefit and what it means for your experiencing doesn't coincide, does it? Maybe your sigh contains your wish to be able to stay in paradise, the land of milk and honey.

My attitude toward the patient was not at all unfriendly, rather one of surprise at the paraverbal manner in which she expressed both her dissatisfaction and her listlessness. My comment therefore expressed some sympathy for the patient.

P: Well, I've had to fill in a lot of such forms, starting with the preliminary examinations at the university. At the time I didn't object, although I could have.

A: In this case we're talking about something to your advantage, and you sigh.

While I was saying this, I thought about the fact that her sigh could be a reaction that had become chronic to a feeling that too much was being asked of her, and could reflect a shift in her protests to the level of paraverbal utterances. The sigh would then also fit the distinct feeling she gave me, namely that she dressed tastefully and could act accordingly but that her face nevertheless contained an expression of a gloomy mood, despite her make-up.

P: Yes, I lose control whenever it's a matter of something to my advantage. In the last few days I've become more anxious; at work I have to take over and train a new group.

Proceeding from her comment that her anxieties were stimulated by the increased demands being placed on her knowledge and competence as the person responsible at her firm for further training, I concluded that the patient had a fundamentally self-critical attitude.

A: You may be able to comprehend your anxieties when we deal with the questions of what you are confident you can do and what is expected of you.

The patient then described her school career, which had been disappointing to her. She had failed twice and had to leave high school (*Gymnasium*); she did not explain why she had failed. She had obtained her secondary school degree in an adult education program after she had realized that she was not satisfied with her simple work.

At the next session she sighed as she gave the application back to me. Referring to it, I said, "It's just too much." That was her opinion too. She looked at me, slightly startled that I had made such a direct comment about her mood, grinned a little, but there was no change in her

bad mood.

P: Simply the feeling of having to come to therapy, of having to be here and talk, everything is just too much for me.

A: Then I would like to better understand what *everything* means. Can you mention any examples of how everything changes from being pleasurable to an obligation?

P: Yes, for example, I have to play tennis when the weather is good, or I have to go for a walk. Everything that I want turns into a "You have to do it." When I tell myself today that I want to go to an educational event tomorrow, then tomorrow I'm bound to remember, while I'm in the process of going to it, that it's become another must.

Her pained description made me think of an infant that sometimes wants to say ha and sometimes ho, that doesn't want to (or have to) enter into any obligations. Then I verbalized part of this idea.

A: Your wishes turn into musts, compulsions, the moment you have the feeling that they have become independent, that you have to obey your own wish. You want to be able to say ha or ho at any moment, and without having to fear the consequences.

We then began to speak about her mother, who had had to work a lot, and had talked to herself while she worked, saying "I still have to do this, I have to do that." Her father had tried in vain to tell her mother that she didn't have to keep busy all the time.

I made the interpretation that the patient carried her mother around inside her and acted toward herself as her mother had acted toward herself. She had two sides: one of wishes and one of her conscience, which was very strong. While I was making this detailed interpretation, which I attempted to make emotionally accessible to her, she began to cry. She soon managed to regain her composure. It became clear to me that she was always surprised by her longings to be spoiled and to have her wishes fulfilled, which she otherwise effectively kept under control. After imagining her fantasies and since she had already had a longer therapy, I told her that

this soft, crying side would prefer to be bundled in a blanket on the couch, but that her other side would not permit it.

P: I can't at all imagine lying here and not having to say anything. It's impossible for it to be successful. I wouldn't consider it. I'd feel as if I were even more helpless, I'd feel even more like a patient and inferior to you.

A: Even the idea disturbs you; then it's better to stay in the middle, like Buridan's mule—do you know it? It stood halfway between two bundles of hay and starved. You stay in the middle, in the stagnation that you discovered during your therapy with Dr. B [her previous therapist]. I think the first issue is whether it's at all possible for you to accept the idea that you can turn around if you have the feeling while you're driving here that you have to come.

After a break of a few days, when the patient had a few days off from work, she was furious when she came in because she had not been able in the meantime to free herself of the feeling that she had to do something and that even relaxing had become a must, a bothersome task. The patient gave an example of how it should be. She had gone to bed with a case of the flu and dozed the entire afternoon, and the feeling of being compelled to visit friends in the evening had disappeared completely. She said that this was how it was supposed to be. I emphasized the congruence between her thoughts, feelings, and actions.

The patient then spoke explicitly about a voice inside her that constantly guided and directed her. When she read a book, the voice would tell her that had to read it to the end, ruining all her pleasure. This voice was not a delusion; it was the inexorably impregnated voice of her conscience, which she immediated associated with her mother, who had constantly told her not to do something. At the beginning of school vacation her mother would always say, "Good that you're here; now you can do this or that." The patient's associations clarified why going to bed had been so satisfying; she could just let everything lie where it was, throw her clothes in a corner, and doze.

A: That was a few hours vacation from your watchful and evil conscience.

It soon became clear to me that for her the analyst embodied this internalization. The beginning of the sessions were a regular torment for the patient. The opportunity to speak about what was on her mind her became a demand, a must. She responded to the implication that she could also remain silent if she felt like it by having aggressive doubts.

P: It's just a matter of time until you feel the same way that Dr. B did. In the course of our second year she raised the question of whether I would really benefit from the sessions.

The patient's dilemma consisted in the fact that her own intentional acts unconsciously always had to correspond to her mother's ideas. In this sense, the analytic situation inevitably became a repetition that she countered with a hostile lack of enthusiasm. The primary purpose of her talking in therapy was to satisfy the analyst, which corresponded to the patient's accusation that she had worked hard in the previous therapy, i.e., had fulfilled her mother's expectations. At least her mother had shown her appreciation when she had done something successfully. Yet her deeper, unconscious desire was to receive confirmation *without* having to accomplish something. This was in turn concealed by her strong rivalry to her brother, who was four years older and earned good money as a tax advisor. The consequences of this could be seen in the patient's relationship to her partner. One point of friction was her friend's self-satisfaction; he seemed to be satisfied with himself although he did not earn much money.

The psychogenic underpinning of the patient's lack of self-esteem was strongly reinforced by her physical illness. She was now really threatened by a condition that could be controlled with medication but that in fact could not be overcome.

I managed to weaken the patient's stubborn resistance by trying to avoid certain situations of conflict. If I waited a little longer to respond, there was usually a revival of her disappointment, and any suggestions I made, usually in reference to her momentarily visible mood, helped her to verbalize her difficulties.

She had so many wishes that she wanted to make come true all at once. In her career she wanted to attain a higher qualification, and privately she hoped to read many books. Just when she was deeply engrossed she would be overcome by panic, jump up, and have to go to a bar.

"I want to do so much and don't have any time."

Her pubertal feeling of having lost something subsequently became accessible to her. She had felt that her father did not appreciate her any more because of her poor achievement. There were still many layers of feelings of guilt and shame that had to be worked through before the accusations with which the patient had *successfully* obstructed the first attempt at therapy were diminished.

4.5 Closeness and Homosexuality

Arthur Y enjoyed going to a swimming pool, but felt very inhibited about it. Bathing in the nude, in particular, provided him pleasurable physical sensations, which he felt ashamed of. While discussing this topic in the last session it had dawned on him that I also like to go swimming, which is true although it was not explicitly mentioned. Yet the patient acted as if he had to be ashamed of the special sensation that contact with water, i.e., of his skin with water, gave him. I then startled him very much by drawing his attention to the fact that he had noticed something of my positive attitude to bathing, swimming, and water.

P: I hope it doesn't become apparent now that you also like to go swimming without any trunks, because that's what I thought of, and since I spontaneously thought of it I've wondered whether I could dare to mention it here. So, well, so I'll just say it: Then you're the same bitch that I am.

A: When you and I go swimming, both of us in water, then we're connected, one bugger to another. Your unease probably has something to do with contact.

I switched from the word "bitch," which has various connotations, to "bugger" in an effort to relate the patient's pleasurable experience more closely to its unconscious homosexual components.

P: Then there isn't any distance left between us, and that brings me back to my question of why I'm being so cautious.

The patient spoke again about contact and what we have in common when we swim in the same water.

A: The distance isn't entirely gone; each of us has his own skin, his own border.

P: This conversation is very disagreeable. It just amounts to blurring the distance.

Arthur Y mentioned that in earlier therapies he had found that keeping his distance gave him a sense of security:

P: For the simple reason that I told myself, the larger the distance, the greater the superiority of these analysts and their learning and the better my chances of being cured.

A: But that made you even more inferior, leaving you to hope that the stronger your admiration, the better your chances of getting something would be.

P: But they didn't try hard to change this condition, but maybe I'm not being fair to them.

A: And maintaining the familiar balance also provides relief, even though it is connected with much suffering.

This intervention was a reference to the beginning of the session, when the patient had expressed his concern with the fact that it was not easy for him to break out of or change patterns of behavior formed over decades. The purpose of my "bugger" comment was to raise the conflict to a genetically higher level, from the anal to the phallic.

Some time later this topic was raised again in another context. A scheduled meeting with his boss about a reassignment of responsibilities precipitated a completely irrational disturbance and a worsening of the patient's symptoms. Arthur Y was sure of his boss' respect and sympathy, was superior to his competitors, and led in sales.

P: But I experience it as if I would lose my territory or have to accept substantial limitations. I know that my boss values my opinion and that he accepts me as a partner, yet I still have

the feeling of being helpless, at the mercy of alien forces.

The patient was even afraid that his boss might fire him if he raised any objections. All of his compulsive symptoms and anxieties had grown stronger.

P: I simply have the feeling that I'm not a subject, just an object.

After the patient had provided a detailed description of the objective problems resulting from the proposed realignment of work, it became clear that the rivalry between him and his colleagues would increase because he wanted to extend his area. He wanted to have some compensation for the increased stress that he expected. He had started waking up early, which tormented him. He would lie in bed sweating and afraid of what would happen that day.

P: There is the fear of failure, the anxiety about these fantasies, these compulsive fantasies, they could become so strong that I wouldn't be able to move around normally any more and you could see that something was wrong . . . . Although I have always proven myself in the past 25 years, I'm simply afraid of being nothing, just a picture of misery. It makes me sick. For example, I tried to analyze my agitation myself, to get over the problem. I recalled a teacher from boarding school who almost raped me, and I noticed the horrified feeling I had when his face came close to me, his repulsive mouth and his ugly, protruding buck teeth. It was so on my mind—it must mean something—that I repeatedly thought about blood and slaughtering animals, and I'm so fascinated by pigs. Then I thought of this man, who was probably an unhappy bitch, but in my experience he was a repulsive creature. If I had had the power I might have literally butchered him just like a pig in a slaughterhouse.

One anxiety that this patient had was to end up a sex offender. This anxiety was precipitated by a movie and was linked to the role of a specific actor (see Chap. 9). The patient's associations moved from the teacher to the actor to scenes in the movie. I asked about the similarity between the actor and the teacher, to prepare a transference interpretation. The patient confirmed my assumption.

P: Yes, I realized that while thinking about the whole matter, and it calmed me down so much that I fell asleep, and I told myself that my experience with this man wasn't so terrible after all. I had classmates who said that it wasn't that bad. He only meant well, he only wanted to give us some consolation. Yet I was very afraid of him and somehow have suppressed this fear and not really let it out in the last few years.

A: Something important now is prompting your memories. You've entrusted yourself to me. In connection with your desire to go swimming, especially naked, you've had the thought about me: "That bitch might go swimming naked too and tempt me into physical pleasure."

P: Well, yes [laughing].

A: Here you entrust yourself to me. The relationship could be misused and turn into one . . . too close . . . a homoerotic one . . . two bitches.

P: Yes, yes, that's true. I think I sometimes experience you the same way I did this teacher. Right now that's very clear to me, and it's very unpleasant for me to talk about it.

A: The subject is whether you experience it as something good, without any boundaries being transgressed, only good, not misused.

P: I've often thought, like with the teacher Mr. Benignus [the fictive name used in this treatment], that I was on a certain trail that could lead me to gaining control of my anxieties and overcoming them. And such comments, like that I experience you the same way I did him, irritate me. They make me feel insecure and anxious. Because if it were to turn out that you are really like he was, then I would be at your mercy just like I was then.

A: No, you wouldn't, because you're not as dependent on me as you were on your teacher. You're in a completely different situation. It still sounds a little as if you were just as dependent and couldn't bash my teeth down my throat and expose me to be a bitch and lead me to the slaughterhouse.

Arthur Y then described in very vivid and expressive terms the teacher's unshaven face and how it had scratched him. First he developed fantasies about how he could stick a knife into his fat neck and let the air out. The first manifestations of his neurotic anxieties occurred in connection with these experiences, both temporally and thematically, as the patient related at the end of this session.

P: When I was about 12 or 13 years old and read in a detective story that a man died after being stabbed in the back, I was terribly afraid that the same thing could happen to me. I tore up the book, threw it in the toilet, and flushed it down. It must have been around the time when I had the problems with the teacher. Then it went away again, this anxiety. Perhaps I felt I was a bitch as well, and maybe I even had an impulse to, well, how should I say it, to somehow give myself to this man, if not in this way. But all of that was years ago and shouldn't keep me as preoccupied as in the last few days. Well, the feeling was just horrible.

A: Yes, that was a long time ago. The subject was revived by the therapy, by your coming here, namely the subject of, well, how you will come to terms with another man. Are you still the small, dependent boy who can't defend himself? Are you loved only if you subjugate yourself? Or can you express your doubts, your dissatisfaction, or demand something?

Commentary. As the phrasing of the interpretation shows, the analyst emphasized the revival of old problems in transference. The questions he raised contained an indirect encouragement for the patient to critically examine past and present relationships. He suggested answers that enabled the patient to establish some distance and thus to have a new experience in his present interpersonal relationship to the analyst. In this sense many interpretations contain a suggestive component, which however is very different from the obvious attempts at persuasion that gave suggestion such a bad name. The stimuli contained in psychoanalytic interpretations are not at the level of persuasion. As we explain in Vol.1, the patient is encouraged to make his current experiences the starting point for critical reflection.

4.6 Resistance and the Security Principle

In this section in Vol.1 we attribute identity resistance and the security principle a comprehensive function exceeding that in Erikson's definition. At the descriptive level they resemble narcissistic defense. Yet while the latter concept is embedded in the untenable economic principle, the concept of identity resistance belongs in a comprehensive theoretical framework that takes the results of modern social psychological research on the development of the ego and self-esteem into consideration without neglecting the significance of sexual gratification for personal identity. In contrast to Erikson's integrative theory, Kohut viewed the development of the self and the drives as separate processes, and despite his later modification of his self psychology this view leads to inconsistencies within his system and does not do justice to human life. The process of satisfying various kinds of needs leads to the development of security and self-esteem.

A strong identity resistance can be observed in all patients who do not accept the fact that they are ill and, subsequently, do not desire to be treated. The circumstances are then reversed: those near the patient suffer and attempt to convince the recalcitrant relative that something has to be done. Yet how can you convince someone who is apparently satisfied with himself and in fact thinks he is healthy—but is considered by those around him to be ill and crazy—that he should try a therapy that in his view would at the most lead to change he does not desire?

Identity resistance represents the triumph of the human capacity for self-assertion at any price, even at that of negating the principle of biological self-preservation. Perhaps it was rather in passing that Freud (1940a) attributed the ego not only the task of *self-preservation* , as he had previously, but also that of *self-assertion* . (This difference is eliminated in the *Standard Edition* because Strachey translated each of the German words—*Selbsterhaltung* and *Selbstbehauptung* —as self-preservation.) This human capacity is the precondition for anyone assigning a higher value to self-assertion in the achievement of ideals than in the preservation of one's own life and sacrificing oneself for a good cause. This is the result of decisions rooted in the freedom of the

individual. The situation is different in the cases of self-assertion found in identity resistance; here there are good reasons for assuming that the individual is unfree even though he rejects the notion that he is ill, unfree, and in need of help.

Identity resistance and the security principle pose numerous ethical and philosophical problems as well as serious questions of analytic technique. Who gives us the right to attempt a therapy of someone who at the most only half-heartedly considers himself a patient? We are faced with the dilemma that treatment is even less possible that it is otherwise, for example, to unintentionally analyze someone with anorexia and to refrain from active interventions if self-preservation has reached its limits and death seems imminent. Particularly the therapy of anorexia nervosa confronts analysts with problems that seem hopeless. This dilemma results in complete paralysis; Kierkegaard referred to it in his religious philosophical interpretation as "illness unto death." From a psychoanalytic perspective it is possible to localize despair, as the manifestation of illness unto death, in the self. In doing so we attribute a psychodynamic meaning to Kierkegaard's (1957, p. 8) sentence: "Despairing of not wanting to be yourself; despairing of wanting to be yourself." This contrast characterizes a dilemma that dominates many people. Chronic anorexics especially impress their environment with the decisiveness with which they hold on to their very idiosyncratic selves. The therapist becomes the source of temptation, who attempts to make a self image available that arouses their own resistance. The despair does not transpire between two self images but between the individual and his environment. Thus how can we use psychoanalytic means to intervene in a dilemma and struggle with female patients who for years have made their cachexic body image their second but true nature and who view the analyst as a troublemaker? In these cases identity resistance is literally linked with a balance that has an inertia of its own after years or decades of constancy: this identity has become second nature.

Clara X brought the copy of Rosetti's painting The Annunciation that she had painted to the 427th session; this painting had impressed her for a long time. The Maria is almost

cachexic. That the copy is a kind of self image can be seen in the addition to the signature, Maria the Anorexic. Clara described the junction she was at: she was still sitting there (like Maria) and was indecisive.

Her thoughts still revolved around the image of a fairy sitting at the junction to point her in the right direction.

A: Give the fairy a chance, all the fairies sitting there-and yourself too.

P: One evening recently I saw the fairy sitting there and myself still burdened with the same habits. The fairy smiled, half amused, half disconcerted, asking "Why are you doing that?" I have to move around to get tired, in order to fall asleep and stay close to the fairy. The fairy said there was a real mountain of mush, like around the land of milk and honey, and that I would have to eat my way through it.

Clara X exhibited all the signs of revulsion.

I considered the picture to be an expression of the struggle we were having at this junction. Clara viewed my allusion to a struggle as an opponent, without describing it more closely.

Struggle was a subject that had played a important role from the beginning. The fact that I had predicted in the first interview that there would probably be a hard struggle had made Clara X angry. The struggle had become more intense in the last few weeks and months and had taken on the form of the patient's image of a junction. A good fairy was part of this metaphor; it was a maternal transference figure, and the patient wanted to stay at its bosom. Yet it also had the function of leading her away from the anorexia, which had become her second nature.

My interest in her self-representation was thus concerned with her struggle to maintain her previous identity and now, at the junction, with her attempt to make a new beginning. Its immediate relevance could be seen in the fact that the patient first interrupted me when I

repeated the sentence "Now that will . . .," saying "Hum," and after I had completed my sentence ending "be a hard struggle" she continued:

P: Yes, I thought of that again this morning too. I'd like to know who is going to struggle against . . . .

A: Hum.

P: And I don't really want to have to struggle with myself. Just against some parts of me. Right now that's funny. I've accepted the idea that I have to try to eat more during the day, and I do. Usually it turns out that I want to eat some cake. I buy something in the bakery, but then I immediately have the feeling that it's not really the right thing. Cake isn't the most nutritional food. And so my wanting to eat cake doesn't make me feel quite right. I used to solve the problem by not even thinking about food during the day. I kept my head free for other things, something that is frequently reported in the literature on anorexia, which I always read with mixed feelings . . . with great interest. I had gotten over the phase in which my thoughts constantly revolved around food, as is the case for many anorexics and which I think is pretty degrading.

It is true that the feeling of being hungry changes in severe and chronic cases, enabling some patients to achieve the condition that the patient just described with the words that she "kept her head free for other things." She had managed to limit the times and places at which she satisfied her feeling of being hungry, restricting it primarily to eating cookies at night.

It seemed natural for me to draw Clara X's attention to the difficulty that arose when she attempted to modify her behavior. She experienced the fact that she now had to concern herself more with food and everything associated with it to be degrading.

P: Then I quickly get to the point that I think too much about my household and shopping. Nonsense. There are other things that are more interesting and more satisfying. Yes, right now I'm asking myself, hm, whether I should take something along from home for a snack or buy something, and what I should eat and what I should give to Fransziska [her

daughter] to take along? I can make big decisions out of these questions and let my indecisive anguishing between yes and no and good and evil go unchecked in this small matter. But then I've had enough of it again; yet why shouldn't I attempt to want to eat and to enjoy it? Yesterday morning I was at the point of thinking "Hum, . . . " but then it was gone again.

A: Yes, inner necessity is important in such changes. You know that the feelings of being hungry and wanting to eat can change. You apparently used to be very free, but in contrast to you I think this freedom was only apparent. However, it was an excellent way to get past a lot of things. Getting started is very difficult.

P: Yes, an apparent freedom. I really wonder whether I can get used to simply eating at certain times. Just thinking about it makes me feel bad. I've at least made an effort to eat something during the day. That's why I was really a little baffled to have lost a little weight. Is it the fear of craving something or what? On the other hand, I really have a very positive feeling toward life and feel like doing something again and want to get up in the morning. My condition last year—you're sure to remember it, as I thought that everything around me was dreary and boring—is a thing of the past.

The patient then described her hectic daily routine as housewife and mother. She was very unhappy with these tasks. "Now home to the jail, make something to eat, put the kid to bed, and then I feel jailed in." Her detailed description ended with her telling me about her incredibly hectic manner, which pushed her and made her be unfriendly and impatient.

Then she related a wonderful daydream, which might be viewed as a sign that with the help of a good fairy which she herself had invented she could follow a different path to find a modified identity. At the center of her story was her mother, who had a lot of time, waited for the children to come home, and had harmonious and close ties to them. She described a day with her mother as if it were in a fairy tale. Clara X doubted whether I, as a man, could understand her almost timeless happiness. She was outraged by punctuality and regularity and by the rhythm she had to keep in her household.

P: Bum, bum, bum, my husband would like to have everything done at home just like it is in the factory. His expectations provoke strong feelings of dislike and anxiety in me. I can't express it in words, and I think you don't understand it. It's terrible.

A: I think I can understand it, but it's logical that you are skeptical because I live here close to bum bum. Daily schedule, time. If my schedule says the session is over, then that's how it is; it's a disturbance that doesn't correspond to the daydream. Letting punctuality be imposed from outside is disturbing if we contrast it to this enjoyable image.

P: What, do you think that my fantasies are really only related to the beginning and end of the sessions up here. That is . . . .

A: Yes, that was a little hop, skip, and jump. I wasn't only thinking about the beginning and the end; in between there's a lot that can be done. No, I was only thinking of this one hop, toward the end of the session. I mentioned a parallel to one tiny point, the interruption at the end of the session. Whether it's true is something else.

Excerpts from later sessions show how difficult it was for Clara X to form another image of herself. It wasn't possible for me to be as unintentional as she wanted me to be. In any case, a comparison I drew between another, beautiful picture that the patient had painted and her reality greatly offended her.

She thought her body and appearance were ideal. She was afraid of being like a stuffed goose and not being able to slip "through the bars of her prison."

I raised the question of why she had formed the repulsive image of the stuffed goose. She emphasized that the sore point was the prison. She doubted whether any man could really understand how a woman could experience the role of housewife to be a prison.

A: By staying skinny you're really expressing your aversion to your marriage. And in the process you're also struggling against your chocolate coating.

The patient had introduced this ambiguous term, and ever since it was used to refer to her

sweet side, both in a literal and metaphorical sense of the word. Clara X made external circumstances responsible for the fact that it was impossible for her to make her chocolate coating, i.e., her sweet and tender longing, come true, which tied her all the more to her nightly "orgies." The patient satisfied the hunger she suppressed during the day by eating large amounts of candy at night when she was half asleep, and managed in this way to at least keep her substantially reduced weight constant. These typical night-eating binges, to use an expression Stunkard (1986) introduced, can also serve as a substitute satisfaction. And the patient did in fact claim that her husband was partly responsible for the continuance of her illness because he overlooked the tender and feminine side in her Death skeleton.

I explicitly acknowledged the realistic component of her difficulties. Furthermore, I told her that being rejected and offended in the guise of Death had apparently also led her to employ her condition as a weapon. This was a special form of *self-assertion* she had cherished for a long time. Any modification would lead her to look more pleasant and no longer be a skin and bones. She would lose the identity she had developed in the course of decades and be more pleased with herself. She would then be like Sleeping Beauty [in German, thorn rose] but without the thorns, beautiful to look at, because she had also painted the picture. "If you permit me to say so, I like Sleeping Beauty too."

Consideration. I alluded to a very impressive water color that the patient had given me some time earlier. The circular painting shows girls interwoven in the shape of a rose, and the use of color emphasizes their breasts. The cautious manner in which I expressed myself might seem exaggerated, but caution was called for. The patient's sensitivity was demonstrated by events later in the session and by which ones she remembered and retained. I let myself be led into contrasting the rose woman with the repulsive image of Death that Clara X had described, without at the time taking into consideration that it makes a difference whether a patient uses a negative self-image to refer to himself, or whether the analyst employs the same expression. The fact that two people do the same thing does not make it the same.

Clara X referred to her paintings throughout analysis. They were frequently related to

topics we had discussed, but frequently also provided insights into unknown aspects of her experiencing. They were self-representations that vividly expressed her inner condition. The following excerpt makes it clear that painting and making presents of her pictures naturally also had a communicative function for her. I attempted to use them as a means to influence her inner life and vivid imaging. We have thus returned to the decisive question: What can the analyst do to facilitate change?

P: I don't even want my husband to see this picture. I painted it when he couldn't see it, and then rolled it up. Because I have the feeling that in his opinion it might be repulsive.

A: But perhaps you were also afraid that he would make some comment. Maybe he would have made some comparisons.

P: He might have said, "Are you completely crazy? Now you've started painting naked women."

I asked in an empathic manner about her fears of being hurt. Maybe that was the reason she had the idea that a female analyst would understand her better—from woman to woman, from Sleeping Beauty to Sleeping Beauty.

The patient began the next session by making the observation that she was upset. "You compared me, the picture of Death, with my own picture of the rose woman." She said she did not like comparisons; they were typical educational tools. "My parents say, `At your age I was already able to do this and that.' It hurts to be compared."

A: But what is it that hurts? That you are also the rose woman?

P: That you prefer the rose woman.

A: Yes, yes, the comparison reminded you of what's missing, of the deficit.

P: No, the point is that you're posing conditions. I felt your wish, or request or question, and it seemed very ungentlemanly. "Could you bring the picture along once more, so that I can make a copy of it? I don't have one. I gave it to you." Demanding something back like this

isn't right. There's a little spite involved: "But it's my picture!"

The patient emphasized this again:

P: There is some spite involved: "But it's my picture!" There's some piggishness involved in saying, "If the oldster uses the picture like that, then I at least want to have something from it."

A: Wonderful, hum. So that it can't be used against you anymore. You experience it as if I used it against you, and now it could be that if you had a copy, then you could also use it for yourself, and it wouldn't be so one-sided. And I didn't experience your giving it to me as a formal cession. I view it as a picture between you and me, not as my possession. I see it as your picture of yourself and also as the ideal you have of yourself.

P: It has both parts, but the moment I gave it to you—it makes me happy if you accept it—it was meant as a present. [Long pause] At the moment I don't have the feeling that the picture could represent an ideal for me.

A: And at the moment you have a strong feeling that people don't like you the way you are, and it's terrible when people set conditions. Yet it wouldn't be rejection if looking different made you more pleasing. And I assume that you like your chocolate side better than your ascetic one, too. I also relate what you said about yourself to me. But I'm powerless.

P: It's not true that you can't do anything. You act as if none of your words fall on fertile ground.

A: Well, I can't do anything unless you accept something. And one thing it depends on is whether I can offer it to you bite size. But when it is too bite size, it gets difficult again. It really is a hard struggle, but I do think that you are enormously fertile ground and could be even more fertile. What would happen if you gave up some of your power and discovered that it wasn't a loss of power but an increase in a different kind of power? You can certainly feel that there is power in your picture, in your Sleeping Beauty. Of course, you'd be more sensitive and more sentimental about having needs and showing them when they aren't

noticed, recognized, or satisfied. That's bad.

Consideration. Here I made the patient aware of my countertransference (see Sect. 3.4). Telling the patient about a mood precipitated by his behavior can have a therapeutic function, as can be seen in Clara X's reaction. Letting her participate in my countertransference had the effect of serving as an anchor for both of us. I knew and could somehow sense that precisely my open and honest admission of being powerless would mobilize the opposite attitude in the patient. Clara X was really not looking for a powerless, castrated man, otherwise she would remain infertile too. The therapeutic problem consisted in putting the fertile elements into such bite-size pieces that words and deeds would be equated with life, not with terrible elements and ultimately with death. Transforming the destructive no into a constructive yes to life means acknowledging biological rhythms and temporality. Although being able to say no belongs to human nature, no mortal who says no in a destructive manner has ever fallen from heaven. Regardless of what philosophers and theologists have to say about the constructive significance of negation, arduous psychoanalytic investigations are necessary to be able to understand and explain the development of pathological negativism. It is the self-destructive form of one's own aggression, and also denies that the "object" is affected. This enables anorexics and other pathological nay sayers to deny the mortal danger they are in. The perception of the danger must be rediscovered in transference.

P: [After a long pause] That sounds convincing. But I can't really imagine that it's true.

A: It's nice that it at least sounds convincing. In that moment neither of us has power over the other. It's true that I mentioned it, but by finding it convincing you have annexed it, have incorporated it. For a moment we're in agreement. Of course, it can always be ridiculed; somebody might say that there are nicer things.

P: I wasn't thinking of that just now. It's such a nice feeling that I can't believe it. It just can't be true. There are three buts, five ifs, and five other conditions just waiting around the next corner; they are not mentioned right now, but they're there.

The patient referred to an earlier comparison with porcupines.

A: The feeling of being in agreement contained a barb, as if I weren't satisfied with the agreement itself and wanted to have an immediate success.

P: I cannot imagine that you're satisfied with a momentary agreement.

A: Yes, I think that nobody is entirely satisfied with one. You would also like to have more, but don't dare to make the moments last longer. Your dissatisfaction comes to you from outside then: I want more, not you.

Commentary. The analyst made too great an effort to achieve a change. Just like in the proverb, the result was just to disgruntle the patient. Clara X criticized his "educational" goals, which points to the fact that the analyst apparently did not have much confidence in the patient's other self. Otherwise he would not have given her so much encouragement, even if indirectly. The analyst's admission of powerlessness was apparently also made with the therapeutic intention of motivating Clara X to reflect on her strengths and of helping ease the sacrifice. In short, there is more to an identity resistance that has formed over twenty years than meets the eye.