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Inner Emigration

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> Wikipedia informs us about the origin and meaning of the term "inner emigration":
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> "Inner emigration is a controversial term used to describe the situation of German writers who were opposed to Nazism yet chose to remain in Germany after the Nazis seized power in 1933. The term was coined by Frank Thiess in his response to Thomas Mann's BBC broadcast on the subject of German guilt" (Wikipedia, 2018).

The term's definition and the moral issues surrounding it have long been a subject of debate. Some argue that certain writers who stayed behind in Germany subtly criticised the Nazi regime, allegorically or by implication, while others contend that such criticisms were "so subtle that they are invisible". The debate is further complicated by the varying degrees to which different writers were under threat, and the varying strength and nature of their protests. Some writers who claimed to be "inner emigrants" appear to have done quite well for themselves during the war, while others saw their works banned or were imprisoned.

I encountered such states of inner emigration when first visiting young psychologists in Moscow in 1992 that for a number of years had formed a private discussion circle studying psychoanalytic texts. Not that they were in a life threatening situation, but their retreat from public life and especially their retreat from material goals was obvious. The best way to survive psychologically was to be absorbed in inner personal spheres like poetry, or, in this case, psychoanalysis, as the representation of a world one wanted to live in.

Another encounter with the expression "inner emigration" happened while I was working with my colleague Anna Buchheim, who for some years studied all my patients with the Adult Attachment Interview. One of these patients used the term "inner emigration" to describe her situation as a lonely child.

The clinical material[1]

This patient, a fifty-year-old female teacher working at a gymnasium, had asked to consult me as Head of the Psychotherapy Department at the university. Before the first appointment I received a carefully typed long letter describing not only her complaints, but also excerpts from psychoanalytic publications. The patient's accompanying comments contained her self-diagnosed psychodynamic issues.

At the initial interview, I met a clear thinking, politically well-educated middle-aged, good looking woman, who kept a watchful eye on me along with her demanding friendliness. She had selected me, she said, as an expert who was known to her by the Ulm textbook on psychoanalytic therapy. Her next move, however, was letting me know that the psychometric forms she had been asked to fill out before the interview were a disgrace. As all patients get a running number for archival reasons, she had annotated the formal questionnaire forms with wild out-off-the-mark devaluating remarks, such as "where are we – is this a concentration camp?" She regarded filling out the forms as an "act of rape". She thus made it clear that she was the person to run the show.

She then continued the interview by saying she would be looking for a therapist who would accompany her and be able to help her to master a "life problem". With this she refers to an endangerment that had happened to her after a first unilateral break-off by a lover. "*It really crashed me down, you know. The very moment I gave in to his seductive moves, I was on the needle and he let me drop"*. She then was very precise in specifying that such a vulnerability only would be possible in an intimate relationship. "*You know, usually in work and everyday social relationship I can handle situations very well. We met as we shared a preference for a rare kind of musical instrumentation. Originally, I was not inclined to get involved with this guy; but he kept trying, charming me and go so I finally gave in."*

The moment she gave in, meaning that she slept with him, he no longer was really available. Not by phone, not by letters. What had started as a joint, shared artistic company had turned into a nightmare. Her desperate fights to get at least his voice on the phone left her feeling crazy.

She then described how she developed a state of intractable psychic pain that started in the weeks after her desertion and continued since then speaking of by now ten years! She knew it was "unresolved anger" but also sadness and sorrow about being caught in a

[1] The patient has allowed to use this material.

sadomasochistic trap. “I also criticise myself for not having been cautious enough. I should have known better”.

Her painful mental state and manifold somatic correlates had been slightly mitigated by a five-year-long, once-a-week supportive psychotherapy with a supportive elderly female therapist. This therapy had helped her to control her suicidal ideation. However, from time to time, she returned to stating that “if this feeling can’t be changed I’m going to kill myself. But when this happens I shall take two or three other persons with me.”

Her intense, easily activated anger was directed at her ex-lover and two chiefs of psychotherapeutic hospitals that had treated her. In her point of view, both of them had maltreated her. She had filed a law suit against one of them and achieved a reimbursement of 50% of the bill for his not doing his job properly. This was a rare clinical situation; countertransference feelings are easy to imagine: the patient that menaces one with either including you in extended suicide or at least going to court.

My involvement in the initial interview quite soon contained a heroic mixture of scepticism and curiosity. She made me curious by her very emotional statements such as, “never use the term transference and never talk about my father or mother. Whenever when I hear those words, I get sick.”

On the other hand, being attracted by the Ulm textbook on psychoanalytic therapy and being an academically-trained person, she must have known what non-sensical demand she opted for. Coming to a psychoanalyst without talking about father or mother! It was a power play; clearly, she wanted to re-install the sadomasochistic interaction and she needed me as a narcissistic extension to stabilise her grandiosity.

The diagnosis of a narcissistic personality disorder with a borderline organisation structure was based on her intense angry responses to her intimate partners accompanied with intense states of inner emptiness. Situations of loss of control led to rapid interruptions of relationships – a capacity that in her late successful career as a local politician was of great use.

She accepted a psychoanalytic therapy twice a week in a face-to-face setting – a more intensive treatment what I had wished for was out of question for her.

Her positive resources consisted of a creative altruism and a capacity for adaption and work. Helping weak pupils in school, or poor female employees in the local government exposed her talent for identification with all victimised people.

The dynamics of the initial interview so far reflected her written self-description as having been traumatised early in her life but having managed well for a considerable period.

Since childhood she suffered from a fear of darkness, a symptom I learned about later in treatment.

Stemming from a small village where she and her parents were living with the maternal grandparents, she must have encountered substantial carelessness from her mother, while the father was working in a nearby city, coming home late in the evening. In many sessions she would detail what this meant. "*We were poor but never so poor that the mother could not have cared for her little girl's clothing*". Therefore, no birthday parties were provided for her, nor was she invited to other girls' parties. The best moments she remembers as a child were her being alone with a shepherd dog in the meadows. She had to walk quite a bit to school, but these long walks only strengthened her self-reliance. The role of a brother ten years her senior remained unclear for long stretches of our work; later she could clarify that at least the relationship with him improved when he met her husband with whom he could share private activities.

A definite positive experience in these early years was her maternal grandfather who allowed her to use the old piano play children's tunes. He would tell her fairy tales.

Her development in puberty and adolescence was clearly dominated by her growing self-reliance and independence. More a tomboy than a girl, she felt well and socially competent and always had excellent marks at school. She decided on her own to give up her church denomination – an option offered to all young people aged 16 – and get involved in local politics; although she does not recount whether it was supported by her father or not. Only after his death did she find out that he had been a member of the Social-Democratic Party. And it was only then that she could remember that he took her to Sunday morning political meetings when she was little.

She studied political science and the German language and became a teacher in a regional town close to her home village. As a student, she married a colleague, ten years her senior, who also taught at the school where she would later work as a teacher. How they got involved is a moving story: they joined an excursion to the Berlin wall and when the bus stopped "we were the last two to leave it". One version could have been that the two young people were already engaging in some flirtatious actions, but her version was to comment that they both were deserted children: emigrated to a nowhere land. Remembering the sad atmosphere in front of the wall, this statement was truly telling.

The very fact that she was married did not seem to play an important role in the drama she offered to me. She shared musical talent with her timid-anxious husband, but she developed to a level of semi-professional competence. For many years she and her husband

lived in a relative social and intimate stability. They engaged in little sexual activity with her being always the initiating partner. Yet, based on her growing dissatisfaction, their stability as couple was gradually undermined, and she began to engage successfully in local politics and in her life-changing affair.

The patient had paid for her former treatment out of her own pocket in order to maintain an illusion of being a "non-patient". Although for practical reasons, we all prefer private payment, I insisted on the formal procedure of insurance coverage to which she was entitled in order not to facilitate her disavowal of not being a patient. Reviewing this decision from now I might have allowed the patient this token of autonomy as she constantly sought and found ways of demonstrating her power in her relationship with me.

The treatment was complicated right from the beginning. A stabile therapeutic alliance or an observing and experiencing ego was hard to realise. The rapidly generated intense idealisation of my "superb technical qualities" would suddenly be ruptured by psychic depressive breakdowns stirred by comments she regarded as unsuitable. After such sessions, she would send me a fax threatening never to come back. With the help of ensuing telephone conversations about what happened, we survived many crises and slowly achieved a more stable therapeutic alliance. Ruptures of therapeutic alliances have recently become a prime topic in the field of psychotherapy research, and indeed I learned a lot on how to handle such ruptures.

The therapeutic process was characterised by ups and downs that resulted from rapid changes of identifications. Sudden primitive defences of splitting all-good and all-bad from one moment to another caused a breakup of her psychic capacity for integration. The same process took place in her bodily complaints of intractable somatic pains that could disappear at once when the therapeutic relationship had been restabilised.

Therapeutic work – apart from time and again re-establishing the working alliance – mainly focused on the current relationship to her mother. She was taking care of this 81-year- old demanding lady, who still could not find any positive features in her daughter. By and by, the biographical perspective on the mother-daughter relationship opened way to help the patient work through her unconscious masochistic involvement in the repeated efforts to get support and recognition from her mother.

Only after 18 months in treatment where we again and again talked about the importance of her musical abilities and the support she had experienced by a female music teacher later in her time as student was she able to bring in specific materials concerning the abuse. As a child, her father returning from work would often terrify her in the dark, which

she always connected to her being very frightful, even until the present day if someone approaches her from behind. It seemed likely to assume some sort of a rough paternal infringement, although I could never substantiate it by any clinical material.

However, she finally reported a situation with a musical teacher when she was twelve. Her mother had insisted to go to this church musician in a local village whereas she had preferred to attend lessons by another teacher She didn't like the church teacher from the start. But when he sexually molested her, she could not talk about it to her mother – let alone to her father.

After two years, the patient's state had considerably changed. Instead of continuously looking for the badness of the world, and especially that of her mother, she had reached a sort of thoughtfulness, what may be looked at as an increase in the self-reflective function. Now she could observe that whenever my words did not conform to her ideas, she would get furious and helpless. We could differentiate her and her mother's part in the relationship, and she decided to accept the help of a geriatric service for the mother. She understood that some moments of self-caring did alleviate the job of caring for the mother, like listening to music beforehand.

The concept of transference in terms of her lifelong experiences made it possible to understand her experience of – in her reading – my maltreating her. Her sense of powerlessness as her core experience became well-identifiable. References to her father remained rare. In these first two years, she denied any connections with this unknown person, but then the denied father-imago entered the treatment via a troublesome transference enactment. She mentioned a dream in which a strange person appeared looking like a fatherly figure. I tried a transference interpretation: maybe your father is alive in the presence. The patient snapped at me: "you are a traitor, you are the companion of Dr. Buchheim" and quitted the treatment. What had happened?

After six months in treatment I had asked the patient to take part in an Adult Attachment Interview performed by my colleague Anna Buchheim, as this was a newly-established line of research at our department. Obviously, the patient had experienced my working relationship with my female colleague as a threat to her fantasised relationship with me.

The Adult Attachment Interview of the Patient[2]

[2] I am grateful to Prof. A. Buchheim for allowing to use the material of the AAI which she

She was classified as preoccupied and additionally with an unresolved state of mind regarding the loss and the trauma. In the following section, I will present parts of the AAI-transcript to clarify the coding procedure:

The Transcript Example: A Preoccupied State of Mind

I: hmm hm how would you describe the relationship to your parents, your mother and father, when you were a child?

P: -- hm- this long silence says a lot (laughs), I couldn't rely on them, I couldn't rely on them, never.

I: hmhm

P: I still can't, my mother needs to be cared for today, and other people have to coordinate with me all the time, the neighbours and the social institution, they have to check if she is lying or not; these are experiences with her, I would say "aggressive caregiving"; I was not able to be ill, and when I was ill, then, these teas, I didn't like, that's why I haven't been able to drink these herbal teas up to now, just without sugar, something like that; hmm… being ill was really a mess for me, hot potatoes around my neck; hmm.. I would say aggressive caregiving, I tried to be healthy again as fast as possible, today I can be more generous with myself in that case very slowly, being ill, but that costed me many years, with my father I didn't have a good relationship either, I can't report something positive, very little, my mother always told my father what I did wrong, she did that probably also with my ten year older brother; she would tell my father, and when he'd come back in the evening, he'd hit us, something like that; it just happened yesterday, two weeks ago I got frightened; he always scared me when I was a child, I still suffer of that, it happens often today that I get frightened when somebody is in the same room, though I know who is present. I don't have any feeling of security, and I always thought, some day we will have a breakdown and my father will be unemployed; he was popular in his job but as a child I always had that feeling that everything can fall apart very fast and I worked in early years, also in the holidays, and tried to earn some money; I always had the feeling there was no security, nothing to rely on.

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performed.

This passage shows that the patient is still struggling with her past and she could not present an objective picture of her childhood experiences. She accuses her mother in an angry manner and oscillates between the past and the present. She is scared by her father, and still suffers from a stable insecure feeling. She does not provide a coherent speech, often loses track, and gives too much information. She violates the criteria of quantity and relevance.

In the AAI the patient indicates her unresolved state of mind by showing: a. she denied being abused (hitting) by her mother, b. she forgot the day when her father was dying.

Transcript – an Example: The Unresolved State of Mind with Respect to Abuse

I: Have you ever felt being threatened by your parents when you were a child?

P: no, being threatened, no I didn't feel like that, I can remember that I always thought, when I felt too bad, I could commit suicide, hmm… this change, when my mother would hit me, I thought she was hitting me to death, when I would came home too late; I had a lot of anxiety, to be hit like that, but when it happened I thought I would survive, that was the feeling I told you before, this kind of inner emigration; death was never scary for me but a solution in a way.

The patient shows a logical contradiction when being asked about any abuse in childhood. She oscillates between memories of having enormous anxiety, when her mother hit her, and a disbelief that she felt threatened by that. She is judging death simultaneously as a solution and a terrifying event. Crucial criteria for the coding-procedure is, that she does not remark on this contradiction by herself, which highlights the unresolved process.

The Perspective

Summarising the main characteristics of the patient in the AAI, I will introduce some convergent and divergent aspects of the attachment and psychoanalytic perspective. The procedure followed was: the attachment researcher (A.B.) gave her "AAI-diagnosis" and I commented on these summaries from my clinical perspective:

AAI-Characteristics of the Patient

She often accuses her mother in an angry manner "I couldn't trust my mother, until now", "it was aggressive caregiving", "I still suffer", "I could cry thinking about

it".

She remembers only negative adjectives with respect to the relationship to her parents in childhood "not understanding", "not honest", "torturing".

My Comments:

"As an analyst I am really not satisfied with this finding. Although it is true that the exclusive focus on the negative aspects of relationships has been one of the patient's main attitude towards specific objects, it is surprising and calls attention to the need for the analyst to find where and how she hides her positive longings. She does it by vicarious identification, that is, by acting in a caregiving way to pupils or to the daughter of her brother. Hence, she unconsciously identifies with the objects of her benevolent treatment."

She often violates the criteria of coherence (quantity, quality)

My Comments:

"This feature of incoherence seems very dominant in the verbal exchange at times when our working alliance has been endangered. Then the sophisticated person she can be all of a sudden turns into a menacing angry woman who talks too much and displays little logic."

She is often not able to find an adequate distance from the immediacy of her experiences; "I can't make peace with my experiences, though I feel a change".

My Comments:

"My approach entails the question of the functional value of her not being able to make peace. As an analyst I ask myself: At the present moment, is it good for her to confront me with my inability to help her to find peace?"

She is oscillating between past and present memories, with little differentiation between the past and the present.

My Comments:

"The AAI finding made me more aware of this peculiarity of style of discourse organisation; maybe as clinicians we tend to downplay or disregard this, as it happens so often in our work. I have learned that colloquial style may be more indicative of pathology

than has been usually assumed."

> She is not really able to reflect or to mentalize in an objective or forgiving manner; rather she shows a pseudo-psychological analysis of her childhood experiences, e g. with the term "inner emigration".

My Comments:

"The pseudo-psychological style appears to me to be a feature of her long time struggle to accommodate to her early experience by using later devices, for example borrowing from her studies in politics where "inner emigration" was an important expression. From my point of view it could be a capacity for use of the metaphor that has helped to mentalize experiences in her way."

> She speaks of a role-reversal: "my mother was a neglected child, I had to care for her. She abused me as a parent-like object."

My Comments:

"From my perspective, these are the products of 'sub-optimal' solutions the patient has found; it was part of my task to help her undo the role reversal and to accept that she might want to be cared for too."

> She denies being abused by her mother (hitting) and she forgets the death of her father (unresolved state of mind).

My Comments:

"The role of the father is still quite opaque. Here the AAI helps to understand the power of her denial concerning the father. By now I learned from her that only after her father's death did she discover that he also had been politically active. Using this information in the treatment as the first step of clarifying that she might have something in common with him opened up a new phase in the yet open-ended treatment."

Looking at the commentaries, I have a consistent *divergent approach* in treating the patient's tendency to evaluate parental objects in a negative manner and in estimating her capacity to reflect. I give less weight to anger and aggression toward her mother. I focus

more on her positive identifications and interpret her inability to make peace with her mother in a functional context. In the clinical material I describe, my difficulty was "holding" this preoccupied individual in treatment. Obviously, my attitude in tolerating her aggressive states of mind, and in searching for her strengths and resources, had an important impact on establishing a secure base.

When AAI-criteria gave hints of the pseudo-psychological style that characterises preoccupied subjects, I regarded her strategy of distancing as largely adaptive in the psychodynamic context. From the attachment perspective, persons are judged as "hyper-analytical" when "the subject comes across as psychologically-minded but in studying the narrative his/her reflections are mostly irrelevant to the task ... the transcript reflects a state of affairs where the search for insight is quite compulsive, yet unproductive. This description fits the patient's way of reflecting her experience in an 'overproductive manner'". But this also shows that we have to assume that the semi-structured interview situation produces other tasks than the therapeutic one does, and, moreover, the criteria of coherence or self-reflective function might be "too strict" for clinical subjects.

Nevertheless, the advantage of the AAI-procedure lies in its careful analysis of single expressions, the focus on logical contradictions, and on the subject's cooperation in producing and reflecting the attachment-relevant topics. In the AAI, the patient's negative affects preoccupied her attention and "disturbed" her capacity for cooperative principles. I agree that the patient showed unpredictable oscillations in the transference relationship as well. The AAI criteria confirmed my awareness of her sudden changes between the all-good and the all-bad, the past and the present. I believe that clinicians might learn from reading word-by-word transcripts of sessions that reveal defensive processes in a much more evident way.

In general, the classification "unresolved state of mind" and "preoccupation" of this case seems to be a "classic combination" of attachment-patterns in patients with borderline-pathology. For me the "observable" recognition in the AAI of the patient's repression of her father's death and its significance to her is my strongest argument for the application of this measure in the beginning of the therapeutic process. This information validates the opaqueness of the patient's father in the treatment. In the correspondence with Bowlby's thoughts about segregated systems as a crucial aspect in understanding psychopathology, here the patient's breakdown of defence during the discussion of loss and also abuse, elicits further aspects for the observation of therapeutic change.

Coda

The patient returned after a year-long break, not for a continuation of the conventional treatment, but for an enduring exchange of e-mails lasting for fifteen years already. She maintains a fixation onto me, denies any interpretation as a father transference, insists in informing me about her ongoing life. Meanwhile she is in the state of a pensionary, is productive as a journalist, takes care of her ailing husband who has suffered two strokes, and is finishing a detective fictional story where her ex-lover is murdered. From inner emigration to a lively life based on the experience of a holding enacted paternal environment.