6 From the Initial Interview to Therapy

Introduction

This chapter focuses on the all-important step from the initial interview to therapy, complementing the corresponding chapter in Vol.1. This step can be demonstrated particularly clearly with regard to those patients who are often considered unsuited for psychoanalysis or analytic therapy. Experience shows that social class, delinquincy, and adolescence are factors posing special problems, at least in the initial phase (see Sect. 6.2). The manner in which the analyst deals with the patient's family is another of the factors that can influence therapy one way or another (see Sect. 6.3). In this chapter we extend the detailed description of the problems associated with third-party payment, given in Vol.1, by referring to a concrete example (Sect. 6.4). We also devote a separate section (Sect. 6.5) to the consequences that peer reports within the German health insurance system can have on transference.

6.1 An Initial Interview

The initial interview was preceded by a brief telephone conversation. A psychiatrist, after having conducted numerous diagnostic examinations, had recommended that Ludwig Y undergo analytic therapy and given him the addresses of several psychotherapists in private practice. In the following months Ludwig Y had not succeeded in arranging an appointment with any of these therapists. I had several reasons for offering him an initial interview at short notice. The polite and modest way in which he posed his question, which seemed to be completely devoid of emotional involvement, led me to ask myself if this might have contributed to the fact that he had been turned down or referred to other therapists. During our telephone conversation I began to assume that he needed help much more urgently than he was able to express.

Ludwig Y arrived right on time. He was about 30 years old, tall, very slender, and looked miserable. For months he had been vainly undergoing examinations because of his diverse psychosomatic symptoms, which affected especially his cardiovascular system and digestive tract. Despite his bad condition he had not stayed home from work, but rather demonstrated that he was a very conscientious employee.

At the very beginning of the initial interview I noticed the contradiction between his tenacious and untiring search for a psychotherapist and a certain incapacity to convey the fact that it was urgent. This impression, which I had also had when he called to make the appointment, became the focus of my thoughts that he was in bad condition and just managing to keep his head above water. My first intervention was to refer to his ability to keep going, which he had retained despite his worries and helplessness. He was pleased when I told him that he had taken the advice to undergo psychotherapy seriously and not ceased to call and try to make arrangements for therapy. He confirmed this in his somewhat reserved manner, saying that persistence was one of his strengths. Then he turned to me and explicitly repeated the word "persistence."

I could hear how proud Ludwig Y was of this word and how it touched him. His rapid reaction to my reference to his surprising persistence had reinacted something between us. He and his father had often held their conversations in a refined language that was a level above ordinary life, and had felt close when this enabled

them to forget the very simple circumstances in which they lived. Later another aspect of Ludwig Y's relationship to his father became clear and made his persistence in looking for a psychoanalyst comprehensible. This was that his father had pedantically followed recommendations handed down from above and that he considered his father a model of how to assert oneself in a friendly way.

A: What makes you so persistent?

P: My second marriage is in danger of breaking apart! One fight after another. And we exchange terrible words.

A: Words that go back and forth between you and your wife?

P: [Silent for a while] For me, arguing is almost out of the question. And I can't get mad, either. I learned from the psychiatrist that the reason for everything is that I don't have a personality. He gave me a kind of homework. I was supposed to think about what I really like, but I don't like anything; there's nothing at all that I could say I like. For example, when I look at someone else's record collection, then I can say, "Yes, he loves classical music!" But my collection is complete chaos; jazz and classic are all mixed up. And something else, when someone tells me that he is overwhelmed by a Mozart mass or that a Beethoven sonata brings tears to his eyes - no, that's entirely foreign to me.

A: You've just taken a look around here.

He was encouraged by my comment, and glanced again, this time openly, from one corner to the other. I referred to his curiosity by saying, "Now you're starting from the beginning!" and we both laughed.

P: Yes, I can see flowers. And there are flowers in the picture, too. I have to tell you that I am surrounded by a layer that prevents everything from pentrating deep into me. And if nothing can penetrate inside, then there isn't anything that can stay inside either.

A: And so you think that if there's nothing that can stay inside, then there's nothing that can stir. You cannot get angry. As a result, you are at peace with other people.

P: Yes. But *now* I'm foundering. My wife criticizes me for often being innerly uninvolved and not having any initiative. It makes her furious, and then she makes a fuss and tries to provoke me by using ugly words.

He mentioned several examples of how his wife complained about how she had to do almost everything by herself because he didn't make any suggestions or take responsibility. Then he changed the subject.

P: I've observed myself a lot recently. I didn't have a girl when I was younger. I couldn't ask anyone because I was always afraid I would be left standing there alone. So I just didn't bother. Until one came and asked me, and I married her because *she* wanted to. It was destined to fail. We had terrible scenes before getting divorced. I let her have everything, made debts, and fled home to my parents. I was depressive then. I had to have psychiatric treatment. They examined me for some mental illness, which I didn't have. Then they gave me tablets.

Ludwig Y summarized his thoughts in conspicuously short sentences. He had apparantly already thought about it for a long time. Now and then his eyes turned moist, but he quickly suppressed his feelings as if he thought it might bother me. He also excused himself when he thought that he had interrupted me or that I had wanted to say something. I briefly summarized this observation, which gave me an explanation for my first impression that he let himself be bossed around.

A: I have the impression that you're making an effort to give concise and objective descriptions of what concerns you, and that you're being careful to let me go first

and to refer to what I say because something in you wants to give me the impression that your're a particularly pleasant person.

P: [Laughs a little, as if he knew it] But if the results are different, they turn out to be all the worse.

The patient returned to the fact that he was very worried that it was impossible for him to hold on to anything. He said this had even made him once think that there was something wrong with him, i. e., that he might be mentally ill.

Consideration. I had not told the patient anything new when I commented about the polite and modest way in which he adapted himself to a situation. But feeling himself understood, he began to describe the *new items he* had discovered in himself with greater urgency and emotional involvement. I again noticed his capacity to make precise perceptions and statements, which confirmed how much he was able to absorb and retain.

A: There's an apparent discrepency between your thinking that you can't keep anything and your subtle descriptions, in which you note everything that's necessary to get an idea of your difficulties.

P: Yes, I'm proud of my ability to express myself.

Immediately after this positive statement I ended this first interview by referring to the fact that our fifty minutes had elapsed. We agreed on an appointment two days later to continue our discussion.

Ludwig Y brought his referral from his family physician along to the next meeting. He was wearing - as became apparent at the end of the session - a watch with an alarm tone set to go off after 50 minutes. He drew my attention to a mistake in the personal data contained in the referral, but did not say anything about the fact that "psychosis" had been entered as the presumed diagnosis. I thought I could tell that Ludwig Y wanted to tell me something important.

P: Something has been on my mind. Sometimes I'm a rebel and go on the attack. But all of that comes from my head. That's where things are stirred up, while inside I feel empty. It's all very confused.

A: It's associated with your anxiety that what you say might be very confused.

The patient did not react to this comment and continued to speak about the emptiness inside him.

A: I think that you use the emptiness you're talking about as a kind of fantasy object. If it's empty inside you, then there isn't anything else left to make you feel dangerous in the role of rebel and attacker.

P: [Beamed at me] So, I have a fantasy object that I use to protect myself? Yes, if I have to go that far to protect myself, then it would really look bad inside me. I wonder what's going to come out.

A: People have such thoughts when they're considering whether to undergo psychoanalysis.

P: So I'm in good company, with a lot of others.

A: Yes, and some of them don't dare to have any therapy, because of this anxiety.

P: I'm sure that I can't continue living like I am.

Consideration. At the beginning of the session the patient had provided bits of information that belonged in the context of his adaptive behavior in the first hour. I waited for further material to find out more about his anxiety and defense in the brief framework of the initial interviews. I had probably referred to his anxiety too early. Yet the patient had not completely disregarded my comment, but simply continued talking about his *feeling of emptiness* . On his own he took the step from my interpretation that his feeling of emptiness was a fantasy object to using the word "protection," while still remaining relaxed. I also used the situation to further the

process of making a decision about psychoanalysis. I wanted to inquire about other data for the insurance application. The fact that the patient did not mention that psychosis had been entered as the presumed diagnosis might have indicated that he was worried that his feeling of emptiness might be an indication of something worse.

After a pause Ludwig Y asked, completely out of the blue:

P: Is my *instability* a part of it?

I pushed the referral, which was still on the table, in his direction.

A:Have you read the diagnosis, and is it what you're referring to?

P: Read it, yes, but I don't know what it means.

A: Psychosis means mentally ill, something we mentioned in our previous talk.

P: So? No, I don't have it.

A: And you've never been in a psychiatric hospital?

P: No. [He added quickly] And neither has anyone from my family.

A: In your opinion, which diagnosis applies to you?

P: I don't know enough to say.

The patient listened to my explanation of the difference between psychosis and neurosis, without showing any interest. He apparently wanted to continue talking about his instability.

A: Perhaps we should go back to what you referred to as instability. I think you wanted to say something else about it before I changed the subject.

P: When somebody leads the way, I always go along [laughed a little]. Well, I was once magically attracted by slot machines. I'm ashamed of it now. I got into bad company, a bunch of drunks! [The patient laughed at me out loud and nodded.] Everybody was bragging. That was at the time I separated from my first wife.

A: Alcohol helped what was going on inside you, and otherwise stays inside, come to the surface.

P: Drinkers and children tell the truth. Well, then it looks bad in me. It makes me feel afraid.

Consideration. I did not believe that he was one of those who made big claims when he had been drinking, and assumed that he participated - in his fantasy - in the actions of the others when some of their inhibitions were washed away. This led to my next intervention.

A: Primarily you *observed* and attempted to find out more about yourself by observing the others.

P: I love doing that. [He described, very vividly, how he watched people, for example, at the train station and later told his wife long stories about what he had seen.] Naturally all of this is my own story. I know that.

Toward the end of the session he asked a question that was directed to each of us:

P: Will I manage to achieve anything?

A: The way in which you picked up what I said today, and further elaborated on what I showed you, specifically what goes on in you to enable you to avoid anxiety - you used the word "protection" to refer to it - shows that it will be possible to continue.

The alarm on his watch rang, announcing the end of the session. Both of us, of course, had to laugh. Such moments as this, when we both laughed, played an important role later in the therapy.

Consideration. During our discussion of his referral, my attempts to get more information out of him and to give him information went, at the level of his consciousness, against the grain. I somewhat excused myself by saying that I had changed the subject, and returned to discussing the subject of instability. But in the following material, the patient returned to his anxiety about becoming crazy, although

he did not use the word. In replying to his question about whether I believed that he could achieve something by working with me, I did not refer back to the subjects of mental illness or being crazy, but summarized the points about which we had been able to reach an understanding in our two diagnostic interviews. Specifically, he had feared that he would be considered an alcoholic because he had participated, rather passively, in drinking bouts; he used the term "instability" to diagnose his own overall condition; and he felt understood as a result of my comment that he had gone there in the attempt to find himself by observing others.

Ludwig Y did not wear his alarm watch to the third interview.

P: I left my watch at my father's yesterday. But first I have to tell you something. There has been a change. This morning while I was waking up I noticed what was happening outside through the slits between the shutters. I heard the birds. I had the thought that something in me had opened since our last talk, just like the slits between the shutters. I can perceive a little of what is inside me; I understood something. I see that my lack of inner sensations is connected with my fears. What am I afraid of?

A: Yes, that is the direction to go.

P: I've already taken a big step forward.

He talked a little about the relief he felt from having more confidence in himself. We spent the rest of the time gathering some more information for the application for insurance coverage.

In his first few sentences the patient wanted to express his regained hope. One cause of concern for him was the amount of time he would need and the tempo of change. Since he made frequent reference to his anxieties, it was apparent that Ludwig Y was concered about how quickly he would be exposed to deeper anxieties and how he could master them with my help. As is frequently the case in initial interviews, he tested how the tempo is set. His question about how much confidence he could have in himself also implied the question of whether he can trust me - a subject that obviously was frequently raised later on.

Summary. There was a direct transition from these three interviews to analysis. It was possible to recognize significant conflicts and to take the first steps toward problem solving. The substantial inner pressure on him declined significantly following my interpretations of his defenses against his anxieties. He described his insights and his hopes, and began to reorder old observations and new perceptions. His anxiety about becoming crazy came to include many different kinds of contents, whose equivalents were expressed in psychosomatic symptoms and partially resulted via regression in a depressive reaction. From experience it is known this anxiety about becoming crazy declines if it is possible to link the *psychotophobic* ideas with individual contents that have accumulated. In the three interviews there were first indications of this. A primary goal was to clarify these anxieties in order to establish a more relaxed level for the therapeutic relationship. In our first meeting there were signs of how he resolved his conflict with his father. This theme was easy to follow in the reenactment in transference. His thoughtful manner and his accurate expressions pleased me, and he laughed together with me at himself and the world just like he had with his father.

6.2 Specific Problems

There is good reason for us to give ample room to the discussion of the specific problems encountered during the transition from the initial or diagnostic interviews to therapy. An analyst does not need to display any special skill in beginning an analysis with an educated

patient from the upper middle class whose suffering makes him highly motivated for psychoanalysis. We have given several examples of a smooth transition from the initial interview to therapy in Sect. 2.1. The initial interview summarized in the previous section (Sect. 6.1) also did not place any special demands on the analyst to apply the psychoanalytic method in a flexible manner. The anaylst's ability to employ indications in an *adaptive* manner is put to a test, however, by the task of motivating patients to undertake analysis who are less accessible for various reasons. Disregarding psychotics, addicts, and borderline patients, who frequently first require inpatient treatment, there are primarily three groups that pose special problems. The groups are identified by categories of social class (Sect. 6.2.1), delinquency (Sect. 6.2.2), and adolescence (Sect. 6.2.3); they are associated with specific difficulties, at least in the initial phases, i. e., during the transition from interview to therapy, regardless of the differences between these groups or between individual cases. Our concern is to test the application of an *adaptive* indication on patients who would not fulfill the criteria of a *selective* indication and would therefore be turned away as unsuited for the standard technique of psychoanalysis. Yet if the analyst adapts himself to the expectations of the individual patient, the group of inaccessible patients is reduced to special problem cases. Thus an adaptive indication saves many patients the depressing fate of being shoved around from one office to the next. There can be no doubt that it is often very difficult to convince an unmotivated individual that psychotherapy is advisable. As a consequence, patients who do not consider it likely that there is any connection between their experiencing and their numerous symptoms are unpopular with psychotherapists whatever their color. Such patients are frequently even rejected on the telephone. Of course, it is a favorable sign that a patient does not let himself be discouraged and makes an effort to find treatment. In this regard the patients we can report on-because they found their way into our offices - are in a special category.

6.2.1 Social Class

Although in this section we discuss case material that is primarily associated with patients from the lower social class, we have given this section a more inclusive title. The reason for this is that we want, in agreement with the study by Cremerius et al. (1979), to emphasize that social class in itself constitutes a factor that can pose characteristic technical problems. It is no coincidence that approximately two-thirds of the patients who have received analytic or psychodynamic treatment in the FRG since the public health insurance companies agreed to accept such claims are white collar workers and that only one-third are skilled and unskilled laborers, the group of the populace insured by the original - and least selective - public health scheme (the *Allgemeine Ortskrankenkasse*). On the other hand, the rich and the powerful also make their way to an analyst relatively infrequently, as can be seen in Cremerius et al.'s study.

We will restrict our discussion to technical problems that occur at the beginning of therapies with patients from the lower class. We follow the definition of class based on the widely used criteria established by Hollingshead and Redlich (1958) and described by Menne and Schröter (1980). Occupation and education served as their criteria for social class.

> Lower class patients are blue-collar workers (including skilled laborers), employees who perform primarily manual labor, and small farmers who have not graduated from a regular school or from a vocational or commercial school and whose father's education and occupation - and possibly also those of the mother--were similar. The occupation and education of the spouses of married women also had to fall into these categories since the social status and socioeconomic situation of a family is largely determined by the husband's occupational status and income. (Menne and Schröter 1980, p. 16)

Thus with lower class patients the following points should be paid special attention, at least during the initial phase of psychoanalytic therapy. The analyst should provide these patients with an especially large amount of explanatory information. The autonomy that these patients experience their physical symptoms to possess should be taken even more seriously than usual since these patients as a rule do not make the discovery that symptoms play a role until later. Psychodynamic interpretations that are made too early provoke mistrust and reinforce

the distance separating analyst and patient. If the analyst cannot put himself into the position of those from other social classes, which includes the conditions under which they live and work, then he lacks the prerequisites for empathic understanding. In the initial phase, abstinent behavior by an analyst who believes he is not permitted to answer any questions repels such patients, for whom this effect is much more pronounced than for better educated and situated patients. Yet if the analyst follows the rules of everyday communication, as Freud spontaneously did in his informal consultation with Katharina, then it is possible to establish a psychoanalytic dialogue step by step. Otherwise reactions such as those described by Schröter (1979) occur. The lower class patient, for example, experiences the dialogue (and the analyst) as "unnormal," is disturbed, and rejects what must seem foreign and incomprehensible to him. Schröter described the formal aspects of the psychoanalytic dialogue as if it were a sin to adhere to everyday forms of communication in the beginning. Yet if interpretations are embedded in a dialogue that by and large corresponds to the needs and expectations of the patient and if their contents are adapted to his experiencing, then in our experience the reactions commonly attributed to lower class patients do not occur. The observation that lower class patients frequently take interpretations to be criticism, insults, and derogatory statements is thus a result of the unempathic application of the psychoanalytic method.

Some of the experiences gained from a comparative study of analytic group therapies (Heising et al. 1982) can be applied to individual therapy. For various reasons lower class patients prefer to maintain some distance. Because the patient is looking for a better world and the talk with the analyst constitutes a new and unusual experience for him, he finds certain positive and negative transference interpretations incomprehensible. It is more usual for conflicts to be carried out with substitute figures, and it not possible to bridge the underlying division into good and evil and to work on it in transference until later. Such secondary transference can be productive for the analytic process. A certain idealizing transference is formed in this distance, and it is tinged by unconscious envy and class hatred. It is necessary to modify the interpretive procedure in which the analyst offers himself as a transference object. Heising et al. (1982) referred to the fact that analysts feel offended when working with lower class patients because the specific satisfaction analysts experience as the object of transference, especially if it can be interpreted, is restricted with this group of patients. The authors raised the question of whether this fact might be related to the failures described in the literature of analytic work with lower class patients or to the view that such patients cannot be treated analytically.

A longer period of preparation is recommended when working with lower class patients, who require explanatory information about the purpose of the treatment. Initiating a comprehensive learning process in group therapy has been shown to be effective (Junker 1972; Reiter 1973). For reasons similar to those in treating somatically ill, it is essential that the analyst first respond to questions very concretely and answer them realistically. If the analyst observes these simple rules, which seem obvious to common sense, many of the alleged features - such as limited fantasy, rigid superego, and fear of authority - attributed to lower class patients (and psychosomatic ones, see Sect. 9.9) and specified as the causes of their being inaccessible to analysis vanish. The inability to view inner conflicts as meaningful and the opposite tendency of holding external sources responsible for an illness are frequent artifacts originating from the impatient expectation that the patient should already have gained insight into his inner conflicts.

According to this incorrect specification of typical features, lower class patients exhibit considerable similarities with many of the wealthy private patients who are unsuccessfully treated for years for a "psychosomatic structure" (see Sect. 9.9). Every indication is that both diagnostic classifications are artifacts. If the analyst gains a feeling for the world of a laborer and makes an effort to employ indications in an adaptive manner, then the initial difficulties recede to the background and the analyst's interest in the life of a patient whose educational level differs from his own if often richly rewarded.

Leodolter (1975) and Wodak-Leodolter (1979) have shown that it is impossible to adequately describe the communication between a patient from the lower class and a middle

class doctor by using Bernstein's (1975) code theory. On the basis of his code theory, Bernstein rejected the possibility of a successful psychoanalytic interview between a lower class patient and a physician typically from the middle class. Since in his opinion the patient lacks the necessary capacity to verbalize, it is impossible for the physician to find a means of access to the patient's world. Bernstein, just like Schröter, apparently proceeded from the fixed rules of the standard technique, which in fact do not permit a dialogue that satisfies common sense expectations. If the analyst frees himself from such restrictions, many observations turn out to be the products of an restricted application of the psychoanalytic method. In any case, one prerequisite for examining verbal and nonverbal exchange is to acknowledge that the range of problems is much more complex than described by Bernstein. For example, Wodak-Leodolter (1979, p. 187) raised the following questions:

1. Does the lower class patient really lack the capacity for verbalization? 2. What are the differences between lower class and middle class sozialization; what forms of distorted communication are present in each case; what is therefore the form of therapy suitable in each case? 3. What does cure mean to the lower class patient; it is at least necessary to discuss the criticism that psychotherapy means "adjustment" to middle class norms.

Moreover, in our opinion it is not sensible to consider "capacity for verbalization" to be a global feature; more appropriate is to distinguish between its various elements and thus be able to realistically consider the particular capacity for simple individuals to express themselves.

First Example

Susanne X, a nearly 40-year-old housewife, came from a rural area and was married to a laborer. The reason she gave coming to her initial appointment was that she frequently got into hopeless situations in which she ultimately became extremely agitated. In her frequent states of psychogenic semiconsciousness she could not remember what she had said or done. She ran away aimlessly. These states were preceded by violent arguments with her husband; the reasons were trivial, the shouting terrible. The tension would not resolve until the next day at the earliest, sometimes taking up to three days. Years of drug therapy did not produce any change. Her family doctor and a psychiatrist responded to her questions about psychoanalysis by telling her, in essence, that she lacked both the money and the intelligence for such treatment. Having grown up in poverty, she had had to work even as a child, and immediately after finishing elementary school she had left home to work.

The previous rejections of psychotherapy had confirmed her expectation that she was too poor and stupid, yet she did not let this stifle her desire to learn more. She had acquired a wide range of information about psychotherapy and psychoanalysis from the media (magazines, books, radio, and television), and then turned to another psychiatrist, who referred her to a (female) analyst in the expectation that she would talk her out of all of these unrealistic ideas. This was supposed to help her bury her wish for psychotherapy for good. In response to my questions, this psychiatrist told me that in his experience analysts frequently did not establish an indication for therapy for the lower class patients he referred.

Susanne X had tried to learn more on her own, out of a mixture of spite, anxiety, and mistrust. She had felt that she recognized herself in various book titles, and after reading Richter's (1976) book *Flüchten oder Standhalten* (Flee or Stand Firm) she made an effort to obtain psychotherapy. After about one hundred hours of treatment, she brought me ten of her favorite books. After even more time had elapsed she asked me why I did not tell her not to read them. The confidence I placed in her capacity for learning encouraged her.

Going through the protocols of the first ten hours of treatment from her analysis, which took place three times a week and lasted three years in all, I noticed that the patient had tried in almost every session to provoke me into stopping the therapy, as if she felt she could not be rejected often enough since she belonged to those from the bottom.

In the initial interviews she described the extreme poverty, the misery, and especially the corporal punishment she had experienced in her childhood and adolescence, and several times responded to my attentive and empathic behavior by saying quite unexpectedly, "Am I in the right place here with you?" She repeatedly gave me such "shoves." I showed her that she expected the beatings she had received from her father to be repeated in the analysis and that she actively worked toward restructuring it accordingly (via identification with the aggressor). She said her father had been course, would shout and hit her, and was only interested in money. She had married her husband because he was the exact opposite, i. e., good natured, but then it was precisely this quality that she complained about in their arguments; for her, he was just too lax with everything and everyone. She said that this put her in a state of helpless rage and anxiety. Her last sentence in the first interview was, "Whoever has experienced evil will always be tempted to be evil themselves."

I made an effort to provide the patient sufficient information in response to her questions about being at the right place. She had told me that she read a lot. I limited the information I provided to saying that I wanted to try to understand her, and that I wanted to get to know her and that she should get to know me before we made any further plans. Everything that was unexpected and new disturbed her, and she would have liked to pick an argument with me right away.

She started the second session by glancing at me provocatively and asking, "Is there any point to this?" My comment that I first wanted to listen to what she had to say to me led her to talk about two subjects in detail. First, she said she was listening to a radio program called "Talk and Let Talk." In telling me about the program she described in detail the features that had fascinated me during our first interview. Yet neither of us verbalized this fact; we simply agreed that this manner of conversing could be very positive. Then she switched to the second topic, describing a couple she knew. In person they acted very endearingly, but otherwise they gossiped and said bad things about her. Yet the patient claimed that she knew precisely what happened since she had grown with evil people.

The patient said the situation of her sister, whose husband had committed suicide, was similar. She went on, saying that if everything continued as it were, then she would not have any alternative to suicide either, and she had everything ready. I inquired about her preparations, and told her that she had the feeling that she wanted to end everything with an evil deed - by committing suicide - precisely when someone was friendly to her, the way she felt I acted toward her. Then she would willingly put away everything she had prepared, only to immediately think about another means of killing herself. What followed was a life-and-death struggle.

I met Susanne X in the hallway near the waiting room before the third session and said, "Be right there." When I opened the door to my office five minutes later, she was standing right next to the door. She had taken my comment literally and explained that she had stood there to hear what I was doing. She complained that since nobody had been in my office, she could have come in immediately. I was there after all! She dealt with this topic by referring to the couple she had mentioned before, who always acted nice but were really only interested in their own good; how mean they were to other people. Then she said that two people had hanged

themselved, one just recently. In this session she said three times that "Now I'm going to settle with them; I'm going there on Saturday." She recalled that the man was like her uncle, who - like her father - was only able to shout, be violent, and chase after money. She thought that confronting a person and asking for an explanation did not lead anywhere but to an argument, and therefore she would have to settle things on her own. She claimed she had already learned something from me; yesterday her husband had made an idiot of himself again by working far too long because everyone wanted him to do something, and then had come home exhausted. This time she had just listened to him, nothing else, while she used to show him what an idiot he was.

Susanne X said I had been right that she would let loose with words because she felt at home in mouthing off. As a child she had not learned how to discuss things. She recalled that her mother had only known two sentences: "You're not supposed to steal" and "You're supposed to obey." In the fourth session she told me about having taken some pictures of trees the day before; she wanted to have pictures of them from each of the seasons. Until then trees had only meant leaves to her, leaves that had to be raked. She concluded that for her even trees represented evil. The patient demonstrated her own psychological talent, which I did not elaborate on, by recognizing her own potential for change and development. She cooperated, and she changed, such as listening to her husband. It was obvious that in acting this way she was imitating our interaction in analysis; if I had mentioned this transference aspect to her she would have had to reject it because she would have thought "What does that have to do with what a doctor does?" At first she refused to think that she had anything in common with people like me; she consciously rejected any such connection. She told me repeatedly that she belonged to those down below and I to those at the top. If I had established some connection between this theme and me, her reaction would have been to raise her defenses against anxiety. She would have started complaining that what she did didn't have anything to do with what I did, and would have referred to the flattery of her friends which she at this moment could have handled better. It was possible to therapeutically exploit the fact that the patient used largely the same adjectives to describe members of her own family and other people, and that it was thus easier to establish a direct connection than it is with fairly mistrustful patients. I was at first surprised that the patient used the same expressions to refer to her husband as to her father and uncle, namely avaricious, domineering, and inhuman.

The fact that the patient had adopted, via identification, her father's manner of complaining was a frequent cause of conflicts with her husband. She adopted insults her father had used, calling her husband a poor joker, a good-for-nothing, and complained that "You're nothing if you don't have any money." In the following sessions the oedipal seductive side with respect to her father became stronger. Unfortunately I very prematurely offered the interpretation that this was how she seduced her father. She looked at me aghast, rejected (as has often been described) any interpretation of her inner conflict as grotesk, and thought I was not credible and strange.

In my opinion the reasons that oedipal conflicts cannot be interpreted or at least not until much later still have not been clarified. Many people live in polarized circumstances or according to a law of all or nothing; for many members of the lower class this has specific connotations. Static descriptions about the presence of rigid superego or weak ego functions are completely inadequate to describe these complicated processes.

I then became more cautious, being careful not to precipitate any new defenses against anxiety. More quickly than might have been expected, Susanne X began to assure me that I should not send her away. "You have to pay attention that I don't go the wrong way!" She spoke more frequently about her mother. She came to the next session wearing a bright red jacket and, laughing, asked if I knew what it meant. She came as little red riding hood who had been sent away by her mother. She had felt sent away because I had not explicitly affirmed her wish for me to look out for her-I had avoided answering her request. From her point of view I should have said to her, "Yes, I will now take over your mother's functions!" She claimed it was my duty as a doctor. In the following period she quickly transformed such disappointments and disparaged the doctor's function. This theme reached its climax much later, in the *final phase* of treatment, when she acted through the deprivation of power at different levels.

After the difficulties related to her social standing had diminished in the initial phase, as described above, it was possible for me in the particularly helpful periods of the analysis to show the patient which items of unconscious oedipal and preoedipal envy she actually meant when she referred to her de facto lack of education. It also became clear that this deficit was reinforced in a vicious circle, both in her experiencing and in actual fact. Once the patient recognized which needs she was additionally trying to satisfy, she learned to distinguish between her different conscious and unconscious intentions and goals. Also instructive was how she restructured commandments and prohibitions, i. e., her superego, that she had internalized and initially felt to be foreign; she substituted her own words for the foreign dictates. This change led to a partial restructuring. About 18 months after the termination of analysis, Susanne X called me to say that she was feeling well. She said she was still struggling against the feeling that the separation from me was a rejection, but that her confidence in herself - in identifying with what she had gained for herself in the course of her analysis - helped her get over it. However, she still sometimes had doubts about whether she had profited less from analysis because of her past.

Second Example

The following example demonstrates that we can employ ego capabilities peculiar to a certain profession in order to balance social differences and the feelings of inferiority associated with them.

Victor Y was 37 years old when he came to me because of insomnia and somatic symptoms; he had suffered from them since his "defeat" - a test he had failed. He had worked as an electrician since he was 17. Because of his skills he had felt confident enough to take a test for a promotion, but the conflicts he had with persons in positions of authority ruined his opportunity.

A period of several weeks elapsed between his telephone call for an appointment and the beginning of his seven-month therapy. Referring to the fact that *he* had requested this delay, he explained his technique of coping with conflicts with authority by distancing himself. He realized, however, that this also had disadvantages for him. I replied that he had also given me the impression of apparently being disinterested. He confirmed this, but added that he definitely wanted therapy.

The patient then provided a precise description of the test whose outcome had been so disastrous for him. In even more detail he told me about how supervisors

and ordinary staff acted toward one another and vividly described typical experiences; there were even some humorous moments.

Suddenly he looked at me and stopped, just as if he had wanted to ask me, "Did you start at the bottom too?" He wanted me to understand him. He had done everything to get a promotion - "And now!" He suddenly began crying and said that he was losing his friends now too. The only thing the others could talk about was cars. He claimed he wanted to get out of this situation. Friends and relatives would also poke fun at him, saying he was just taking the easy way with his job. He felt misunderstood and continued having difficulties falling asleep, but added that he had so much on his mind, yet was still against taking tablets. "But now, my parents," he suddenly said; "you'll have to excuse the sudden change in topic. They were just visiting. I noticed that I don't want to turn out to be like they are. My mother only knows how to consume and keep father under her thumb. Father had once been the authority; he had been a corporal, and everybody had had to obey him." He told me that he tended to exaggerate his symptoms, just like his mother did. As soon as he would feel any pain, he would tell anyone and everyone about it. He added that his wife could endure a headache or backache for days without mentioning it. The patient wanted me to understand him correctly; he said he did not start screaming, just acted grumpy, but that this might even be much worse. He also told me that one other thing he did passionately was to straighten up the house, such as in the kitchen, but without it being any help to his wife. And he always had to sit on *his* chair. He went on to describe several other compulsive and superstitous actions.

Victor Y was the parental advisor to the class one of his children was in. He described how, prior to a meeting of the parents, he would feel pressure on the chest, and pointed to his heart. Then he would let someone else talk first, gather some information, and then it was easier for him to speak. I said that he was afraid of being attacked if *he* went first. He agreed, saying he avoided it by always letting the others speak first. He now felt he had to change the subject again suddenly; he said his face would turn red when, for example, his supervisor came, and there was absolutely no reason, none at all. Before falling asleep he would prepare long speeches he wanted to hold the following day, but then he would improvise instead of saying what he had prepared. I answered that he did possess self-assurance if he could improvise like that. Rejecting my comment, he said he would let off a tirade, attacking others, and then could not stop feeling guilt. He thought it would be better if he did not say anything at all, adding that his neighbor acted the same way and quarreled with everyone.

In the next session he was quiet, expecting me to give the command, "Start talking!" He said that he was busy sorting out his thoughts for a while, and that he would say something when he was finished. He claimed he did not need the therapy, and then commented about how bad he felt. "So," he said, "do something about it!"

He then started to tell me everything imaginable, in a dialogue all his own, even referring to himself by his first name. By doing so he made it impossible for me to say anything, yet he apparently was also giving me a picture of how he talked with himself before going to sleep at night. While on night duty now something had happened to him. "It was just time to stop and the phone rang. It was Mr. Z, and was I ready for him! He asked why there was still snow in front of his workshop. Because it had snowed. Why hadn't it been cleared away. Because the people clearing the snow hadn't got there yet." *Then* he had felt well, saying that Mr. Z was the kind that blew up right away, and adding that he could argue with him because he asked such stupid questions. He blushed. It had not been until he was standing in the shower that he had known he should have done it differently, namely listen first, then say

"yes," then that something had gone wrong and that it would be taken care of. If it had happened in the evening he would not have slept a wink all night. "He, he must pay attention to everything, he thinks it's his responsibility." The patient said he would like to have a job like that, too, because he could do it. He confirmed my comment that he picked the wrong time to say out loud how he felt inside and made himself guilty. He recalled a few examples of how others coped with their aggressions.

In the next few days he felt bad, walked around stiffly and awkwardly, and at work only did as much as was absolutely necessary.

This patient, who described several versions of his conflicts with authority in the first two sessions, had shown me in the very first quarter hour - by nearly asking if I had had any vocational training - that my development as a doctor had naturally been different from his and that *he* , not I, was competent with regard to his vocational situation. I listened attentively to his long explanations and knew that this was how he could draw pleasure from his competence. I was thus able to recognize the patient's ego capacities that he, because of the dominance of his superego and his compulsive traits, would otherwise not have been able to portray in such a natural, secure, and unanxious manner. He then described how he had to make competent and responsible decisions at work, and that when making these decisions he very rapidly felt he was being insulted. As I told him that he did not feel secure with the real authority he did possess, he suddenly started to describe the company doctor. The patient described him as someone who did not achieve enough for a qualified physician, despite everything he was responsible for. This doctor had prescribed him a cure at a spa that had been very nice but had not helped at all; the medication he had prescribed had not helped either. In the next three sentences the patient, who was not very articulate, described how *he* viewed the development of his difficulties. When his father had said something, it meant having to obey the earlier corporal, but when his mother said something, it meant he was under her thumb and lost all independence. He feared he was like his mother, adding that he did not want to be like her.

By means of the dialogue that he initiated with himself at important spots, the patient showed me, first, his symptom - his brooding that kept him from falling asleep - and, more importantly, how he avoided transference. Sometimes he quite consciously took control of the session. The dialogue and cooperation between us was able to continue because I did *not* offer the interpretation that he had to start a power struggle with me because of the omnipotence he feared I possessed.

After working through his unconscious (oedipal) aggressions he was freed of his neurotic inhibitions, yet certain intellectual inhibitions continued to obstruct his advancement. On the other hand, he no longer needed this advancement in order to come to terms with his rivalry with his father (and substitute persons).

In the last session of his therapy, Viktor Y used numerous technical terms to describe an event that had occurred during his night duty. My statement that I could not say anything about it because I did not know enough about the subject made him laugh triumphantly. Then he was pleased by my comment that he had made a decision in a difficult situation, responded flexibly, and did not postpone an inevitable repair. Yes, he agreed, he thought he had become more humane. He said he was no longer the eternal grouch that he had been known as, and people did not even recognize him any more. He made me laugh again by suddenly saying, "Just don't be afraid that I'm going to go screwy!" He summarized what had changed and came to speak once more about the test he had failed. Half laughing he said, "I'm beginning to accept the fact that I will remain an electrician instead of going straight on to an institute of science and technology." I then briefly summarized the difficulties

he had complained about at the beginning and had now overcome, such as losing his temper, becoming furious at the wrong instant, and not finding the right word at the right moment. Agreeing, he said he had stopped playing this game. He added, after pausing to think, he would have to live through, experience, and also create the strength he might have, even though his nerves might not always be strong enough. I replied that this was a good conclusion. He stood up and said "Yes," and that he would inform his doctor, and in doing so mischievously avoided the usual good-byes.

6.2.2 Delinquency

By employing an adaptive indication, as we explained and grounded in Vol.1, it is possible to successfully use psychoanalysis to treat delinquents. Yet it quickly becomes apparent that this designation is misleading since it is by no means the case that only the families of delinquents and society at large suffer from such asocial and delinquent behavior. This is a very divergent group of persons, and many delinquents who have been written off and are apparently beyond hope do in fact suffer from their incapacity to control their own behavior. Approximately thirty years of experience, especially that gathered in Dutch institutions of forensic psychiatry, justify cautious optimism that such persons are accessible to psychotherapy (Goudsmit 1986, 1987). Given the appropriate modifications, the use of the psychoanalytic method is far less heroic than indicated by the Menninger Project. At the time the Menninger Project was conducted, it was a "heroic" undertaking - according to Wallerstein (1986), who referred back to Ticho - to continue using the standard technique even in cases that, as we know in hindsight, would have required greater flexibility in combining therapeutic techniques.

The modifications, whose effectiveness has in the meantime been demonstrated everywhere, are directed at establishing a therapeutic relationship. Many delinquents have not experienced reliable family ties in childhood and adolescence.

If an analyst has established a therapeutic relationship with a delinquent, it is important that he be particularly cautious because subliminally a disturbance might develop. Such individuals all too often know that they can take another person for a while before it comes to a surprising end, and from the perspective of the patient the end is almost always the other person's fault. As is well known, the favorite defense mechanism of these patients is projection to the outer world. The fear and anticipation of this expected end leads some patients to undertake the unconsciously guided attempt to bring about the termination themselves. In this case there is a tendency for patients to flee from inpatient treatment, or to pretend to achieve satisfactory cures in outpatient treatment. It is important for the analyst not to fall for such attempts at self-deception, which may be very tempting. If he does, the two parties may decide to terminate treatment as successful although each of them privately suspects that the patient will subsequently have a relapse. The continuity of the therapy can be assured by soberly evaluating which length of therapy is required. Thus it is also in the patient's interest for the analyst, despite his empathy for the patient's momentary situation, to maintain a friendly distance and not to let himself be used by the patient, such as to obtain short-term satisfaction.

It is often necessary for the analyst initially to accept the patient's notions about therapy, in order to gain his confidence, and not to attempt to impose rules that the patient will rebel against because for many patients rules have always been handed down from above. In the case described below, hypnosis was performed several times at the patient's request, and psychotherapy was subsequently combined with kinesitherapy. With many delinquents it is almost essential that a social worker participate in the course of the therapy.

Example

Initial Interview and Biographical Data

We will follow the detailed notes that the analyst made, summarizing them with the author's approval.

Simon Y's treatment began with a telephone call, followed by an initial interview the next day. He was 37 years old, had a police record, and came to the analyst in an emergency. The analyst offered "first aid"; decisive was that the analyst did not primarily view the patient's wish for hypnotherapy - that the patient tied to a threat to commit suicide - as a kind of extortion but rather as an indication of the severity of the emergency. Otherwise their contact would not have extended beyond the telephone conversation, which the patient would have taken to be another rejection. The analyst's willingness to adopt a comprehensive view of the repertoire of therapeutic techniques and to take Sandler's (1983) adage seriously that psychoanalysis is what psychoanalysts do was an essential factor is creating a basis of confidence. There must have been a fortunate coincidence of factors on both sides that enabled a supportive relationship to be established in the very first interview and that this even enabled the patient to wait three months for therapy to begin.

We presume that the patient managed to wait for such a long time because he viewed the analyst's offer as his last chance and because the initial interview had given him sufficient hope of being able to find support and security. The patient had expected a repetition of his earlier experiences, which he described in the following way: "I'm afraid there's no hope for me any more; that's what all the other doctors have said before turning me down." After sobbing for a while, he asked the analyst, "Why are you wasting your time with me? Nobody has ever spoken with me as long as you have." At this moment the analyst could truthfully assure the patient that he had decided to try to assist him in his struggle to change his life, yet without knowing whether hypnosis was the right method. However, if the patient believed it would help, he was willing to try it.

Several reasons that provided the subjective basis for the analyst's decision to attempt therapy can be gleaned from his thoughts and feelings, which he described in the following way: "It's a mixture of great pity and indignation at the manner he has been treated, and a feeling of impotence: What can I do to help in this case? Nonetheless in the course of the initial interview I gained the impression that I could work with the patient and that a genuine attempt to treat him has never been undertaken . . . . I feel I have to emphasize that I did not have the feeling that I was coerced into making the offer."

When the analyst made his offer of therapy he was not familiar with any of the details of the patient's case history or with the records from other institutions. With the patient's approval the analyst requested and studied these reports. The external data about the nature of his delinquency corresponded with the information the patient had provided; we now cite from the analyst's brief summary of this information in order to make the course of Simon Y's treatment more comprehensible.

This patient was borne out of wedlock, was unwanted, and has been pushed back and forth, i. e., away, for his entire life. From the fondling home after his birth he was sent to the prejudiced parents of his mother, who thanked God that his Dutch father - who had been a member of the resistance - had been arrested and killed in a concentration camp. In elementary school he was isolated and handicapped by his stuttering that became progressively worse. He had cried a lot as a child, which was a symptom that later so irritated professional helpers that they did not know how to handle him. The well-meant advice of a school doctor that the 11-year-old and weakly boy be sent to a reformatory in the western part of the country led to new and severe traumas. Because of his dialect he stayed an outsider among the local youths. He vividly recalled the separation from his mother at the train station as an

example of evil betrayal because she did not heed - and as he later realized, probably could not have heeded - his begging and pleading to let him stay. He described the two years he spent in the home as terrible.

He was discouraged by his isolation and his incomplete education, and after returning to his home town he broke off two attempts to obtain training to be a mechanic after just a few days. After working irregularly as an unskilled laborer he passed the driving test. After being convicted of burglary he was sentenced to 6 months on probation. Then, during a longer period in jail awaiting trial he rejected the company of other prisoners and the work he was assigned to do. After being released he did odd jobs working as a truck driver. He was often off because of headaches and backaches. The usual referrals back and forth between the social and psychiatric services were intensified. He did not know how to use the help he was offered, and stopped two stays in a psychiatric hospital. At the age of 22 he was sent to a center for crisis intervention, where he became fully aware of his pedophiliac tendencies, which he had hardly practiced previously. He had lived with a younger (male) friend and had hoped to establish a stabler life with him. When his friend ended their relationship, he fell at first into desparate rage and then into depression and thought about committing suicide.

Simon Y fell through the cracks in the network of social psychiatric services and consiliary examinations that are the consequence of the divisions in responsibility and competence. On the basis of thorough psychological testing, his IQ was determined to be 104. His drawings were at the level of a 12 year old. His capacity for social adjustment was considered minimal, yet the result of an MMPI was surprisingly normal. Over the years he had been prescribed large amounts of psychopharmaceuticals, which he had stopped taking long before the initiation of psychotherapy. Finally, the result of further psychiatric examinations was that no help could be offered to him; it was at this time that he mentioned his pedophiliac tendencies for the first time and asked whether hypnosis could not free him from them. Reading about yoga had given him this idea. As a result, he was referred again to the department for social work with the instruction that other housing be found for him. Simon Y had lived for years in a dilapidated house, in isolation since the separation from his friend, his only companion being his dog.

Simon Y had thought a lot about the meaning of his life and his difficulties and sought solutions on the basis of his belief in reincarnation. He feared he would no longer be able to escape his isolation and was insecure as to whether he was truly pedophiliac or not. He had not been moved by his brief sexual relationships to women, but he was enthusiastic about being with teenage boys. "Maybe they give me the love that I was denied earlier." The fact that this thought might have been suggested to him in one of the many talks he had had does not alter the fact that Simon Y still accurately described his situation from his perspective.

The analyst who offered him treatment divided the therapy into phases according to external data and thematic focus. Below we give several passages verbatim and summarize others. After approximately 9 months of work the therapeutic relationship was sufficiently consolidated that it was possible to initiate analytic psychotherapy. For didactic reasons we are interested in this long phase of preparation and how the analyst structured it. We conclude this description when the shift to psychoanalysis took place.

First Phase of Treatment

Simon Y's personal and social situation did not deteriorate during the three month waiting period. He arrived punctually at the agreed time. Looking embarrassed and

as if he had been crying, he only said "Here I am." Since a pause at this moment can be disastrous, I asked him once more how he had had the idea of undergoing hypnosis and what he expected from it. He told me about his earlier experiences with yoga. His yoga teacher had told him that an individual has a very deep unconscious life and that it was sometimes possible to look behind the mask by using hypnosis. I replied that this was true, but that looking behind the mask was in many cases insufficent for really working through what was hidden there. I also pointed out that it was quite possible that we might encounter very shocking things behind the mask. Furthermore, I mentioned that it was possible to record what happened during hypnosis, thus giving him the opportunity to hear for himself what he said during the hypnosis. He answered that he thought it was a little horrifying, but rejected my offer to leave out very troublesome topics, saying "If we do it, then everything" - he could take it.

To test his ability to enter a trance, we began with the relaxation exercises from autogenic training. This was a failure since the patient was unable to concentrate.

Commentary. The analyst's intention was to direct the memories about affectively strongly prominent, forgotten, or repressed experiences that the patient recalled during hypnoanalysis to a more intensive conscious study and therefore suggested that the dialogues conducted under hypnosis be recorded. In the process hypnosis would lose it secretive and magical character, becoming part of the analytic procedure and allowing the transference and countertransference processes taking place in it also to be worked through. In this regard the introduction of the tape recorder into the therapeutic situation made it possible to expand the range of adaptive indications. It thus became possible to carry out the transition from the preanalytic treatment provided during a flexible introductory phase of unspecified length to an analysis of transference and resistance in a methodologically correct manner. Thus, to supplement our comments on this topic in Sect. 7.9, an analyst can undertake such analyses precisely by means of using a tape recorder, instead of despite using one. Even patients whose mistrust of the analyst's secret means of influencing is so large that they bring their own recorder can also be given therapy according to an adaptive evaluation of indications.

The patient began the second interview a week later by commenting that there had been hardly any change. Then he had to laugh and said, "Funny, but you hope for some change although it's clear to me that it's not at all possible." He wanted to try the relaxation exercises once more, and this attempt was also a failure. The patient then asked whether it was possible for me to record the relaxation exercises on a tape he could take along to practice at home, which I agreed to do. With a small smile he concluded, "But I'm going to continue coming. You can depend on it."

As was to be expected, it was not possible for the patient to do the exercises at home with the tape recorder either. Since the Christmas break was approaching, we talked in detail about how to proceed. I made the patient the offer that he could call me at home if he had any serious difficulties. After the break he told me that he had had a very bad three weeks; he had felt terribly lonesome and had been repeatedly overwhelmed by the idea that his life was meaningless and that everything was useless. He was also plagued by frequent headaches, which forced him to lie down. The rest of the time he had taken care of his dog: "Without my dog and the prospect of coming here, I wouldn't have managed to survive these three weeks."

Simon Y did not have a clear idea of what he wanted or did not want in life, or of what he wanted more and what less. I therefore advised him to prepare a list of what he wanted and what he did not want at all or not much, which he brought to the next session. It was apparent from his list that what he did not want was associated with assignments he was given by third parties, especially by the authorities. The things

he wanted were all connected with improvements in how he lived, with his ailments, and with his limited opportunities for having contact. The biggest item in our interview consisted of his insecurities in life. It became apparent that it was impossible for him to feel at ease in any area. The only area he did not have any problems was with his dog; he knew his dog understood him without him saying a word.

Commentary. The analyst took over the functions of an auxiliary ego by making clarifying suggestions. The patient managed to gain a better impression of his own goals, which were quite vague, by preparing a list. Identifying his goals in this way facilitated the course of the interviews because it was possible to refer back to something tangible.

Second Phase of Treatment

Simon Y talked in detail about his feelings of inferiority, which started back in kindergarten and were reinforced at school. His teacher stopped asking him questions because he was too dumb. He said it was like that everywhere. I expressed my conviction that he had many profound ideas. And furthermore, the psychological examination had clearly shown that he was not dumb. The problem was that all of these experiences had given him an inferiority complex, and it was our task to overcome it.

He talked about his being alone, his feeling of being alone, and pedophilia, in addition to about his inability to concentrate and his inferiority feelings. He said that he meant something to "the boys." Almost blushing, he added that he was not thinking about sex. Then he gave me a lecture explaining that pedophilia was caused by a predispositon and that it was impossible to do anything about it. Since I did not make a comment, he asked, "Or is it possible that all of this is somehow related to my own experiences as a boy?" I gave the simple answer, "I think so."
Consideration. The identificatory character of his love to the boys seemed clear to me, yet it was still too early to make any allusions to it.

In the next session Simon Y first talked about the feeling of insecurity he had in all of his relationships. He asked me again whether it might not be connected with his earlier experiences. Then I reminded him that we had wanted to make an attempt at hypnosis in this session. Relieved, he answered, "Yes, naturally I've thought about it but I didn't want to be the one to mention it because you might have thought that I want to have my way at all cost." Less clearly he then stammered, "And besides I wanted to see if you hadn't forgotten it."

To achieve a trance, I chose the fixation method since the patient had amply demonstrated how bad his concentration was. It took a rather long time for him to enter a slight trance. He was visibly dissatisfied with what he had achieved, as shown by his statement "I didn't notice anything." It was obvious that he had doubts about my skill. When I told him that it was often difficult at the beginning, he did not seem convinced.

I was not amazed that Simon Y came to the next session complaining. "A bad week, didn't do anything, didn't feel like doing anything, and lots of headaches." I did not tell him that this stemmed from his disappointments at the last session, but suggested that we continue with hypnosis. This time he entered a trance more quickly and it was much deeper. He recalled his departure from his mother, when he was sent to the home in the western part of the country. He immediately began to cry, telling me between his sobbing that he had felt terribly abandoned. He was completely lost in his pain and asked repeatedly, "How can a mother do such a thing to a child?" He also remembered that he had vomited on the train platform because

he had felt so agitated and anxious, but his mother had been unrelenting. He was so agitated that I suggested that he would feel better and relaxed after he woke up. Simon Y was conspicously composed and calm after the hypnosis. He was silent for a while before saying that he could recall everything. After a pause he added, "I don't dare even think that I'm in treatment here and that it's going to continue."
Consideration. I did not tell him that he feared that I might send him away, just as his mother had done. Such an interpretation would have constituted too great a burden at this point.

Commentary. The patient's fundamental anxiety about being sent away and pushed around, i. e., his lack of security about having a fixed place in life, and his anxiety about being sent away again led the analyst to first strengthen the therapeutic relationship and not to interpret the anxiety. In our opinion the most important issue is to put the interpretation of anxiety about a renewed loss into a proper context. The rule that the analyst should interpret the anxiety at its point of urgency is frequently understood to mean that this is the deepest or strongest point at which the anxiety originated. If, in contrast, the analyst orients himself on which anxieties a patient is momentarily able to master, then the urgent points are different and the analyst can refer to a wide spectrum of affects. From this perspective there is no reason not to refer to the patient's anxiety by name and to assure him at the same time that as far as anyone can judge the continuity of the therapy is assured for quite a while.

The patient came to the next session in a fairly good mood, which was conspicuous. It had been a good week, at least for him. After he had made some introductory comments, I suggested that we continue with the hypnotic treatment. He could not concentrate and perspired, finally entering a trance and returning to kindergarten. Somewhere there were some other children, but he could not give more precise details. The teacher was nice. Simon Y saw himself in a sandbox, where he felt satisfied. He was not being teased.

After the hypnosis I asked him if he had not felt lonely playing in the sandbox while the other children were playing together. Simon Y gave me an amazed look and said, "Haven't you realized yet what a relief it was for me that the other children weren't bothering me? Being left alone was precisely what was nice. And the teacher wasn't bad either." He also told me that his mother had got rid of his little toy bears while he was in the home; "She didn't realize how important they were to me." I thought to myself that he had thus lost a transitional object.

At the end of the next session I gave him a small package containing a small toy bear and said, "It's not the same as you used to have, but maybe you will like it anyway." Simon Y beamed from one ear to the other when I gave him the package. He did not open it and silently left for home.

This week went very well for him, and his headache went away after a half a day of quiet. He told me how much he had enjoyed getting the little toy bear. "What a wonderful gesture that was." Then we returned to hypnosis, and this time he entered a fairly deep trance very quickly, a present for me. At first he was silent for a while, but then he became increasingly tense, swallowed several times, looked around anxiously, and said that he had previously not known that he had been sent to Amsterdam. He was just told, "It will be good for you to be together with other children." He now said that his mother and a social worker from the foundation supporting war victims had accompanied him to Amsterdam. Then he cried again for a long time. "How could my mother do this to me? She didn't know better, but as my mother she should have understood me." He added that every inmate in a jail was better off than he had been because the inmate knows what he has done. Simon Y

had not known why his mother had sent him away. At the home he had learned to be disobedient.

During the hypnosis there was a catharsis, and afterward I asked him if he had later ever spoken with his mother about this terrible time. His decisive answer was, "No. That was completely impossible. Mother would have been mad if I had wanted to talk about it." Since then he had given up the idea of talking about it with her.

At the end of this session Simon Y asked me if I agreed that we could now proceed without hypnosis. He said that not very much new material was appearing, and he had now learned to overcome his shyness and talk with me frankly. I agreed, adding that we could still try hypnosis again if he wished.

Consideration. Giving the patient the little bear was an unusual intervention. I had of course thought for a long time about whether I should do it and whether I was buying the patient's affection. I finally did it because I thought that it was a good idea for the patient to have a visible and clear sign of my presence and my involvement, especially since the treatment could only take place once a week. The further course of the treatment showed that my assumption was correct. The therapeutic relationship was strengthened considerably, which in turn had a clear influence on the therapeutic process.

Third Phase of Treatment

Simon Y was feeling much better. He raised the question of whether his frequent outbursts of crying during hypnosis had been a revival of his earlier suffering or an abreaction. I answered that it was probably both.

After the Easter break he told me once more about his youth, this time in particular that he had not had a father, and also about all his feelings of powerless and humiliation. In the next session he spoke about his pedophiliac behavior, saying that he found adult men repulsive and did not know how to act toward women. He preferred 15- to 16-year-old boys because a relationship with them was not binding. It was impossible for him to establish a firm tie. Yet he also regretted the fact that the boys all grew older, ceased to be interesting to him, stopped exciting him, and usually went their own ways. It was a disappointment built into such relationships. He then raised the question again of the sense of life "on this lonely star." I let him tell me a lot about himself, not making any interpretations and only asking questions to keep him talking. The topic of the following session was his passivity. He said he was able to do nothing for days, got terribly bored, and became tired very quickly. At times he would get very angry with himself, but was unable to understand why. Nonetheless, in the meantime he had registered himself for an athletic project where he lived. He had done it in such a way, however, that nothing could come of it. I told him about the possibility of kinesitherapy and asked him what he thought of the idea that I register him for it. He reacted unexpectedly positively, saying that it appeared to him to be a good thing to do.

Just one week later he asked whether there was any news about the kinesitherapy. He said he had had the idea that he had to organize his life differently, that things could not continue as they had, and that nothing was free either. During one of our first sessions I had told the patient that it would be good if he got more exercise and that his dog was bound to enjoy it, too. It was easy to see that the patient was not in good condition. He told me that he had walked and cycled a lot in the last few days, leaving him suffering from muscle aches. He was so isolated from others that it was impossible for him to bear permanent company. And he was angry

once again that his life was wasting away so senselessly. Then he mentioned a new factor. He had had a conflict with the municipal administration, having been given a reminder to pay his dog tax, which he found completely unfair. Simon Y complained bitterly about the bureaucrat's unfairness. But then a miracle happened. Completely by surprise, he had received a letter from the city informing him that because of the special situation he was being freed of the obligation to pay the dog tax. Simon Y was happy about his victory, but at the same time said that he was not really concerned with the tax, just with getting his way.

My assumption that winning this conflict would strengthen his self-esteem turned out to be an illusion. In each of the following two sessions Simon Y complained that he felt lonely, that his situation was hopeless, and that everything was senseless. He had received news that he could move into a small new apartment at the beginning of July, but he reacted ambivalently to it as well. "There's no purpose left." His attraction to the boys grew stronger and stronger. "Nothing works any more; there's just misery and frustration." Although I had just been informed that he could soon start the kinesitherapy, I did not say anything about it in this session.
Consideration. I had the impression that I would only have given him some superficial consolation by telling him about the kinesitherapy and would actually disturb his efforts to solve his conflict. In addition, the summer vacation period was approaching, and it seemed a good idea to me not to give him the good news until shortly before the summer break.

In the next session I told him that he could start the kinesitherapy after the summer break. Simon Y replied, "If you had told me that a year ago, I wouldn't have accepted. I wouldn't have believed it would happen. Today I intend to continue." Afterwards he told me about a dream in which he was in prison and felt sullen and completely indifferent. It was at this point that he told me for the first time in detail what had happened when he committed his crime.
Consideration. I thought that his dream reflected his real situation, being alone, especially prior to vacations, but I still thought it was too early to offer an interpretation, especially considering the approaching summer break.

Simon Y asked what I was doing during my vacation. He had imagined something like Nepal, a safari in a reserve in Africa, or at least one of the Caribbean islands. I told him that I would spend my vacation in an ordinary mountain village in south Tirol, and gave him my address. Simon Y did not have any plans himself. How should he have any? Just some hazy idea about driving far away into the Sahara desert, together with his dog, in his old delivery van. At the end of the session he told me, "Don't worry about me, I'll get over the long gap in good shape."

Fourth Phase of Treatment

Simon Y was lethargic when he came to the first session after the summer break. He was not at all inclined to move into a new apartment. After remaining silent for a while he told me that he had met a 14-year-old boy about four weeks ago. The boy attended a school for children who were emotionally disturbed and had learning difficulties; Simon Y described him as being very sensitive and attached. The boy often spent the entire day with him, but they had not had any sexual contact yet, although the boy was seductive. We had a long talk about the pros and cons of such a sexual relationship with a minor. Simon Y was convinced that "If a boy wants this kind of thing, then it's a sign that he needs it, and then it couldn't be harmful." He himself referred to the legal difficulties; "If the boy were one year older, then the

police would be more likely to look the other way." After Simon Y had raised the issue, I asked him whether he wasn't deterred by the risks associated with such a relationship. He answered spontaneously that he did think about them but that a person had to take some risks in life, and that in addition the boy had already had several experiences and would not say anything. Important for him was less the sexual contact than the tender feelings he felt toward the boy. He added, "But if he clearly leads me into having sexual contact, then I don't know if I can resist him." Consideration. It was clear to me after this session that the therapeutic relationship was now secure enough for him to tell me about these things without being in the least afraid. At the same time I asked myself the question I had not asked the patient, namely if the fact that he had established ties to this boy was not a consequence of the summer break.

Several hours later Simon Y came into my office very excited. He had been threatened in his house by a group of older boys and managed to escape through the back door. In response to my questions he admitted that he had had sexual contacts to one of the boys several years ago, but that this boy now had a girl friend and was filled with hate toward Simon Y. We talked in detail about this being one of the risks of sexual contacts with younger boys, and I summarized: "The boys want adventure and sex, while you desire a relationship you cannot have with people your own age. The result is that you have diametrically different interests, and therefore such a relationship cannot offer you what you expect. And besides, it can only last a very short time." Simon Y said that this last point was especially important to him and that he shyed away from a longer-lasting relationship. Moreover, he said he could not act differently since pedophilia was inherited. I replied that we would continue talking about this topic later and that things were not as simple as he imagined. During the next two years we talked about this topic over and over again in different contexts.

I had the impression that the preliminary phase was completed after nine months of therapy and that the therapeutic relationship had been consolidated, permitting us to slowly enter the phase of analytic psychotherapy. It is usually impossible to clearly distinguish between the two phases, and this was true of this patient as well. The main result was that a fairly stable therapeutic relationship had been established and that the patient was ready to cooperate and was motivated. It was also important that the transition to analytic therapy took place as continously as possible and that nothing abrupt happened in treatment that came completely unexpected for the patient. It hardly deserves emphasizing that interpretations are always directed at the patient's experiencing and at his momentary understanding and insights.

The goal of the subsequent therapy had been defined, namely to give the patient the opportunity to find meaning in his life, which he had experienced to be senseless. The question that was always in the background was the degree to which he was "predisposed" to pedophilia. This case confirms our experience that an effective treatment of pronounced and fixed psychosexual disturbances is only possible within the framework of a comprehensive psychoanalytic therapy. Motivation, of course, plays a very special role in the therapy.

Summary of the Treatment

It is necessary to distinguish two periods in Simon Y's treatment. The first covered the period from August until October, the second from the end of February the following year until the conclusion of the period reported here in February a year later. Let me add that the treatment is still continuing.

Shortly after the beginning of the first phase the patient brought me a notebook containing his personal comments and asked me if I would be willing to read them during the next week. The primary topic of his comments was the story of the euthanasia of his dog, which had been incurably ill. To keep it from suffering, Simon Y had fed his dog the sleeping tablets he had saved "for an emergency." His notes revealed his intense emotions, his normal intellectual ability, and his state of neglect.

A topic that dominated the first period was his frequent crying. He began crying during the interviews after he had had a crying fit in one of his sessions of kinesitherapy. He viewed his crying as a sign of his inability, yet also felt a strong aggressive force within him, which he was afraid of. He requested hypnosis once again, in the course of which he had a crying fit, worse than anything he had experienced since the initial sessions. Conspicuous was the fact that the patient hardly cried any more after we had discussed the fit in the context of his most recent experiences. Other themes that frequently recurred were his loneliness and his inability to make social contacts. After this he made his first small and hesitating steps to make contacts; for example, he helped at a traffic accident and volunteered to help at an animal home. At the animal home he was turned down; he was very surprised, however, that he had accepted this rejection as something normal, not letting it affect his entire life. In this phase pedophilia was a secondary topic; occasionally Simon Y asked why it was that he found precisely these boys so interesting. Yet the time was not ripe to discuss this topic.

It came as a complete surprise to me when he announced in October that he wanted to end the therapy. He felt independent and strong enough to try to continue without therapy. He also mentioned that he had contacts to a commune that was ready to let him join. He was very impressed that there were people outside of therapy who accepted him for what he was; he could even bring his dog. He also asked whether he should get into contact again sometime, and I answered that I would be pleased to hear from him.

A few months later he called me, and it was more than a coincidence that he called at exactly the time he would have had a session. He told me that an acquaintance of his had committed suicide in an extremely dramatic way. He came the next day and gave me the impression of being calm and unexpectedly self-secure. He was very saddened by the suicide, yet was easily able to imagine what had happened since he himself used to have such thoughts for many years. He also made it clear that he no longer had such thoughts. Then he told me about the commune. Once in a while he had conflicts, but he was always able to talk about them. I had the impression that the head of the commune was rather authoritarian. Simon Y also mentioned the name of a girl who lived there, and after our conversation he seemed satisfied and returned to the group he lived with.

It was clear to me that the treatment had not been concluded; my impression was reinforced by the fact that the group he lived with seemed to exert more influence in the direction of dependence than of independence. After a few months Simon Y returned again. At first he was depressed by the fact that he had left the commune. He viewed this as a failure, and it was only after several weeks that he realized that it was a gain, not a loss. He had not given in to the pressure to submit to the others. This strengthened his self-confidence, even in some otherwise bleak sessions. At this point, therapy focussed entirely on his pedophilia. It was then time to offer the interpretation that he was looking for himself in the boys, that it was a matter of identificatory love, and that he admired them because they were - at least externally - the way he had previously wanted to be, namely independent, free, not tied down, and free of anxiety. He could see that his younger friends were

psychosocially disturbed; he recognized that their behavior was almost exclusively subordinate to obtaining direct oedipal satisfaction, that they viewed others only as objects of gratification, and that they were not or not yet able to establish a permanent personal relationship.

Analyst's Concluding Commentary. At the time of this report, two questions are at the center of the interviews. First, why is it so difficult for Simon Y to free himself internally of these younger friends? And second, why does he have so much anxiety toward women? He rejects homosexual contacts. Finally it should also be mentioned that he has not had any sexual relationships to his earlier friends for a long time.

A lot has happened during Simon Y's therapy. In many regards he has changed in obvious ways, a fact that his acquaintances confirm with admiration. We both know that his therapy has not yet been completed. Its length depends on the specific goal we pursue in therapy.

6.2.3 Adolescence

The crises that occur in adolescence are signs of *new combinations* and *adjustments* (Freud 1905d, p. 208) that we today view, following Erikson, from the perspective of identity formation and the search for identity. Blos (1962, 1970) described other aspects as separation and individuation processes, while Laufer (1984) focused on the integration of sexuality. The adolescent has qualitatively new kinds of experiences with himself, his body, his parents, and last but not least in his search for people outside his family. These aspects are still being given too little consideration within the psychoanalytic theory of adolescence. The adolescent not only attempts to actively influence his enviorment, but in handling his conflicts also tests new strategies (see Seiffge-Krenke 1985; Olbrich-Todt 1984). It is in this context that Lerner (1984) referred to adolescents as the producers of their own development. These results of developmental psychology are important for the conceptualization of the treatment of adolescents because the technique and goal of therapy have to be formulated in correspondence with the dynamics of development.

In diagnosing neurotic disturbances in adolescence it is necessary to remember that the adjustments expected of adolescents can be avoided, blocked, distorted, or delayed for numerous reasons. The disappearance of traditional initiation rites in modern civilization isolates adolescents or leads to a new kind of group formation. As a result the familiar ambivalences, shifts in mood, and polarizations are manifested in particularly strong forms. The adult world loses its sense of being ideal, and the adolescent searches for new role models. Rebellion and admiration quickly trade places, and the therapist is usually viewed very critically as being an agent of parental and social norms. Frequently there are excessively strong desires for autonomy, which make it more difficult for an adolescent to accept the advice and help of an adult.

Problems of therapeutic technique even begin with a patient's increased inclination for self-observation, which, in the form of a disposition to reflect, is actually a desirable precondition for therapeutic work. Is it not inevitable that the adolescent who both observes himself more and yet also isolates himself would resist our offer to examine together the world of his thoughts and emotions - regardless of the nature of the disturbance? The analyst is thus not justified in automatically interpreting in a traditional manner the skepticism the adolescent brings to therapy, especially since the pubertal insecurity previously linked with sexual maturation is today given a different meaning and is expressed in various ways.

The other aspect of an adolescent's concern with himself is his craving to gain experience. The purpose of this craving is, admittedly, not primarily to turn away from thoughts and emotions. This is another of the traps awaiting therapy, for the analyst should not discredit this craving for experience as acting out. The adolescent's primary goal is to act and gather experiences to expand his still incomplete self-esteem. Self-observation and the craving for experience thus form the two poles of an adolescent's all-encompassing wish to

experience himself and the world. Erikson (1968) has especially described the significance of *experiencing* for the resolution of developmental crises in adolescence.

The cardinal question is whether and how the relationship between the adolescent and analyst can be employed as a "means to a end" in order to facilitate changes without getting too entangled in the complications posed by repeated transferences. Blos (1983) considered transference in adolescence the vehicle of a blocked development, calling transference in the therapy of adolescents two-sided. By reviving infantile positions and transferring aspects of self and object representations to the analyst, the old versions are actively remodelled via transference, creating a new revised version. The question is how the transference should be interpreted when adolescents use regressions for neurotic reasons to block the processes of development and separation. The reverse is also true. The transference wishes directed toward the therapist contain the danger of reviving traumatic experiences and are therefore warded off. This is the reason that it is important for the analyst here - in contrast to analyses of adults - *not* to put himself at the center of the transference at the beginning and sometimes even not for a longer period of time. By offering rigorous interpretations of the regressive components of transference, the analyst would take the place of the real parental figures and actually impede the separation. One of the paradoxes of the therapeutic situation is the occasionally very rapid manifestation of intense emotional reactions, which usually reflect some justified intense anxiety about the revival of infantile positions of dependence. It is therefore very important to induce a we-bond, as first described by Sterba (1929), as was attempted, for instance, by Aichhorn (1925) and Zulliger (1957).

The adolescent requires more than just insight into defense mechanisms in order for the blocked process of development to resume. His desire for the analyst to be a person to help him out of his deadend has to be understood to be an expression of phase-specific endeavors, for he would otherwise remain anchored in unconscious infantile expectations. The analyst's task is to differentiate between past and present, inner and outer worlds, and transference and real relationship in the analytic situation. The patient's utterances are properly freed of infantile residues if the analyst's examination of them allows for phase-specific desires as well as repressed infantile wishes (Bürgin 1980).

The issue from the very beginning is to structure the analytic situation so that the adolescent can use it as a sphere for making discoveries. The goal is to achieve a balance between *discovery* and *disclosure* . It is more than an anxiety about passivity and regression that prompts adolescents to want to transform the analytic situation into a *real* one. One meaning of their wanting advice from the analyst, desiring to know what the analyst is thinking or feels, and their attempts to provoke him into making emotional reactions is that they are attempting to attribute the analyst a human existence and thus to prevent him from becoming an omnipotent and anonymous figure. The adolescent does not primarily want to identify with the analyst to become similar to him, but wishes to distinguish himself and thus experience his own identity.

The preconditions for the course of analysis are created in the initial phase of therapy, when it is essential that the patient gain insight into the particular nature of the analytic situation as a place where discoveries can be made. Much depends on the therapist's ability from the beginning both to develop an understanding of the fears that his adolescent patient really has and to keep an eye on the fact that he has come to receive help. The younger the patient, the more important the real relationship at the beginning; transference can develop out of it gradually, depending on how the analyst acts toward his patient. It could be said that the adolescent first has to determine how and for which purposes the analyst can be of help to him.

Example

The parents of Otto Y, who was 18 years old, had scheduled an appointment for their son because he had been collecting old shoes for about three years. At his parent's urging he had taken part in a group therapy 18 months before, and as a result of this

therapy, which had only lasted six months for reasons beyond his control, he had become more outgoing and felt less dejected. Yet there had been no change with regard to his "shoe problem." Since I had this information before the initial interview, Otto Y was justified in assuming that I knew the reason he was coming. He was a tall young man who was very friendly but somewhat embarrassed when we met; he even bowed. To keep his embarrassment from becoming too great, I said to him that he probably knew that I had been told about his shoe problem and asked him to tell me what he himself thought about it. He responded by putting his problem out into the open: "I'm in love with shoes." This opening remark baffled me, yet I also thought it was very clever. He had cleverly managed to overcome the embarrassment of the situation and at the same time put me to a test. He wanted to know whether I, just like his parents, wanted to take the shoes away from him and to normalize him. I said, "I can imagine that it isn't always easy to be in love with shoes."

He then began to tell me the story of his shoes. He said he had collected shoes since he was a boy, but only shoes without shoestrings. He said he objected when his mother wanted to throw shoes away. His collecting had intensified about three years ago, and he also looked for shoes that people had discarded. At this point he did not mention the fact that shoe collecting also had a sexual signifance for him. He told me that he sometimes thought he was homosexual, because he did not have any feelings for girls. It became clear, in contrast, that shoes exerted a very decisive influence on his inner and his external worlds. While he did his home work he often had to think of shoes and lost his concentration. Yet there were also areas in which he functioned well; for example, he liked to paint in his free time.

The longer I listened to him, the more I noticed how well-behaved and willingly he related his anamnesis. Although it was possible for me to surmise something of his own unrest, the rather fluent manner in which he presented his report made me keep my distance. I therefore told him that he had told me a lot about himself, but that I still had the impression that there was something else that disturbed him more than the problems he had mentioned. He was silent a moment before telling me a little about his earlier therapy. In hindsight, he said that this therapy surely had helped him because he was less depressed, but there had been no change in his shoe problem. I then managed to show him that he was afraid of talking about his shoes with me as long as he had the impression that he was only coming to please his mother. I then referred to his parent's expectations; when they scheduled the appointment I had learned that they wanted at all cost to come to speak to me. I assumed that he knew about this, and therefore told him that he probably wanted to be present at this talk because he would like to know whether I let myself be influenced by their expectations. He would surely want to use the talk to find out what my attitude was to his shoe problem. We did not schedule a date for the beginning of therapy to let him make a decision about further talks.

Commentary. Whether it is necessary to talk with the parents of adolescents at the beginning of psychoanalytic treatment must be decided on a case by case basis. Contact to the parents is generally problematic if the adolescent seeks therapy himself because the consequence might be a breach of confidence. A discussion with the parents is also not necessary in the case of older adolescents if the latter have achieved a satisfactory degree of outward independence. If the analyst has decided to see the parents, then he should hold this talk in the presence of the adolescent patient. We recommend in such cases that the analyst not offer any interpretations about the dynamics of the family ties that they mention, but to restrict himself to learning something about the family's past and present situation.

During the family appointment Otto Y was a passive but attentive observer of what happened. In contrast to his mother, who had tears in her eyes when she talked about the shoe problem, his father did not seem particularly irritated. I was able to follow the roots of the still close ties between mother and son back to his childhood. In the period until Otto Y started school, Mr. Y was very busy in his carreer. I also obtained valuable information about the beginning of the shoe collecting. At the time Mrs. Y had been very worried about her older daughter, who had a serious illness that made a life-threatening operation necessary. She probably had felt very alone with her needs. It was likely that, in consolation, her son meant something special to her. This had obviously impeded Otto Y's separation from the family during adolescence. The occasionally fierce exchanges between mother and son were not only an indication of the separation difficulties, but they seemed to provide a disguised incestuous gratification, with which Otto Y secretly triumphed over his father and his world. At the end of our conversation I pointed out that Otto Y had used the shoes to build up a world of his own that was out of bounds to his parents. Something similar also applied to therapy. I added that if Otto Y decided to start therapy, then it would not be easy for them as his parents to accept the fact that they could not participate in it.

At his next appointment Otto Y acted as if the family conversation had never happened. In doing so he showed me that he knew how to cleverly avoid disagreeable situations by constructing two worlds for himself, a world of external events and his inner world that he attempted to make inaccessible for others. He was thus able to avoid conflicts in himself and in his contact with his role models. It also became clear that he had already decided in favor of therapy, yet he remained reserved and cautious. It was still his goal to find out whether I would interfere in his own personal affairs after all. He chose a topic that was particularly well suited for this, namely telling me that he wanted to be a conscientous objector but that he had not yet made up his mind entirely. And glancing at me, he said he would turn to somebody who should be able to help him for advice. There was a trace of his anxiety that it might turn out that he was really homosexual. It was easy to recognize his intention. He wanted to know how I would react to the topic "homosexuality," and mentioned further details intended to provoke me into showing my interest in homosexual experiences by asking follow-up questions. Two years earlier he had met a student in a recreational camp, which had stirred him very much. He had admitted his shoe problem for the first time to this student and later taken his advice to attend the group therapy.

It was impossible to overlook his anxiety about homosexual transference wishes. This anxiety had two aspects. On the one hand, it disturbed him that I left the opportunity open for him to find out if he wanted to be homosexual; on the other hand, he was anxious that I would try to "normalize" him in accordance with his parent's expectations. In order to keep the psychoanalytic interview open as a place for him to make his own discoveries, I told him that he wanted to know whether he could talk about everything with me here, including about his homosexuality, to clarify who he was and how he wanted to develop in the future. In doing so I asked him to accept a frustration, in that it was obvious that he was looking for immediate help to make a decision both with regard to the question of being a conscientious objector and to the possibility that he was homosexual.

Moreover, he also showed me how insecure he still felt about making his own decisions. It seemed as if he wanted to check if I would really react differently to his anxieties than his father-Otto Y felt his father had let him down - and than his mother - who interfered too much.

Otto Y now began to tell me about his more "normal" conflicts. He was having problems at school; for instance, he had to be tutored in mathematics and he even had the feeling he was worse than the others in art class, his favorite subject. The world of shoes offered him refuge. While doing his school work he often thought about how he could get the next pair of shoes. At the same time he felt the anxiety that he might be discovered by someone else or that his parents might observe him sitting at his desk with a pair of old shoes. At this point it was important that I show him how he suffered from being different than other adolescents his age. I interpreted his longing to be able to live like other adolescents who did not need any therapy, and linked his ties to the shoes with his ties to his parents, especially to his mother. He was afraid that he might offend his mother by openly admitting his passion for shoes instead of keeping it a secret. I therefore told him that he hoped that I would see both apsects, the one in him that was attached to his shoes and his mother, as well as the one that was seeking a way to separate himself and to go his own way.

At first this interpretation intensified the emotional tension in him. The more he opened himself to therapy, the more difficult it became for him to speak with me. His anxiety about feeling ashamed moved to the forefront, while he became franker toward his parents, even daring to mention for the first time that he went looking for discarded shoes. And he admitted to me that he liked to take the old shoes to bed, which made his parents feel disgusted. At the same time he denied that his passion for shoes had any sexual significance and pretended to be ignorant. For example, he claimed to have heard the word "masturbation" recently for the first time and not known what it meant. This was a sign to me not to attempt quickly to make the sexual quality of his shoe fetishism a theme.

It was not until much later that I learned that he had attempted for a while to masturbate with his old shoes, but had given up because he did not have an orgasm because of delayed ejaculation.

The fact that the periods of silence became longer stimulated the tendency in me to force my way into him by asking insistent questions. He apparently developed very intensive ideas about me, accompanied by corresponding resistance. My curiosity to inquire about the details of his fetishism made me realize that he both wanted to provoke me into overreacting and seemed to expect that I would free him of the burden of the hard work on this theme. For the patient, I was the expert who, in contrast to his parents, did not get disgusted and was able to listen to everything. My growing curiosity made it clear to me that I was supposed to assume the role of a clandestine fetishist. By making allusions and hesitating, he was attempting to make me eager to know more about his world of shoes, and he was apparently able to better control his excitement and the situation. It would nonetheless have been premature for me to refer to this regressive transference dynamic. It was much more appropriate to interpret his ambivalence toward me because it offered him protection against regression. I therefore picked up the idea that I was the expert for whom the patient was merely an unusual case, and told him that this idea represented his attempt to protect his private world of shoes from me and to keep me at a distance.

This interpretation seemed to be criticism, resulting from a disappointment I had experienced and was unable to recognize until later. Although I knew how sensitive precisely this patient must be to such ideas of adults, however well meant they were, I was still offended that he responded to my transference interpretations by saying "Oh, my oh my." Whenever I attempted to show him how he experienced the therapeutic situation, he felt forced into a corner "by these allusions to the situation," as he referred to them. "I don't have the vaguest notion what I should say." Gradually a little game developed. He said he was anxious that I might tear him to pieces if he

told me more about himself - just to respond to my next interpretations by saying, in an offended and accusing tone, "oh, my oh my" again.

I came to understand this "oh, my oh my" as an expression of his anxiety that I would use the transference interpretations to talk him into accepting my view of things, thus undermining his independence, which was instable as it was. To have to recognize how insecure and uncertain he was would have been even more shameful than for other adolescents. After I was able to show him how he was putting me to the test by saying "oh, my oh my," to determine whether I would react by being offended or whether I would take it as an offer with which he indicated how difficult it was for him to face his inner contradictions, he began to speak more and more about how critically he acted toward himself.

His own values led him to condemn his passion for shoes, which he was only able to maintain by splitting it off from his everyday life. He therefore resisted my interpretations relating what he tried to keep apart.

Otto Y feared that the therapy might destroy his freedom to have alternatives. There were a number of examples of his anxiety about making up his mind. For instance, at the beginning of treatment he had expected me to advise him in deciding for or against military duty because he was actually innerly incapable of making up his mind. The same was true of his decision as to painting with oil or water colors; I had told him that "There are two sides. You desire to be clear and decisive, but are at the same time anxious. There is something grand in keeping alternatives and not having to make up your mind. This is the reason you're resisting me, because you fear that I'll take something away from you by forcing you to make up your mind." He agreed, but added the objection that he really wanted my advice and felt left alone when I did not give any. The goal of his desire for advice was to prevent a conflict with his inner world and to keep his anxiety about being ashamed in check, which was becoming stronger and stronger. He turned red when I told him, after a fairly long period of silence, that he apparently now felt that I was demanding that he unveil the thoughts he was ashamed of. He said he was afraid because he had no idea where the therapy might lead. I discovered that there was a concrete reason for this statement, learning that the sessions aroused him to such a degree that he would walk the streets and look at shoes. He had recently seen shoes that had fascinated him very much.

I thought this was an indirect reference to my shoes, and felt that he would have to feel ashamed and resist my discovering this connection instead of leaving it up to him to make this discovery himself. My request to reschedule one session created just such an occasion; in the following I give excerpts of the protocols of two sessions, which I wrote from memory immediately after the sessions. The rescheduled session began with ten minutes of silence, which was unusually long for this patient.

P: At home I've misplaced a list of adverbs and searched everywhere for it.

A: Perhaps it's not a coincidence that you mention this list just now because here you often try desparately to find the right word.

P: Oh, my oh my, overinterpreted once again. That just fits the cliché of the psychoanalyst. I mean something entirely superficial, and you immediately assume something at a deeper level.

A: You are convinced that I constantly want to learn more about your passion for shoes and don't even realize that right now we are talking about rescheduling a session, something that might make you angry you because you have to do as I request.

P: Yes, I was a little angry and had the feeling that you are deciding for me. But now everything has been decided.
A: So that we shouldn't concern ourselves with your anger at all.
P: At home I'm sometimes pretty angry at my parents. Often it's just some feeling inside, but sometimes I'm desparate and cry, for example when my mother criticizes me because I've misplaced something. It happens quite often, and then she complains that I'm unreliable.
A: And you often feel as if you have to cry here when you feel I'm pressuring you.
P: Yes, sometimes I do. The point is that you are not supposed to be just my psychoanalyst, but an average person, so that I can maintain my dignity.

I had to think about the word *Verlegen* , used in German both for *rescheduling* the session and for misplacing the list of adverbs. I wondered about how he used "oh, my oh my" to resist becoming dependent on me in the same way as on his mother. He thus also had to protest against transference interpretations that mobilized his regressive desires and conflicted with his desire to be separate. He offered me the following figure for a relationship: He was looking for a list of adverbs that he had misplaced, his mother demanded that he be neat and complained to him because by misplacing it he eluded her control. With regard to transference this meant that he feared I could adopt the role of a demanding mother figure who expected to be told about everything and whose interpretations destroyed his freedom to choose, undermining his own initiative. On the other hand, by putting me in this role he was able to avoid the conflicts with himself, his affects, and his fantasies by insisting that everything be taken concretely. Yet then there was the danger that we would get caught up in a vicious circle of accusations and counteraccusations. Thus it was necessary for me to make his part in transference clear to him. By returning to the idea that I was supposed to be just an average person, he referred to the fact that he felt embarrassed in my presence. He was embarrassed, in part, because he always felt insecure about how much he could reveal about himself without putting himself at the mercy of his own regressive desires. It was therefore also important for him to be able to determine the time at which he would open himself to me. Consequently, at the end of the session I referred to the fact that rescheduling the session had apparently reinforced his anxiety that he could lose his control of himself and of me. He replied that this made him feel very embarrassed, so that he was no longer sure whether he still wanted me to grasp what was going on in him. He saw me as a psychoanalyst who overinterpreted everything.

Otto Y arrived for his next session exactly one hour too early. Since he never waited in the waiting room, but always knocked on my door at precisely the right time, it was impossible for him to have noticed his confusion. After he had remained silent for a while, I opened the session by asking him whether he had noticed that he had come too early. At first he was certain that he had not confused anything, before becoming hesitant.

P: Oh, my oh my, then I must have really confused it with Friday's session.
A: "Oh, my oh my," you otherwise only say it when I tell you something that you resist.
P: Yes. [Longer pause]
A: Before you go any further, we first have to find out what ideas you have about what I should do so that you will come to feel secure enough again.
P: [Intensely] Well, everything I say disappears in the back of your head, and I have no idea what you do with it. Second, we don't have a goal here, not even a preliminary one, and third, I'm afraid that I'll lose the last rest of my dignity and

self-respect when I'm here although I would like you to help me maintain my self-respect. But we talked about this in the last session too.

A: In the last session you apparently had the feeling that you might lose your self-respect.

P: [Confused] What actually happened? Just now I can't recall. So much has happened in the meantime, I was at a birthday party, there was a music festival, and yes, now you're certain to begin wondering why I can't remember it any more.

A: It's becoming clear to me how difficult it is for you to switch from the one world to the other each time. Here's everyday life, and here's therapy, where we talk about your shoes. [The patient interrupted me before I could continue.]

P: And here I'm always reminded of your shoes. [He smiled while he said this.]

A: Precisely, and then you have the desire to possess them.

P: In end effect, yes, when you stop wearing them some time. [Long pause]

A: At any rate it's clear that you're struggling against always being reminded of it.

P: Because I'm afraid that I'll let down and won't achieve as much. And there are two things I haven't told you yet. Since I was small I've had the problem that the thought that animals are killed to get leather is repulsive. And I think this is the reason I can't throw shoes away. And besides, it's extremely difficult for me to talk with a person wearing shoes that I like. A physical attraction develops. But if the shoes don't suit my taste at all, then it's even more difficult to start a conversation with the person wearing them. Your shoes have something that's very important - they don't have any shoe strings.

A: I think you're not only talking about shoes but about a longing linked to the shoes. Being very close to someone is the issue. And if I wear shoes that both of us like, then I come so close to you that for this very reason it's difficult for you to talk to me.

P: While you were just saying that, I had an unpleasant-pleasant feeling that went deep inside me. [While leaving, he added] At any rate I won't forget today's session.

This session marked an important step toward consolidating the working alliance. Otto Y had secretly included me in his world of shoes some time previously without being able to talk about it. My shoes had both excited him and frustrated him. Since he had become increasingly fascinated by them and them alone, he felt himself becoming increasingly dependent and was ashamed of it. He viewed the rescheduled session and the fact that he had come too early for the following session as embarrassing indications of how reliant he had become on me. To have admitted all of this to me would apparently have meant to him that there would not be any borders between us any more and that I would have complete control of him. By raising the question that we would first have to find out what I could do to help make him feel secure again, I gave him the opportunity to attack me and distinguish himself from me. And by stating that everything disappeared into the back of my head and that we did not have a goal that would distract him from shoes, he referred again to his anxiety that he might be completely dependent on me, making him lose all self-respect. He showed me how he lived at two levels and had already begun to exclude me from his world of shoes. He drew a boundary between his two worlds, and switched from one to the other; although this isolated him, in this way he was able to continue enjoying the satifactions offered by his shoe world. By asking him how disturbing it was to switch back and forth between these two worlds, of his shoes and of everyday life, I gave him the opportunity to let me take part directly in his world of shoes, opening it for a moment and thus integrating a little of his split off world. He

both admitted something he had previously kept for himself and also partially identified with me. By making it clear to him that I wore this pair of shoes because *I* liked them, it became possible for him in this session to confront the conflict between his longing for physical closeness (the reason he wanted to possess my shoes) and his desire for separateness (the reason I should not give him my shoes but resist his desires). He began to let himself have insights into his unconscious conflicts, which was closely connected to the experience he had with himself and with me in this session. In this sense, this session can be considered a turning point in this therapy. Otto Y began to recognize that the issue was not his shoes in a concrete sense, but what they meant, for example his desire for closeness and his anxiety that this closeness would amount to self-sacrafice. In the further course of this therapy, the patient began saying "hum" instead of "oh, my oh my" in response to interpretations he felt touched by. The "hum" left him the alternative of either telling me why he saw something differently, or beginning to work with. He stopped experiencing my interpretations to be interference, and instead took them to be tools with which he himself could work.

Commentary. To determine the conditions under which Otto Y's fixation for this fetish developed, it is necessary for his fascination with the world of shoes to be retransformed into the story of the conflicts related to the unconscious fantasies and pleasureable desires that he originally had toward a role model and that he tried to express indirectly in the fetish. It is also necessary to start from the biographical fact that this patient had lived in two worlds since before he turned 3 years old. He lived in and with his fascinating fetish, which was a symbol that indirectly expressed all of his fantasies, imaginary thoughts, and illusions and which probably originated out of various transitional objects. Nonanimate objects, which do not have any disturbing activity of their own, are very well suited because there are practically no limits on someone using them as the object onto which all imaginable conscious and unconscious fantasies are projected. Separated from an individual's personal development and from interpersonal relationships, a fetish finally also becomes a sexual object in the narrow sense of the word. The fascination that certain shoes can exert demonstrates the immensity of man's imagination. Yet even it cannot ignore the fact that shoes can be beautiful, ugly, attractive, or repugnant. It is noteworthy that the patient suffered from knowing that his love was directed at an object that was only available to him because an animal had been killed. The leather was an unconscious reminder to him of the killing of a living being, i. e., of aggression and destruction. It is instructive that the patient was only fascinated by shoes that were closed while all shoes with holes for shoe strings belonged in a negative group and even exerted a disturbing sensation. It is possible that the patient unconsciously took the holes to be a mar that, according to the displacement of perception onto the smallest detail, reminded him of every kind of injury and destruction. Closed shoes reestablished an unblemished world, yet one that was burdened with guilt, i. e., with the killing of animals.

It must furthermore be noted, regarding the psychodynamics in this case, that the patient's fear of possibly becoming homosexual - precipitated by his close friendship with a university student in whom he had confided - was another sign of his tie to the fetish, which inhibited his development. This tie apparently completely restricted his freedom for heterosexual contact and led to an absence of pubertal changes, disturbing both to him and to others.

This description of the psychodynamics, intentionally kept very general, integrates many important points of the psychoanalytic theory of fetishism and yet does not preclude any possibilities about what might occur in the course of therapy. The symptom formation was able to ward off conflicts from both the oedipal and the preoedipal phases of development (Freud 1927e, 1940a, p. 203; Greenacre 1953; Stoller 1985).

If we attempt to identify the common denominator of the views of different authors on the psychodynamics of fetishism, we discover that these views are focused, on the one hand,

around pregenital and androgynous desire, and on the other, around the themes of controlling and exerting power. The fetish that is later sexualized frequently originates from a transitional object; the intensive satisfaction and security provided by the fetish is associated with this transitional object. As a result, therapy first leads to a disturbance because the patient's anxiety that the analyst will take away the object with which his entire happiness and feeling of security is associated. Although the analyst in this case was aware of this problem and made an effort not to appear as an agent of the patient's parents whose goal was to normalize him and take away his fetish, he still got into a dilemma that was closely linked with the development of transference. Especially with symptoms as in this case, there is an intense feeling of shame tied to the revelation of perverse practices. The patient was able to open himself step by step despite serious inner difficulties. In some instances, however, we can see that the analyst's interpretation of the patient's strategy to separate himself contained elements of criticism although his intentions were just the opposite. Thus the patient must have taken it to be unspoken criticism when the analyst offered the interpretation that he, the patient, wanted to keep all his options open instead of making up his mind and that he struggled against the analyst because the latter might take something away from him. This type of interpretation can be found very frequently, being made by well-meaning analysts who assumed that the patients would understand on their own that it was obvious that nothing would be taken away from them and that any anxiety that this might happen was unfounded. We recommend that the analyst, instead of suggesting that the patient realize that his resistance to transference is unfounded and give it up, examine the momentary genesis of the resistance together with the patient, i. e., that they look for the causes of the resistance in the here and now. In doing so, they must assume that the patient has good reasons for being disturbed. A good example can be seen in the passage of this patient's therapy in which he overcame his confusion. After the analyst had asked the patient for his opinion about what should happen so that he would again feel secure enough, the patient mentioned three points that have to be realized step by step in every analysis in order for it to reach a positive conclusion, i. e., achieve therapeutic change. Every patient is dependent on what the analyst thinks about him and where analysis is going, and the patient's self-respect is regulated by his relationship to the analyst. The comments that this analyst made about how difficult it was for the patient to switch from one world to the other sufficed to stimulate the patient to describe his transference fantasies about the analyst's shoes. In this unforgettable session the fetish became manifest in the transference neurosis. The analyst provided sufficient support in the process so that the working alliance was consolidated. Of course, this merely established some common ground, i. e., a similarity in taste regarding shoes. The task then became to work with the patient to develop positions at other levels that could lead out of the fetish. Such a tight "shoe" can only be overcome if the individual already has one foot somewhere else.

6.3 The Patient's Family

As we explained in Vol.1 (Sect. 6.5), it is necessary for the analyst to act toward the patient's family in a manner in accordance with medical ethics, which includes maintaining discretion. This sounds less rigorous if we say, along the same lines, that the analyst is bound to serve the patient's best interests. It is the goal of every psychoanalytic therapy to promote the patient's autonomy. Since it thus automatically impinges upon ties the patient has already established, the consequences of psychoanalysis have always been significant for spouses and the couple (Freud 1912e). Under exceptional circumstances, e. g., if there is a psychotic illness or a serious danger of suicide, it is both legally unproblematic and medically necessary for the analyst to keep in contact with the patient's family and for a decision to be reached that is acceptable to all the parties. Yet there are also indirect ways in which the patient and analyst can involve or exclude absent third parties.

Before we turn to a few typical problems, we would like to describe treatments that transpire to everyone's satisfaction. There are several reasons for choosing this point of

departure, one very important one being that in recent decades there has been too little awareness of the fact that the improvement or cure of a patient with a neurotic or psychosomatic illness is a process that, taken as a whole, provides the participants and everyone else concerned far more pleasurable moments than disturbing ones. Just to consider our experience in this regard since an earlier publication some 20 years ago (Thomä and Thomä 1968), we can see that one characteristic of therapies that are largely free of complications for the families is the fact that the changes the patient undergoes extend and enrich the *scope of family life* . An important precondition is that the relationship possess a viable basis that has been strained primarily by the neurotic symptoms of one of the partners. In a different situation, for example if the partnership originally developed on the basis of neurotic ties or has been sustained by them, changes in the neurotic equilibrium lead to substantial complications. The partner not in therapy naturally responds negatively, suffering, for example, from the fact that the partner who previously was dependent has become more autonomous and freed himself of his neurotic dependence.

Let us consider treatments that are free of complications more closely, starting from the one position that we believe is appropriate, namely a three-person psychology as elaborated by Balint. In the actual psychoanalytic situation this triad is abridged to a dyad, which we would like to refer to as a "triad minus one." The fact that the third person is absent, present only in the participants' thoughts and not in reality, has far-reaching consequences. The resolution of the dyadic and triadic conflicts that develop depends on all three parties. Keeping one's eye on the patient's own best interests may well permit the analyst to lend an ear to the patient's spouse, to allude to the apt title of an article by Neumann (1987). These metaphors are not intended to distract analysts from the responsibilities that follow from their clearly defined therapeutic task. To lend a ear to the patient's spouse means to us above all applying our psychoanalytic knowledge about triadic (oedipal) and dyadic (mother-child) conflicts in such a way that the individual patient attains autonomy compatible with a happy relationship. The goal of achieving a postoedipal heterosexual relationship is a guiding utopian fantasy, probably reflecting a deep-seated human longing that is apparently represented by the psychoanalytic pair. It is the object of envy and jealosy from without. On the other hand, the analyst, precisely during the development of transference, must also be aware of the voices of those outside therapy, even though he generally only hears these voices through the patient's mouth. This is the reason that members of the patient's family frequently assume that it is impossible for the analyst to obtain an accurate picture of what the patient is like in reality and how he really acts. This results in tensions, which however can be alleviated or defused. Each of the three participants can contribute to this, and the typology of complications depends on the attitude and behavior of each of party and on their interaction. Since we have described the typical constellations in Vol.1 (Sect. 6.5), we will now provide an example of how a spouse can be involved.

Our frankness about the consequences that analysis may have for a spouse has led us to pay special attention to whether, for example, patients use their spouses for negative transference. If the analyst pays attention to the types of transference, analyses are freer of complications and fewer family members express the wish to speak to the analyst. For therapeutic reasons we prefer the patient himself to provide his spouse sufficient information that the latter does not insist on satisfying a wish to speak to the analyst. It is a cause for concern if a patient completely excludes his spouse from his analytic experiencing. We therefore discourage analysts from recommending, as part of the basic rule, that the patient not speak with others about the analysis. Such a recommendation, which many analysts even used to give in the form of a commandment, only leads to unnecessary stress and is never completely obeyed anyway. It is all the more important for analysts to pay attention to what patients tell others regarding either what they have experienced in analysis or the analyst's comments. The masochistic component of many neurotic disturbances, including the tendency for patients to inflict an unconsciously motivated injury on themselves, is another reason it is essential to pay attention to the manner in which patients let their spouses participate, or keep them from participating.

A Case of Possible Suicide

In the analysis of Martin Y, who suffered from compulsive symptoms, there was a manifest danger of suicide that was situational in nature, in this case being resticted to marital conflicts that hardly ever rose to the surface. The result of the equilibrium that had developed in his marriage was that each party avoided emotional involvement with the other. In a typical expression of turning aggression against himself, the patient thought more frequently about suicide, which he kept a secret from his wife. In analyzing transference I was not able to interrupt this development. Patterns of interaction that the patient had acquired since childhood were repeated in his five-year-old marriage. His wife had partially taken the place of his mother, and the patient retreated into spiteful passivity, as he had done before his marriage; she did not have any idea that his symptoms were actually reinforced by her behavior, which was soothing and avoided insisting on clarifying differences. The approaching summer break caused me some concern because I feared that without therapy the unspoken tensions between the couple would grow, as would in parallel the risk of suicide. In this situation I made the recommendation that the three of us have a meeting. The patient was relieved. It turned out that his wife had already wanted to turn to me because of her husband's isolation, but believed that she was not supposed to disturb the analysis.

In order to make the marital conflicts that reinforced the patient's symptoms and the three-person consultation presented below more comprehensible, I will first describe several particularly grave features of the patient's personality that were the determining factors behind his symptoms and behavior in private and in public. Martin Y had tried since his school days to function as unemotionally as possible, and thought he therefore seemed cold, arrogant, and funny. He led a constricted and withdrawn life, as if he were in a cage. He recalled that as a boy he had often said, "This is no way to live." Another noteworthy feature was that something in him only became alive after others became excited. This usually concerned situations in which a life was in danger. Most of all he would have liked to break out, run away, take his backpack, and emigrate to a foreign country to risk his own life. By referring to repulsive examples, his wife managed to make him give up his plans. But then he would think about other ways of breaking out. At work, where he was a model of orderliness and conscientiousness, he intentionally made gross mistakes, risking his job. He said he wanted to be fired.

During the first few months of his therapy, Martin Y caused an automobile accident, missed sessions, and came late. If he felt that I was worried, he livened up. He described how he had grown up in an environment void of emotion. His parents had led a withdrawn life after the death of his younger sister, and for many years he had felt accused of having caused her death. There had not been a chance for him to clarify anything by talking with his parents, which strengthened his idea that he was guilty - after all, he had once overturned his sister's buggy. He later discovered that she had died of a congenital disorder. And because on the day of the funeral he had run with delight toward an uncle who had come from far away and whom he had loved, his father had spanked him, which led Martin Y to have to stutter for some time.

Martin Y cried and felt liberated by being able to recall these memories from his childhood and talk about them. The proximity to his repressed aggression was made clear by sentences such as, "I only want to inhale because I'm afraid that something evil might come out when I exhale." He became able to mention one of his most

frightening ideas, which had kept him from having intercourse with his wife for a long time, namely that he was afraid that he might fatally injure her in doing so. His wife's consolation helped him get over many things. He described her infinite patience that everything would take a turn for the good one day.

The patient had fewer compulsive ideas, anxieties, and impulses. I attributed this improvement to the fact that he had begun clarifying the background of his unconscious guilt feelings. Aggressive impulses had been repressed after the birth and death of his severely handicapped sister. Both verbalized and fantasized feelings of guilt, isolated from his experience with his sister, had led him to expect punishment. This expectation manifested itself over and over again throughout his life, tormenting him yet remaining imcomprehensible to him. It was the consequence of his unconscious guilt feelings, such as Freud (1916d) described for several character types.

One Sunday, just prior to a longer vacation break, Martin Y stayed in bed all day. He said his wife was not at home and he had dozed. Gradually he admitted that he had been making plans for committing suicide. Yet he had always come to a dead end because he was not able to decide whether he should get divorced first and then take his life, or whether he should act first. His wife was shocked when she returned that evening, but was apparently able to quickly regain her composure and distract and raise his spirits. Somehow they managed to patch everything up again, yet even after these tormentous hours there was no clarification.

It was after this event that the three of us met as agreed. Martin Y's wife said that her husband had become quieter and quieter. Often she did not know what to do. When she asked him a question, he would not answer; he would just let her hang. It was completely incomprehensible to her that he wanted to give up at work and still managed to appear happy. She said he was actually very conscientious, just as she was.

I said the point was now for us to clarify the situations that were incomprehensible to each of them, and to examine why he alternated between giving up or wanting to be fired, on the one hand, and, on the other, felt that he had to do everything to complete perfection. Martin Y, who had been silent until now, suddenly came live, saying it was indeed necessary to find a new solution. He claimed that everything would clear up after he gave up his profession to do something else. His wife immediately tried to talk him out this hopeful idea that gave him relief. She reminded him of friends who had flipped out and of the catastrophies that had happened, and demanded that he finally talk with them to find out for himself. Yet she was full of despair, she said, because he refused to do it; he would never talk. Then she began crying.

The patient sat sunken over his chair with his face, emotionless, turned away. After a while he said it was rediculous for her to talk this way and to dictate what he should do. She would say what to do, she would say what he should say and do. And somethimes she would kick him under the table to liven him up even more.

The cool manner in which he raised these accusations probably added to his wife's despair, prompting her to mention other complaints. She said that this was exactly the way things went at his parent's house. He did not say anything there either; he would, especially, simply not respond to his mother's questions. Then *she* answered for him because she felt sorry for his mother. He was outraged again, saying that when she started in this way, then it was impossible for him to do anything. It would be just the same when they went on an excursion and she would constantly say, "Look there, can't you see . . . there . . . and over there . . . how beautiful!" He had eyes of his own, after all. Then both of them had to laugh.

In this more relaxed moment I summarized that our conversation had followed the same course. *She* spoke, she answered, she was the first to show emotions, and she had to cry. It looked as if *she* had to speak, answer, feel, and cry for *him* . The wife interrupted me rather abruptly, saying that no, this was not the way she acted, but with time she had gotten to know him so well, she did not want to be this way, and it was impossible for her to be this way because she sometimes had no idea what was going on inside him. This was true, she said, especially when her husband blurted out terrible words. I remarked that this must make her anxious, particularly when he talked, as he had recently, about wanting to commit suicide. It was understandable that she then reacted so quickly and used all her strength to calm him down and distract him. Well, she responded, she often preferred that he talk like this instead of not saying anything. Of course it was better for him to say more about what he thought. She added that he had recently really pleased her. He had woke her in the morning, saying "Come on, get up! We can't arrive too late." He had been so decisive and had for once taken the initiative, making it really nice. She said she did not want to always be the lead dog, to make his decisions for him, and to have to tell him everything including which clothes he should put on. The patient became excited and interrupted her, telling us that he knew which clothes he should put on. Then *she* interrupted him, claiming he was like his mother; if someone told her "Put on your new dress, you look so good in it," she would start finding reasons not to - this, that, and everything would be wrong and she should have bought an entirely different dress, it was too warm and too expensive. Her husband would not say anything about how nice she looked in the dress. Nothing would be decided. Meals were the same. Although each of them knew exactly what he would like to eat, they could go on for ever. Neither of them would ever say what they wanted to eat. This made the patient angry. He said it was typical. His wife was fast to make a decision in everything. He said the point was now not to disregard others but to take their indecisiveness into consideration. He asked if it were not possible for her to try to understand what his reasons were. We went on to discuss this theme with regard to other everyday examples.

It was the first time that the couple had been able to talk openly with one another and think about their disappointments for a long time. Each of them promised to make an effort during their vacation to break this vicious circle of being silent, letting the other one play their role, and withdraw feeling enraged and not understood.

After the vacation break the patient said that our conversation had enabled them to become more willing to face conflicts. Another result was that the patient had experienced my behavior as taking his wife's side, because I had shown too much understanding for her anxieties instead of helping him clarify *his* anxieties. In transference I had protected his handicapped sister, and his negative mother transference now began to play a role in therapy. How often had his mother and sister taken sides against him! The patient became able to express his outrage and feel his aggression. Subsequently the patient felt less isolated and the risk of suicide decreased. It was possible to partially free the couple's relationship from the patient's acting out.

6.4 Third-Party Payment

Under the same heading in Vol.1 (Sect. 6.6) we described the general implications of third-party payment and, specifically, the principles according to which German compulsory health insurance programs cover expenses from analytic psychotherapy. In the meantime similar guidelines have been adopted in Germany by the private health insurance organizations and

by the state in its subsidies of the health expenses of government employees. Thus it is now necessary for analysts in Germany to submit applications for payment for practically all of their patients to the appropriate health insurance body or government agency; these applications are then reviewed by peers with regard to the indications for psychodynamic or analytic psychotherapy. The guidelines of the compulsory health insurance programs (latest version from May 1990) differ, however, from the government subsidy policy with regard to the length of treatment. There are also differences between the various private insurance organizations. Internationally, the third-party payment is also gaining increased attention (Krueger 1986).

German psychoanalysts now have to file applications justifying their therapeutic approach according to the principles of the etiological theory of psychoanalysis. In these applications the therapist must make it plausbile to the reviewing analyst that the recommended treatment can lead to a alleviation, improvement, or cure of the patient's neurotic or psychosomatic illness or that it promotes the patient's rehabilitation. He must estimate the chances for change, i.e, make a prognosis. The purposes of these applications, which are submitted to reviewing psychoanalysts who then decide whether to *recommend* approval or continuation of analytic psychotherapy to the health insurance organization, are similar to those of diagnostic case conferences. It has to be demonstrated that the psychodynamic explanations are in agreement with the steps in therapy. Another purpose is to show how the patient reacts to the therapy, i. e., to describe changes in symptoms within the context of transference and resistance. The guidelines explicitly state that regression must be evaluated according to its therapeutic utility; the appropriate passage in the guidelines currently in force reads:

> Analytic psychotherapy refers to those forms of therapy that treat the material in the neurotic conflicts and the patient's underlying neurotic structure, together with the neurotic symptoms, and in the process initiate and promote the therapeutic activity with the help of the analysis of transference, countertransference, and resistance and of regressive processes.

This passage makes it apparent that the guidelines are oriented on a theory of therapy based on ego psychology. Applications for continued payment encounter no problems as far as "regression in the service of the ego" is necessary to master psychic conflicts in a manner that alters symptoms. Yet many analysts find it difficult to justify applications for continuance in the manner that Freud demanded for especially deep analyses. This is particularly true in those cases where therapy exceeds the customary length of time; Freud then linked etiological and therapeutic considerations and justified the different lengths of treatment by referring to the fact that although some problems and symptoms occur late in an individual's development, they can only be resolved therapeutically when their causes in the deepest layers of psychic development have been found. It is in this sense that the guidelines for the payment of analytic psychotherapy require a causal explanation. Regression for its own sake agrees with neither Freud's etiological principles nor his therapeutic ones. In this regard Baranger et al. (1983, p. 6) spoke of a widespread prejudice, arguing that retrospective attribution, one of the most important factors in Freud's theory, has been one of its victims (see Sect. 3.3). The fact that a "cause" does not acquire its causal force until much later and under the impact of subsequent events casts doubt on those theories that view the cause of later psychic and psychosomatic symptoms as lying in the earliest phase of development. Baranger et al. directed this criticism especially at M. Klein's theory. Such neglect of the causal significance of subsequent events is linked with a widespread tendency to consider "regression . . . *in itself* the essential therapeutic factor." An analyst adhering to this understanding of therapy attempts to arrive at deeper and deeper levels of regression and encourages the patient to reexperience early, ideally his first, traumatic experiences. Baranger et al. referred to the illusion, which has been repeatedly contradicted by experience, that reaching archaic situations - whether as a result of drugs or of systematically favoring analytic regression - suffices to achieve progress. The examples of such experience that they mentioned are "the reappearance of the initial symbiosis with the mother, the birth trauma, the primitive relationship with the father, the paranoid-schizoid and depressive positions of suckling, [and] the outcroppings of `psychotic nuclei.'" They explicitly emphasized "that re-

living a trauma is useless if not complemented by working-through, if the trauma is not reintegrated into the course of a history, if initial traumatic situations of the subject's life are not differentiated from the historic myth of his origins" (p. 6).

Medical and scientific responsibility dictates that regression during analysis, i. e., charged by resistance and transference, be considered from the perspective of the *mastering* of conflicts. In our opinion, the concept of working through must also be subordinated to it, because otherwise illusory hopes are created and, under certain conditions, forms of dependence extending to malignant regression are created iatrogenically. Based on our experience as reviewers, a frequent indication of such a course is the disturbing statement in applications for continuation beyond 160 or 240 sessions that there is a danger of a relapse or even suicide if therapy were discontinued. Without wanting to dispute that such situations can arise even in an analysis that is properly conducted, we would like to summarize the essence of our experience both as practicing analysts and reviewers. It is therapeutically decisive that *malignant* regressions be prevented. In our opinion, the ego-psychological understanding of regression means that the best conditions are created in the analytic interview for helping the patient become able to master his conflicts. This includes coming to a realistic evaluation of one's life. To limit malignant regressions, we recommend that the analyst not lose sight of economic facts - an important element of the contact to reality-in the analysis of transference and resistance. In this sense the limitations on performance that the patient is familiar with can contribute to preventing malignant regressions. On the other hand, in some severely ill patients the limitations exert such pressure that neurotic anxieties increase. In our work it has always been possible for us to satisfactorily solve the problems that have resulted. As reviewers, we therefore frequently have the impression that there is a discrepancy between the disturbing statement of what might happen if therapy were discontinued within the periods set out in the guidelines, and the psychodynamic explanation of this condition according to logically comprehensible causal and prognostic criteria.

Application Procedure

We have chosen the following example for a number of reasons. The "report" that the physician conducting the analysis submitted to the reviewer for confirmation that the therapy conformed to the guidelines for insurance coverage, as well as his applications for continued payment were prepared before we decided to write this textbook or to include a description of a model case of an application for payment beyond the customary length of time. Thus the applications have not been fabricated extra for this purpose, and their size is, incidentally, not representative of such texts. This application for continued support is so comprehensive because the analyst filing the application had referred back to notes from a seminar on analytic technique. We profit from its unusual length, however, because it enables the reader to orient himself in detail about the course of the analysis.

In this case it was possible for the analyst to explain why treatment beyond the usual limitations on payment was justified etiologically and with regard to utility, economy, and necessity. Finally, it also lets us demonstrate particularly clearly what consequences the reviewing process has on the analytic process, i. e., on transference and resistance, which we cover in a separate section (Sect. 6.5). The choice of this example lets us, furthermore, save space and avoid repetition, because the coded case history, which is presented in detail under point 4 of the application form, is given in Sect. 8.2.1. Here we can avoid answering the question as to the information the patient provided spontaneously because several examples of the symptoms Arthur Y complained about can be located at other points in this text by referring to the index of patients. Moreover, it is especially important to provide as literal a reproduction of the patient's spontaneous comments as possible because the patient's complaints enable the reviewer to estimate his suffering and to relate them to the other points, particularly to the psychodynamic explanation of the illness.

The modalities of third-party payment are described in detail in Vol.1. To summarize them briefly, the patient who is a member of one of the compulsory health insurance

organizations does not pay the fee directly and does not receive a bill. The fee per session is regulated, and furthermore, physicians and patients are not permitted to make separate financial arrangements. The situation is different with the relatively small group of patients who are voluntarily insured in one of these health schemes and who express the wish to be treated as a private patient. It is then permissable for the patient and analyst to negotiate the size of the fee, and it is the patient's task to turn to his insurance company for reimbursement of his expenses. Thus, here the analyst is not a contractual partner, via the physicians' association, of the health insurance organization. Yet even in this case it is necessary for the analyst to file an application for payment, in which he demonstrates that the indications and the severity of the illness conform to the guidelines, i. e., that an "illness" as defined by the insurance system does exist. An analysis for personal problems, for instance, is not covered by health insurance.

Arthur Y was a voluntary member in a public health insurance scheme and had taken out a supplementary policy to cover any additional fees. He was considered a private patient and the fee was agreed upon. Initially the fee was DM 138 per session, which was paid in full by the two insurance companies, who financed the treatment until it was no longer possible to reliably determine the severity of the illness' symptoms. After the public health insurance company ceased payment, Arthur Y paid for another 120 sessions by himself, now at a rate of DM 90 per session. At this point the analysis primarily served to help him develop his personality and enrich his personal life. Although there is no clear-cut transition from an individual's difficulties in coping with life in general to the symptoms of a severe illness, it is still possible to make distinctions. Yet even from the perspective of psychoanalysis, most important is that a patient learn to recognize the part he plays in living his life and the influence he has on his symptoms.

As mentioned before, the public insurance company paid for more than the regular 300 sessions in Arthur Y's analysis. It is therefore possible for us to refer to this case in order to familiarize the readers with the arguments for which we provided a general grounding in Vol.1 (Sect. 6.6). Moreover, it is our good fortune that Arthur Y belonged to the small group of patients who desire to read the analyst's report. In Vol.1 (Sect. 6.6.2) we recommended that applications be prepared in such a manner that patients can read and understand them. Although it is permissible to deny a psychiatric patient access to his case history and reports under certain circumstances (Tölle 1983; Pribilla 1980), refusing patients in analysis access to reports might lead to very exceptional burdens. These reports are legally not considered to belong to the analyst's personal records that, with regard to countertransference, are private in nature. Yet, whatever the case, we reiterate our recommendation once more, and give the following example. The analyst complied with Arthur Y's request to read (made somewhat later) the application for the second continuation of therapy. Incidentally, at the point in time at which his analyst had prepared the report, he had not reckoned with such a thing happening, either in general or in this specific case. It is surprising that so few patients express the wish to see the reports about them. Arthur Y read the application in the waiting room a considerable period of time after the continuation had been approved. He wanted to find out whether his analyst had reached some agreement with the reviewer behind his back. The therapeutic relationship was strengthened by the fact that the patient found the application contained his descriptions of his feelings. He also found that the psychodynamic reasons for the continuation corresponded to what he and his analyst had discussed and were reasonable. It was especially soothing to the patient that his analyst had agreed to continue the therapy after the discontinuation of insurance payments, and at a fee he felt *reasonable* .

The analyst's report to a reviewer is based on a preprepared form (PT 3a/E); point 6 of this form is particularly significant because it requests a description of the *psychodynamics of the neurotic illness* . This description is the basis on which the diagnosis, treatment plan, and prognosis of the analytic therapy, entered under points 7, 8, and 9 of the form, are grounded. The significance of point 6 is brought to the attention of the analyst filing the report by the statement: "The reveiwer cannot process this application if this question is not answered in sufficient detail!" What are the major points to be taken into consideration? What is expected of the analyst filing the application? He is supposed to describe the causal factors that led to

the development of the neurotic or psychosomatic symptoms or that serve as precipitating factors maintaining the symptoms. At the core of this is a description of the psychic conflicts, especially with regard to their unconscious component and the subsequent development of neurotic compromises and symptoms. Furthermore, the analyst must describe both the point at which the symptoms became manifest and the precipitating factors in the context of the original psychogenesis.

We will limit ourselves largely to this aspect in citing from the description of the course of treatment that the analyst provided in the application. To make this more comprehensible we first cite from his description of the patient's psychic state (point 5a):

Arthur Y came during my office hours reserved for emergency cases, was driven by anxiety, and was seeking emotional support. A positive transference developed, which I deliberately promoted in order to help him get over the Christmas holidays. I prescribed a benzodiazepine preparation.

Commentary. By providing the prescription the analyst made the patient feel he could trust him. It is even probable that the patient would not have undertaken an analysis without the prescription. We discuss the general questions that are associated with this in Sect. 9.10.

To avoid becoming dependent on the medication, the patient only took about four tablets during the four weeks that have elapsed prior to this application. The patient's desparate mood of dispair must be seen as a reaction to his compulsive symptoms. Certain changes in his symptoms during the last ten years can be understood in the context of his situation, and because of the nature of their course it is certain that they cannot be traced back to a phasic depression.

The following summary of the patient's psychodynamic state was given in the initial application:

The patient correctly considers the fact that his brother had cancer to be the situation that precipitated the worsening of the compulsive and anxiety symptoms that he had had for many years. Subsequent to this fatal illness in his family, old ambivalent feelings were activated; he had been unaware of the intensity of these repressed ambivalent feelings although they had manifested themselves in numerous symptoms. The patient is losing his capacity for integration and fears he may become insane, just like his mother. He is considering suicide, to protect both himself and others from worse things that might happen.

The patient is suffering from a disturbance in which he must ward off strong passive feminine tendencies. The patient's character is generally marked by an extreme ambivalence toward his father. Several anal fixations and conflicts are obvious. It is too early to judge whether his mother's depressive structure is of significance. The patient was denied the phallic narcissistic confirmation he had required during his oedipal phase, as a result of the exaggerated demands his parents had made on him. The consequence was a severe narcissistic illness. The induction of his father into the armed services initially offered oedipal wish fulfillment. The patient's conflict consists primarily in the fact that he adopted the demanding ego-ideal from his father and therefore has to strongly resist his passive desires for emotional support. I assume that his conscious anxiety about some sinister "perversion" is rather a sign of his resistance to his own passive tendencies. For instance, when he strokes his son's head - i. e., when he is tender and, via identification, the one being stroked - both turn into devils. Stroking becomes killing. Omnipotent pleasure is contained in the numerous manifestations of his compulsive anxieties: "If I were free of my anxieties, I would be terrribly arrogant.

The initial application contained the following on *prognosis* (point 9):

Despite the long history, the prognosis is favorable, at least regarding the worsening. A significant improvement can be expected, enabling him to retain his capacity to work. The insight I have already gained into the psychogenesis, and particularly into the course of previous psychotherapies, leads me to assume that a fundamental improvement or even cure is possible because the patient is flexible and not a dried-up compulsive neurotic, and because the narcissistic delusions of grandeur and the negative transference were apparently neglected in his previous analytic therapies, which let them retain their strength to cause symptoms to develop.

Application for Continuation for Sessions 80-160

Questions 4 to 8 in the form are particularly important in applications for the continuation of therapy, and may be answered as a unit. The analyst must provide information about what he has learned about the psychodynamics of the neurotic illness (question 4) and make any subsequent addition to the prognosis (question 5). Of particular importance are the summary of the previous course of therapy and the evaluation of the prognosis, including about the patient's capacity for regression, the degree of fixation, the flexibility, and the potential for development. The following summary is taken from the first application for continuation:

The biographical and psychogenetic connections and predecessors of the compulsive neurosis are: sadomasochistic experiences in childhood - being severely punished and cleaned in the large basement where the wash was done and where animals were still butchered, because he would shit in his pants (now: compulsive neurotic anxiety about the color red and blood, together with defense rituals). The first manifestation of an obsessive thought at his boarding school: a brutal teacher on the one hand, a homosexual seducer on the other. As a young boy he coped with his ideas of grandeur by identifying with Hitler; his impotence and feeling of being excluded resulted in identification with the "dirty Jews." (He felt himself to be a Jewish boy because he did not meet the ideals of his parents and those around him.) The fact that his father had not returned from the war and was later declared dead without them reaching a reconciliation left the patient's ambivalence and idealization unmastered. His relationship to his depressive mother molded his entire life. When he would like to sit down and feel satisfied, he becomes just the way his mother had been, depressive and lacking the will or energy to do anything. His feelings of guilt because of his unconscious hatred of his helpless mother reinforced his identification with her. He is not able to enjoy his success. Just recently he recalled a positive side of his mother; she had had a small corner store, where she was happy and successful, but it did not fit in line with the prestige thinking of his father's family.

The *transference* and *working alliance* developed as follows:

It soon became clear that he followed the basic rule slavishly, but avoided anything I was actually or presumably sensitive to. He had a single recollection from his first consultation more that 15 years ago: "Come to the academic hospital," I am supposed to have said with a Czechish accent. The professor and acting director of the Heidelberg Psychosomatic Hospital, a refugee! Scorn and admiration at the same time. His anxiety about being hurt or offended, in particular by the discovery of what he was really sensitive to or by the observation of his personal peculiarities, is

much larger than his anxiety about his fantasies of omnipotence or impotence, which have developed over decades as a result of his retreat.

I am proceeding from the assumption that the increase in his positive self-esteem can become such a threat - in his identification with Hitler - that he shifts everything to the outside, i. e., experiences them as split off from himself and foreign - foreign in the description of the compulsive neurotic perception of "whooshing" noises. He links whooshing noises with the whooshing of a knife being drawn from its sheath, with which a sheep was butchered in the "precipitating situation." Afterwards the whooshing noises were linked with the drawing of a knife and ultimately with murder and fantasies about killing. The patient reacted positively to my statement about the projection of his omnipotence and impotence onto whooshing noises and the sacrifice of the lamb, and emphasized that these ideas actually made it possible for him, first, to overcome the foreignness of his thoughts and second to learn, even if reluctantly, to see them as a part of his self.

Arthur Y, returning to an allusion he had made, asked if the old oak [the analyst] could take all the poison he could inject in the form of doubts. Adding to this vivid image, he said he naturally did not want to saw off the branch he was sitting on. We then talked about his idea that I might turn ill, die, and not be able to continue treating him to the end. For him this would mean being left alone again. My response that he was not completely *dependent* (i. e., that he was not like a day-old babe sitting on a branch who could fall down) was new to him. He was accordingly surprised when I pointed out to him that he had already acquired some autonomy and thus had enough muscles to hold on to another branch. It came as a surprise to him that I phrased the question of how far he accused himself of overburdening me when he was alone as a problem. I drew a parallel to his sister's illness and especially to his mother's chronic illness, which had made it difficult for him to be frank and express criticism. He made himself responsible for his mother's suicide, as if the determination he had shown one day had driven her into taking her life.

Arthur Y had hoped to be well after 20-30 sessions. Yet he noticed how much work still had to be done. He said he had stopped several compulsive actions, but would not have any alternative to committing suicide if he did not become healthy this time. Implicit was that I considered him "guilty" of the delay. I therefore referred to my earlier statements about therapy and emphasized my *sympathy* and *coresponsibility* . I interpreted his idea that I remained *untouched* , like a doctor in an intensive care ward who cannot let himself be affected, as an expression of his wish for me to be an object that was both timeless and immortal. I added that the idea that he was considered guilty must make him feel enraged inside.

Sadomasochistic ideas are often symptomatically tied with the crucifix and the sacrificing of Isaac by Abraham. The fact that he warded of his longing for love and his anxiety about homosexuality with these religious images has also become clear in the transference. We were able to work out that one issue is his longing for his father, which he wards off because of his ambivalence.

Application for Continuation for Sessions 160-240

Since I have already provided a detailed description of the case history, I will limit myself in this application for continuation to a description of the course of the analysis, summarizing several important points.

Therapeutically it has proven to be very advantageous that, especially because of the patient's previous experiences, I have directed my entire attention to the analysis of the psychodynamics of the here and now. The analytic consideration of the changes in his symptoms in connection with the transference processes is instructive, and these changes must be considered negative therapeutic reactions. Their purpose is always self-punishment, especially each time the patient frees or wants to free himself a little from subjugation and masochism. Then there is a reversal to sadism and rebellion, although each success and action is unconsciously tied for Arthur Y to a strong anxiety about aggression and its consequences. This problem goes back to his relationship to his depressive mother, which limited his expansiveness. He identified himself primarily with the rigid superego of his mother and grandmother. It came as a great surprise to me and the patient to note that he felt admiration and fright while listening to my interpretations, which contained words such as "lust" and "gratification." At the same time an identification with the pleasure I provided verbally, in the sense of Strachey's mutative interpretation, developed step by step. Of course the patient's anxieties about closeness and sexuality, including homosexuality such as he had encountered in his traumatic experience with a teacher, became visible at this occasion. These two figures, the sadistic and homosexual teachers, were indeed the central figures in this case; much can be done with reference to them and they also appear in the transference. In this transference constellation, of course, the variables in the setting are especially well suited to serve as issues for handling other items. With his increasing liberation, we also come to discuss sexual problems he has with his wife because of his anal regression and his mixing of pleasure with dirt. In his earlier therapies he took all interpretations referring to sexual topics to be demeaning. Apparently in them such interpretations were so much the focus of attention that the aspect of self-punishment was not given adequate attention.

Another important area is the patient's effort to capture some of what he had missed, by spoiling his children and identification. These processes have led him to feel unusually constricted, and limited his own scope for action. For instance, he has a bad conscience even if he only arrives home slightly later than usual.

The favorable course of the therapy can also been seen in substantial improvements in his symptoms, and not just in the good elaboration of the ones mentioned above. It must be emphasized that Arthur Y has been able to overcome his dependence on the consumption of a quite considerable amount of alcohol every evening without this being worked through specifically. He has reduced his weight by 30 pounds and has become fairly athletic. He had been dependent on alcohol for years, even decades, because he felt it was the only means for him to be able to bear the rest of the day and the following ones. It was impossible for him to sit down without drinking. This dependence made him feel very dejected. One cause psychogenetically was that sitting quietly reminded him of his mother's depression; for many years she had been passive, occasionally even falling into stupor. His greater freedom is also indicated by the fact that no separation problems worth mentioning have occurred during interruptions of treatment during this entire period and that the patient has taken hardly any sedatives during my absence.

Supplementary Application for Sessions 240-300

The patient read this application after it had been completed. He was surprised he was able to understand the text. It was soothing for him that the application described the continuation of therapy as we had agreed.

The frequency of therapy was increased from three to four hours a week at the patient's request because of the intensity of the therapeutic process and to provide him the opportunity to work through the unconscious factors behind his symptoms. The increase has had a positive therapeutic effect, for we are now able to immediately handle changes in his symptoms that occur ad hoc and are related to transference.

The end of a positive development was marked by my informing him of the dates of my summer vacation and by the approaching interruption. During my summer vacation the compulsive symptoms reappeared, taking various forms (fear of harming his son or another member of the family, of seeing his son as the devil, and of having to listen compulsively to the whooshing noises of his own language and suffering from it). It was unfortunately impossible to recognize, and therefore work through, the entire psychodynamic context until later. Whenever the patient felt aggressive impulses, he experienced himself unconsciously to be a devil, whom he got rid of in the person of his son by developing his symptoms. In the transference these became key words, with regard to which the thematic work can be demonstrated. The very fact that the patient felt I was inconsiderate because of the vacation interruption is a sign of his own inconsiderateness. The patient became increasingly aware that inconsiderateness and arbitrariness were his own form of fantasies about power and omnipotence, and his symptoms receded to the same degree. Naturally the earlier compulsive neurotic acts of control, with which he was able to establish a certain balance, are part of this. By means of the expression "devilish tricks," which the patient enjoyed using in our conversations, he became aware of his unconscious tricks, his anal underhandedness, and the pleasure he gained from intrigues. He saw them through a magnifiying glass, and his punishment and self-punishment took on correspondingly strict form. The stronger his lust for life, the stronger his masochism momentarily became. It became clear that there used to be only *one* period of time during which he felt happy, namely during his vacation, but only if it turned out to be successful after intensive preparations. Vacation was about the only time in which he might have pleasure "because of his health." Thus it was all the more serious when he once said that he would not be able to go on vacation because his wife had overdrawn their account for some allegedly thoughtless reason. I, in contrast, became the well-to-do, even uncommonly rich "king" who can do whatever he wishes. In this passage the patient had made himself small, exaggerated the thoughtlessness of his wife, and not taken his secret financial reserves into consideration. Miserliness and envy entered into the analysis. Particularly impressive is the immediate improvement that occurs in the patient's symptoms after he experiences an insight in a very strongly affective manner. He himself draws hope from this, and although he has apparently been completely broken by the remanifestation of his symptoms, the spiral of progress he is making is obvious.

The *prognosis* is favorable despite the severity of the symptoms because the patient is able to work through his problems step by step and to free himself.

Supplementary Application for Sessions 300-360

This application for additional sessions, which went beyond what is foreseen by the guidelines, gave the reviewer the opportunity to make a positive recommendation. One of the reviewer's duties is to interpret the guidelines in a manner that the rules can be applied to special cases. The analyst wrote in this application:

The exception can be seen in the fact, first, that this is a very severe set of symptoms, which, second, it has been possible to influence positively in the previous therapy, and which, third, can be expected to undergo a further improvement, or even reach a cure, if the analysis is continued. This optimism is justified because the psychodynamic explanation given below not only provides an adequte explanation of the still existing symptoms but also clearly indicates that the patient is making an intensive effort to overcome his resistances. He is cooperating very well in integrating previously split off components of his personality. My prognosis is based on an agreement with the patient that after discontinuation of payment by the health insurance organization he is willing to finance a continuation of therapy out of his own resources and that I will substantially reduce my fee. We have already reached agreement on this. I believe that a further continuation of payment is justified on social grounds, because the patient will surely need a longer period of time to succeed in integrating the unconscious components of his ego, which still manifest themselves in symptoms because they are split off.

I will now refer to the central aspect that has been worked out in the previous period of treatment.

At the beginning of the therapy the patient had emphasized that sexuality was the only area where he did not have any problems. Now he has had an important insight that will certainly lead to further substantial changes. Let me add that although I never shared the patient's opinion, I have been very restrained in referring to it. My assumption was that because of the linkage of anality with sexuality every active step in this direction would have made the patient feel humiliated and would only have been a repetition of what he already knew, namely that his nose had been rubbed in his own feces. Sexuality consequently became associated with punishment and humiliation. After he had secured himself sufficient self-esteem in our numerous transference struggles, he risked an attempt to break through his self-punishment and the circle of executionists with whom he had previously identified in combatting his lust for life and any pleasure from life. He discovered that by subordinating himself to a sadistic figure in his childhood he had attempted, in his anxiety and compulsive symptoms, to destroy every pleasure and all sensuality. The result was murder and destruction in subjugating himself to an omnipotent god and its representatives on earth (Hitler, priests, SS thugs, etc.), to whom he offered himself as a love object.

The deep dimensions of this identification can even be seen in harmless anxieties and symptoms that disappeared after he had identified with me in the form of a friendly father figure.

It hardly needs to be mentioned that the patient also has deep anxieties because of the aggression in him that is directed against symbols of power. Restructuring has enabled the patient to face all of his libidinous and aggressive impulses with much more tolerance. One symptom is particularly obstinate, namely his extreme sensitivity to whooshing noises whenever the general level of his anxiety is increased because of unconscious processes.

On the basis of this psychodynamic explanation I request that an exception be made and 60 additional sessions be approved in this case.

The therapy was continued with a reduction in fee and frequency after discontinuation of third-party payment. The patient and analyst were in agreement that the primary goal of the analysis was now to overcome general problems he encountered in his life and whose status as an illness was becoming increasingly dubious. The relatively infrequent and successful continuation of the analysis, which Arthur Y payed on his own at a rate of DM 90 per session, served to stabilize his self-esteem. The judgment that the analysis was successful was based on several criteria. Decisive in our opinion is that the curing of the symptoms can be related to a psychoanalytic process which permits one to infer that a deep-reaching structural modification had taken place. We recommend that the reader follow this process by examining the excerpts of Arthur Y's analysis given in this book (see the patient index).

6.5 Reviewing and Transference

All of the analyst's actions must be examined with regard to their consequences on the relationship and transference. The question of whether the analyst provides a prescription or not, or prepares a certificate or not - everything has an influence on the relationship between the patient and the analyst.

The manner in which the analyst handled a certificate in the context of a substantial worsening of Arthur Y's symptoms became the focal point for working through negative transference. This was a theme that covered several sessions; similar situations occurred several times in the course of the analysis.

Arthur Y was a voluntary member of a public health insurance scheme and was treated as a private patient. Years before he had taken out a supplementary policy to ensure complete coverage. This latter insurance firm had notified him that outpatient therapy was not covered by his policy, but offered to consider some coverage if an illness were present and if the physician providing treatment would prepare a detailed statement supporting psychoanalytic therapy, specifically about its necessity, economy, and utility.

We now give excerpts of two sessions on this theme.

P: Yes, you always return to the business with the insurance and the certificate that I need from you. I had the feeling you thought that I shouldn't leave everything up to you and take account of realities.
A: No, I wasn't thinking about any given realities, but about disappointments. You have already been waiting about a week for the attest.
P: I just have the feeling that you are intentionally holding it back because I haven't said enough about it yet.
A: No, but you see that this is apparently a very important point.
P: I'm amazed that you think this business with the health insurance company is more important than I do even though it affects me directly. I think it's outrageous for the insurance company to deny me something I'm entitled to.
A: And now you've had the idea that I am also denying you something in order to make you angry.
P: Yes and no.
A: Hum.
P: To move me to say more about it.
A: But you have the feeling that you yourself can't do any more, and I referred to the longing about how nice it is if someone can organize everything well.
P: One person.
A: If possible, someone who is strong. It would be funny if this longing weren't there.
P: Yes.
A: Whether you have this longing now?

P: Naturally.
A: Such longing can lead one to not fully utilize his own ability. I've made you aware of this, and perhaps you've drawn the conclusion that I have delayed giving you the certificate, or perhaps you had the idea that I would not do as much for you. Longing, disappointment, or rejection?
P: Yes, if you're in the shape I'm in, then you have the immense desire for somebody to come and straighten everything out.
A: Yes, yes, not just this business with the insurance, but also the anxieties and everything, of course.
P: That there is some danger of not developing one's own powers, that's clear to me.
A: This is probably linked with the fact that you are cautious and don't say, "What a nasty thing for him to make me wait so long before giving me the certificate."
P: Yes, I actually had the feeling that you would not give it to me until I got pushy in some way.
A: Thus, on the one hand you have experienced this as a rejection, but didn't get nasty with me or the insurance company. You didn't get nastier, just your anxieties and thoughts.
P: Sure, when I think about it in this way, it's logical to ask if the certificate is finished, if I can take it with me now. Perfectly clear.

The patient ended a longer period of silence by saying that his thoughts had now slipped away, moving on to his conflict with his boss.

My hesitation to give him the attest immediately had led the patient to change the subject. Yet later he returned to the subject.

P: You still haven't answered my question.
A: Yes, I've just wondered what I could say now, but I haven't thought of anything else. But the matter isn't closed. You would like to hear if you're going to get the certificate now.
P: Yes, precisely.
A: And you've also had another idea, but it isn't closed either.
P: You still haven't answered my question of whether I'm going to get the certificate. Now, yes, so what, then I'll ask again.
A: But then it would have to have been typed already or being typed right now, that is, already have been dictated.
P: Then I'll take it with me the next time.

I raised the question of whether the patient was wondering if he would not get it at all, which he denied. Then the subliminal feeling that I might deny him the certificate developed after all.

P: Now we're getting somewhere. You might say that I haven't developed my own strength and as long as I haven't done that . . . but then I can wait a hundred years if you say that, that I have not yet developed my strength. My impulse now to say, "Damn certificate, there!"

The patient recalled that the receipt of the insurance company's rejection after returning from vacation (just like the delay in receiving the certificate) had led to a worsening of his symptoms, and that everything had been less stable since then.

At the end of the session I summarized what had happened. Since he had the impression that he was being harassed, his rage had mounted. The effect via displacement was a worsening of symptoms.

Commentary. The analyst had required several days to draft the text that was ready at this point in his secretary's office. The patient's uncertainty and anger had increased, largely

unnoticed, and expressed themselves in his symptoms, through a return of repressed affects. In order to reconstruct this sequence of events, the analyst intentionally kept the patient in suspense in this session. Although leaving the matter open at first was productive in this case, this procedure is not free of danger because it is risky to follow the adage that the end justifies the means.

The analyst gave the patient a certificate he had not yet signed in which he drew attention to the fact that the open questions had already been clarified by the decision of the public health insurance company to provide payment. A detailed report, if still required, would only be prepared for a physician competent to judge psychoanalytic issues.

In the following session it became clear that Arthur Y had thought intensively about the certificate.

P: If I had been in your place, I would have bowed to the wishes of the insurance company more than you did . . . . I would have tried a subservant approach. Maybe I would have come to the same result. If the insurance had then paid the rest, then my thesis would have been confirmed - you reach your goal if you are subservient. Your attitude is different, and I'm not yet completely sure how I should formulate my own letter, whether I should express a request or insist on my rights. I believe I am entitled to compensation.

The patient offered further alternative formulations for the text that he himself had to write to the insurance company. He was impressed by my clear and brief statement and found it to be a model of a courageous attitude toward an institution.

A: Hum. Those are two entirely different worlds, and there is the fear that the insurance company might react with spite if you demand something.

P: If I use the subservient expression, they may have sympathy with me and say, "What a poor soul. And it's the poor soul's turn again. We, the big, powerful insurance company can help the poor soul for once. It's just a couple of marks. Throw it out to him, let him chew on them." Yes, this affair is awfully difficult.

A: You know that I haven't signed the certificate yet.

P: Yes, I want the certificate as you have drafted it.

A: You can send it in together with you own letter.

P: I want it as you drafted it; I think it's right, perfectly ok.

With a view to the entire application procedure, I then made a few comments to the patient about the terms "necessity," "economy," and "utility," and also about the concept of illness that the insurance companies employ when determining their responsibility to pay and that peer reviewers employ in their evaluations for the insurance companies. I also explained the meaning of medical confidentiality and mentioned the fact that the applications are handled in an anonymous manner. The patient then ended this theme:

P: I still haven't decided about how I will express myself. Perhaps I can use both forms. Well, somehow I'll think of something. I'm just amazed that such things can have such a strong impact on my mood that I almost feel destroyed. What would it be like then if I got into a real crisis, was out of work, lost my job, had difficulties with my wife?

A: It's sometimes easier to survive struggles with a real and actual opponent than to fight an opponent who is so hard to grasp and where you have to be on your guard.

P: Today you're always referring back to yourself. Well, if I experience you emotionally just like I did that teacher, if that's the case, what consequences can I draw from knowing this? I still don't know, and it makes me feel insecure.

Arthur Y focused on the theme of dependence and considered his efforts to retain my favor.

He mentioned the tape recorder.

P: I still haven't really come to terms with that thing. I have the feeling I am helpless, defenseless, violated. [See Sect. 7.5] Maybe it's because I fear certain parallels. I would probably be a good piece further if I could completely admit to myself that this experience back then was really bad for me instead of always wiping it away. As if it hadn't happened, as if I only wanted to make myself important. [He was referring to his experience with a homosexual teacher at boarding school.]

A: It's terrible to have such an unfulfilled longing and to experience how it is misused without being able to defend oneself and simply being helpless.

P: And it's really comprehensible that you get terribly angry.

A: And it's also comprehensible that you prefer to minimize it.

P: And now I would like to ask you whether you believe that these experiences with the teacher were a substantial factor in the anxieties I developed later.

A: Yes.

P: The answer is a big help to me - a clear answer . . . . The whole muddy business. I just thought of it. I just thought of a comparison. Somewhere I am running in mud up to my waist, keep on sinking down, and then somewhere always manage to get my feet on solid ground, but it's still more or less a coincidence. I don't know whether the next step will be in a vacuum again . . . . But now I at least have some orientation to continue in a certain direction despite the mud . . . . Everything is very difficult. In the words "devotion" and "trust" I see the danger of being mawkish.

The session ended on the theme of the patient's longing for his father, which occurred after he had mentioned the first manifestation of his neurotic anxiety symptoms in prepuberty.