Different Types of Suffering during a Psychoanalysis: A Single Case Study*

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1. Theoretical Remarks

All psychotherapeutic schools agree that a patient's motivation to seek therapy depends decisively on the degree of suffering at the beginning of treatment. However opinions differ as to how important suffering becomes in the course of therapy. Moreover within psychoanalysis one finds contradictory views.

In "Lines of Advance in Psycho-analytic Therapy" (1919a) Freud took a strong position on this question:

> Cruel though it may sound, we must see to it that the patient's suffering, to a degree that is in some way or other effective, does not come to an end prematurely. If, owing to the symptoms having been taken apart and having lost their value, his suffering becomes mitigated, we must re-instate it elsewhere in the form of some appreciable privations; otherwise we run the danger of never achieving any improvements except quite insignificant and transitory ones (p. 163).

The technical means by which Freud tried to achieve this was the rule of abstinence in order to frustrate the patient's instinctual wishes. The energy, finding no discharge, would flow back to its infantile origins and bring their representations to consciousness, leading to the conflict being recalled instead of being acted out. From this point of view the patient must suffer in order to improve.

These considerations - anchored in Freud's theories of energies and instincts - have influenced psychoanalytic practice until today. The

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rule of abstinence, more than any other of Freud's technical recommendations, was set up as an absolute by many psychoanalysts and often has become a synonym for the psychoanalytic attitude (cf. Cremerius 1984 and Körner and Rosin 1985). "Putting the total emphasis on the attitude of abstinence in terms of a pure technique" (Cremerius 1984, p. 776) frequently created an unhealthy climate in psychoanalytic treatments so that even in 1967 Greenson warned in his popular textbook against excessive frustration of the patient because this would produce 'interminable or interrupted analyses' (p. 278). Of course many psychoanalysts soon started to justify the rule of abstinence not so much by theoretical, but by technical considerations, because they were getting more and more skeptical of the economical aspects of the libido-theory. Abstinence was no longer to maintain the suffering of the patient, but to guarantee the objectivity of the psychoanalyst - objectivity as seen from a positivistic ideal of science.

As part of the theoretical advances in psychoanalysis the perception of the principle of abstinence has also changed. Object-relation theorists, for instance, define abstinence as the ability of the psychoanalyst to not assume the role which the patient offers to him unconsciously (cf. Sandler 1976). According to this approach the patient's suffering does not represent a necessary condition for the success of the therapy. The therapeutic appropriateness of deprivation was one of the points in question as well when structural Ego disturbances came to be taken more and more into consideration. Authors such as Balint (1968), Blanck and Blanck (1974) and Kohut (1971) suggested far-reaching modifications in handling the rule of abstinence. Ego psychology also delivered a new theoretical framework for the understanding of abstinence.

There is one approach, which in our opinion deserves particular interest, namely the so-called control-mastery theory (Weiss and Sampson 1986). In this theory the patient's transference behavior is defined as an instrument of reality-testing: in the relationship with his psychoanalyst, the patient wants to test whether his unconscious pathogenic beliefs are true. These beliefs are the result not of instinctual wishes, but of a primitive theorizing originating in conflict situations of childhood. Being influenced by these theories the patient sets aside important life goals and establishes defense mechanisms, inhibitions, and symptoms. It depends on the behavior of the psychoanalyst whether these infantile theories will appear confirmed or refuted. To be abstinent in this context means to pass the patient's test, that is, to *not* fulfill his pathogenic expectations.

With regard to the patient's suffering, the control-mastery theory predicts that the psychoanalyst - by means of being abstinent according to this theoretical view - refutes the threatening beliefs and thus meets the unconscious hope that led the patient to seek help in analysis. Instead of suffering more, the patient will feel relieved and relaxed because of his psychoanalyst's passing the test. This model of the psychoanalytic process was empirically tested against the process model derived from the theory of instincts repeatedly and turned out to be superior (cf. Weiss and Sampson 1986).

Although turning away from the theory of instincts has been significant within psychoanalysis, its external image has scarcely changed. The cliché of the frustrating psychoanalyst who makes the treatment a depriving and painful experience for his patients still exists. Even well-meaning critics (such as Strupp 1978a) accuse psychoanalysis of making a virtue of suffering and of arguing for this from outdated assumptions.

We think that in these objections different sources of suffering related to the psychoanalyst get mixed up. First, it may be the expression of a patient's specific conflict. Second, he may suffer due to specific characteristics of the psychoanalyst's personality, because every negative transference reaction has a larger or smaller component that is focused on the specific personality of the psychoanalyst and how it has been shaped during his professional education, a point emphasized by Gill (1982) and Thomä (1981). And third, eventually the patient may experience suffering due to the psychoanalyst's *technique*. Only this is the context of the suffering related to abstinence.

Unfortunately neither critics nor defenders of a particular psychoanalytic view present empirical data to support their opinions. This single-case study is an attempt to offer data on this subject. We are interested in the following questions:

(1) Which part of the patient's suffering during psychoanalysis is related to his psychoanalyst? Which part has other sources? What are those?

(2) How does the suffering in regard to the psychoanalyst change in the course of treatment? Is it constantly present as one would expect according to Freud? Is it worse at the beginning, while the therapist's behavior is still unfamiliar and strange? Or is there a crisis in the course of treatment? If so, what causes it?

(3) How much suffering related to the therapist is in fact due to his abstinence?

(4) What does the therapist do when he becomes the object of the patient's suffering?

2. Methods

Here we shall be very brief since we have previously described the method (Neudert et al. 1985). We investigated a single case because only this kind of study permits an examination in detail of the variability of suffering during the psychoanalysis. It also offers the opportunity to gather complex and differentiated information, including qualitative clinical data that enable the generation of more adequate hypotheses about the psychoanalytic process. The study was carried out on verbatim transcripts of psychoanalytic sessions by means of content-analysis methods. Since none of the available content-analysis instruments for measuring painful affects (Dollard and Mowrer 1947; Dollard and Auld 1959; Mahl 1961; Gottschalk and Gleser 1969; Knapp et al. 1975, etc.) was suitable for our questions, we developed two special content-analysis manuals.

Manual I was used by independent judges to identify all sequences in the verbatim transcripts in which the patient verbalized painful or unpleasurable feelings. In a second step the judges scored the degree of suffering and the way of dealing with it as it was expressed in the pertinent sequences. This manual consists of four distinct categories and four rating scales. In this chapter we refer to only two of the rating scales:

(1) A 5-point rating scale for judging the *intensity of suffering* in every sequence of the text where suffering was expressed. The various values of intensity from one session are added up to yield a sum score of 'total suffering' (= TS) for each session.

(2) Another 5-point scale on which the independent judges mark the degree of the patient's *helplessness in dealing with his suffering* for every pertinent sequence.

After having been corrected according to the Spearman-Brown formula (cf. Lienert 1969, p. 119), Pearson's r as the coefficient of reliability between judges was .85 for both rating scales.

Manual II was used to measure what the patient suffered from or what he 'blamed' for his suffering. The coding units were the same sequences that were identified according to Manual I. The main categories are 'self' and 'environment'. The judgment is made on a 5-point scale with the poles labeled 'the suffering is exclusively related to self' and 'the suffering is exclusively related to environment'. If the environment is involved, i.e., when the judges check off one of the scale points between 2 and 5, they additionally have to choose one of the following subcategories:

(1) human environment (= h),

(2) therapist (= th),

(3) extra-human environment (= e). (This category includes weather, fortune, animals, etc.).

When the judges are not able to decide who the patient blamed, they are to choose the category 'unclear'.

The measures of agreement were also very adequate for Manual II: the rank Pearson's r (again corrected according to Spearman-Brown) for the rating scale 'relatedness of suffering' was .92 (n = 342), and the Kappa-coefficients (Cohen 1960), which we used to compute the agreement on nominal data, were .76 for the three types of environment and .75 for the category 'unclear'.

Our *sample* consisted of 7 blocks of 8 consecutive sessions each for a total of 56 sessions. We chose this type of sample in order to be able to explore thematic connections across several sessions as well as examine medium-term effects of therapeutic interventions. The 7 blocks were spread over the entire treatment at varying intervals to avoid periodically recurring effects. For a discussion of sampling problems in time-series see Grünzig (1985 and this volume).

3. The Patient

Ms X[1], the patient of the case-study, was in her mid-30's at the beginning of her psychoanalysis. She was suffering from hirsutism (a virile growth of hair). She lived alone and felt lonely, but had retired from social contacts because she was convinced that everybody perceived her hirsutism as a bad stigma. She was afraid to be observed and rejected, in restaurants for example, and developed a clinical erythrophobia.

Ms X still felt very close to her parents, spending weekends and vacations with them. At the same time she felt restricted by her mother's care for her. She had never had a sexual relationship with a man. In her

[1]now better known as Mrs Amalie X (addendum 2003)

view this was caused on the one hand by her hirsutism, which she had had since puberty, on the other by her strict religious attitude, which she blamed for her anxiety and her obsessive-compulsive symptoms. Because of these problems Ms X had developed a depressive reaction, which led her to seek psychoanalysis.

4. Results

The treatment was successfully completed after 517 sessions. Questionnaire data, the treating psychoanalyst's assessment, and a follow-up study two years later corroborated the successful outcome. Therefore we supposed that our process data would also show a successful course of treatment. The variables 'total suffering' and 'helplessness in dealing with suffering', which we considered to be appropriate indicators for improvement, were tested for monotonic trends.

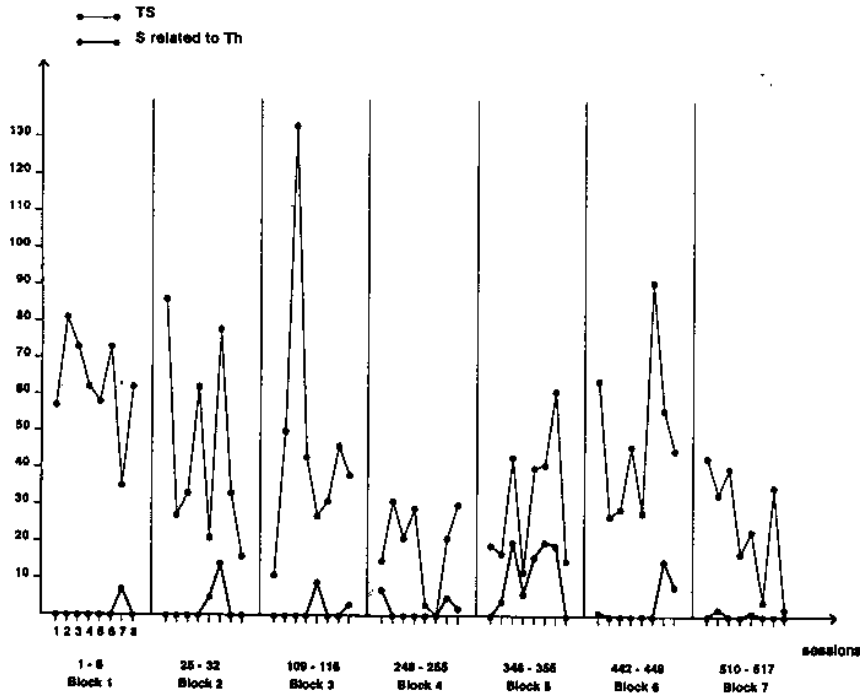

Figure 1 **Open Circles: Course of Total Suffering (= TS): Values of Intensity Summed over All of the Sequences of the Session.Solid Circles: Course of Suffering Related to the Therapist (S related to Th):**

For this purpose we used a nonparametric trend test for dichotomous data according to Haldane and Smith (1947-1949). The course of each variable can be described as a negative monotonic trend, that is, 'total suffering' ($z = -2.14$; $p < .05$) as well as 'helplessness' ($z = -3.67$; $p < .001$) decreased significantly during treatment. Further serial dependencies according to an ARIMA-model (cf. Box and Jenkins 1976) did not exist.

To compare the proportion of the suffering related to the psychoanalyst with the total suffering, we selected all sequences in which the patient's suffering was predominantly (scale point 4) or exclusively (scale point 5) related to the therapist. Figure 1 shows the two variables over time.

It is obvious to the naked eye that the suffering related to the therapist is low in comparison to the total suffering. This is also reflected in Figure 2, which shows the average percentage of suffering related to the therapist per block.

In 6 out of 7 blocks the suffering in regard to the therapist is less than 10%, and in 3 blocks less than 5%. Only Block 5 presents a totally different result with 34.3 %. For that reason we will later explore this block in more detail from a clinical-qualitative point of view. The mean score for the whole treatment is 7.2 %.

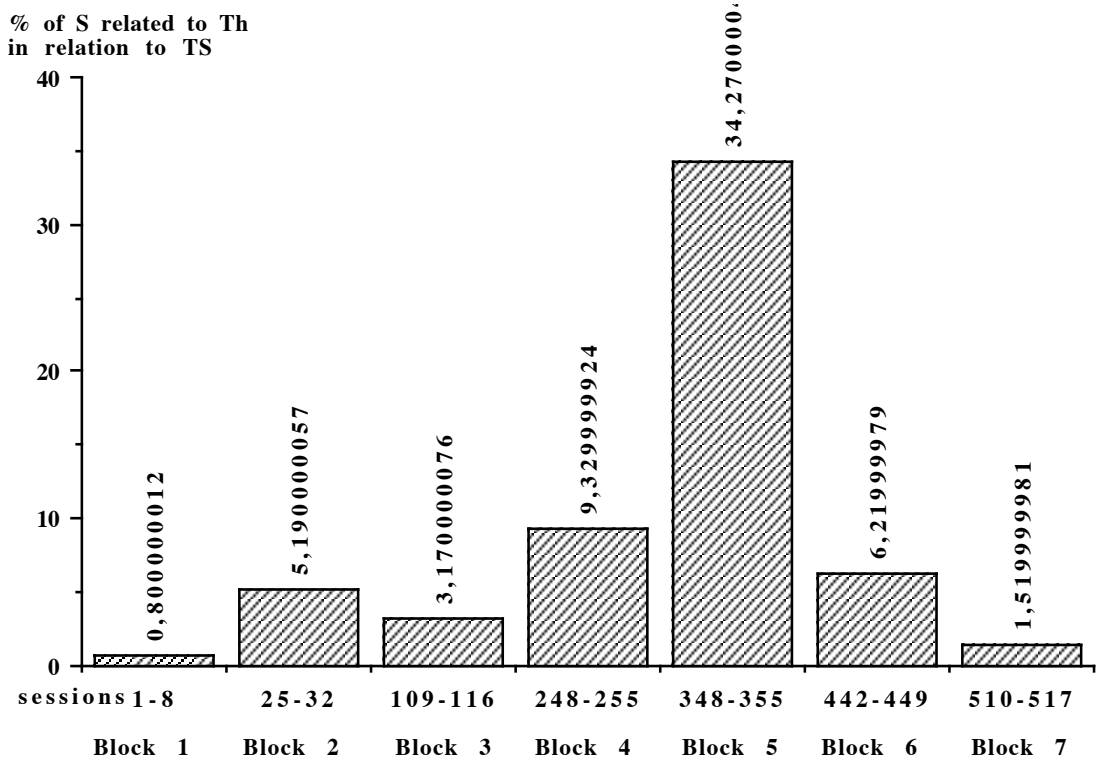

Figure 2 mean percentage of suffering related to therapist

Now what are the main sources of this patient's suffering during her psychoanalysis? Figure 3 shows the percentages of the different types of suffering for the entire treatment:

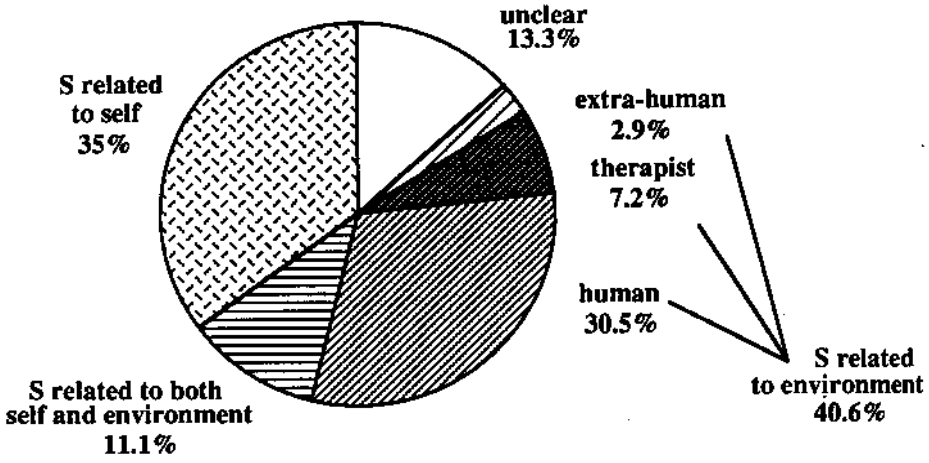

Figure 3 Percentage of the Different Types of Suffering during the Entire Treatment (total suffering = 100%)

40.6 % of the total suffering is predominantly or exclusively related to the environment. Here people outside the therapy seem most often to be the source of her suffering, 30.5% compared with the therapist's 7.2% and the 'extra-human' environment's 2.9%. 35% of the time the patient's source of suffering is predominantly or exclusively herself, and 11.1% of her total suffering is evenly divided in relation to her environment and herself (scale point 3). 13.3% of the total suffering was categorized as 'unclear'.

The interesting fact in the *distribution* of suffering related to the therapist (Figure 2) is that it is uniformly low except in Block 5. One could argue that it might have been difficult for the patient to complain about the therapist; she either may not have talked about this delicate matter at all or tried cautiously to hint at it. But not to talk about one's suffering seems incompatible with the fact that the psychoanalysis was successful. The objection that the patient might not have risked talking

about it would only hold true in our opinion for the beginning of a treatment until a trusting relationship has been established. The second possibility, that the patient might have hinted at the suffering related to the psychoanalyst only very cautiously, is not supported by our data. It is likely that cautiously expressed suffering would have been reflected in an increased value of the category 'unclear'.

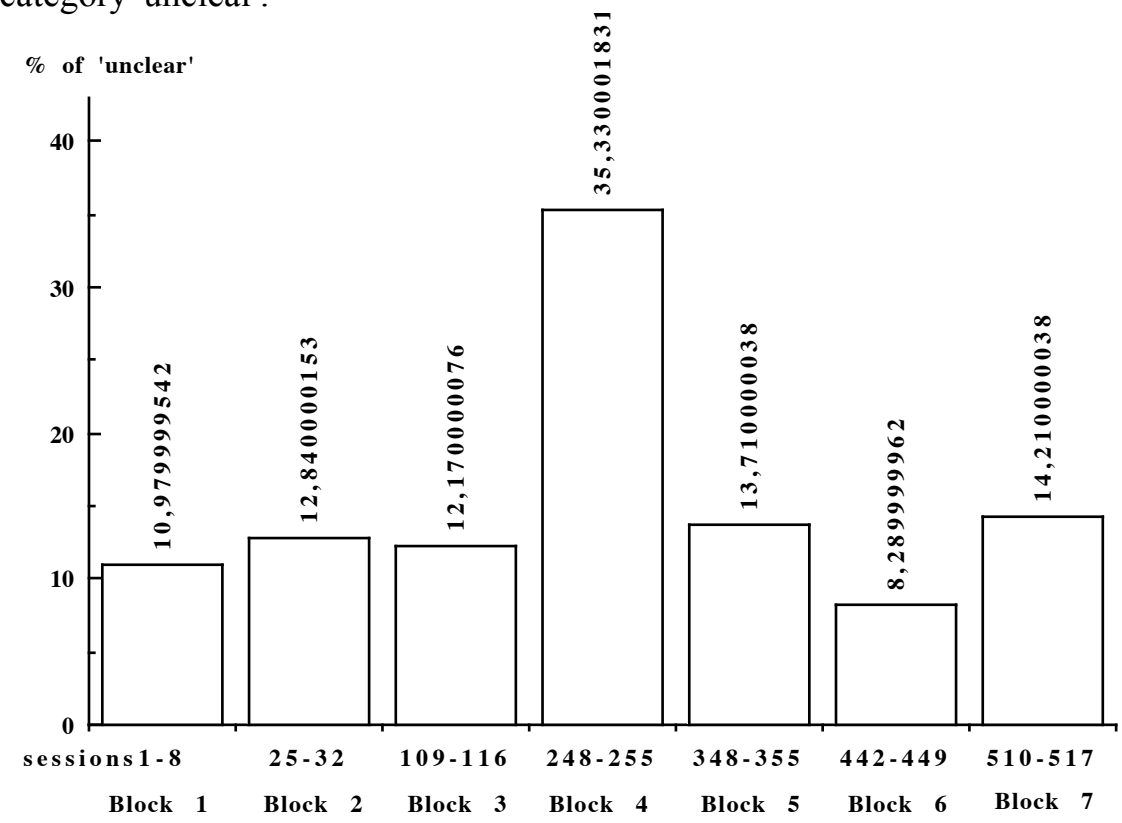

Figure 4 Mean Percentage of the Category 'unclear' for Each Block

Figure 4 represents the percentages of the category 'unclear' for the 7 blocks. The proportion of the category is not higher during the two blocks of the first 100 sessions (with 11.0% in Block 1 and 12.8% in Block 2) than it is in Block 5 (with 13.7%), where the patient obviously expressed her suffering related to the therapist in a direct manner.

So far we have considered only those sequences that received ratings of 4 and 5, i.e., suffering predominantly or exclusively related to the therapist. But the patient's cautiousness might still have found expression in reducing the degree to which her suffering was related to the therapist, thereby increasing the degree to which it was related to herself, i.e., the judges would then have chosen scale points 2 and 3

more often. It was possible to test this alternative by examining those sequences in which the patient spoke in this toned-down manner about the analyst on the one hand, and on the other hand about people who were not present and about whom she could presumably talk more easily. The data do not confirm this alternative. On the contrary, in 78% of the sequences in which any degree of suffering related to the therapist was expressed, this degree was scored as 'predominantly' or 'exclusively'. This percentage of 4's and 5's related to the therapist was even higher than the comparable 63% for sequences of suffering related to people other than the therapist.

In Block 5 suffering related to the therapist reached its peak immediately *following* Block 4 in which the *total suffering* was the *lowest* for the entire treatment (see Figure 1). What might have happened? Could it be that the sudden increase in the suffering related to the psychoanalyst was the result of the psychoanalyst having taken Freud's call for abstinence seriously? Could it be that the therapist, intending to increase the patient's level of suffering, did so by suddenly becoming more abstinent? We tried to answer this question with the help of a very simple and reliable indicator of abstinence, namely, a count of the number of words spoken by the psychoanalyst per session.

Figure 5 shows both the mean number of the psychoanalyst's words per session for each of the blocks and for comparison, the level of the patient's suffering related to the psychoanalyst for each session.

The therapist's mean number of words for the block in question is 855 which is higher than the average of 779 words for the entire treatment. The striking increase of the suffering in regard to the therapist was evidently *not* caused by the psychoanalyst's silence. In fact, if one looks at the entire course of the psychoanalysis, it was not true that the patient's suffering related to the therapist was a function of his silence. On the contrary, there is a small, not quite significant *positive* correlation ($r = .21$, $n = 56$, $p = .06$) between the number of words spoken by the psychoanalyst and the patient's suffering related to him, suggesting, if anything, that the more he talked the more the patient appeared to suffer at his hands!

What then might account for the sudden surge of suffering related to the psychoanalyst in Block 5? Our explanatory hypothesis occurred to us when we took a close look at the variation in all the types of suffering over the course of the seven blocks, as shown in Figure 6. This diagram

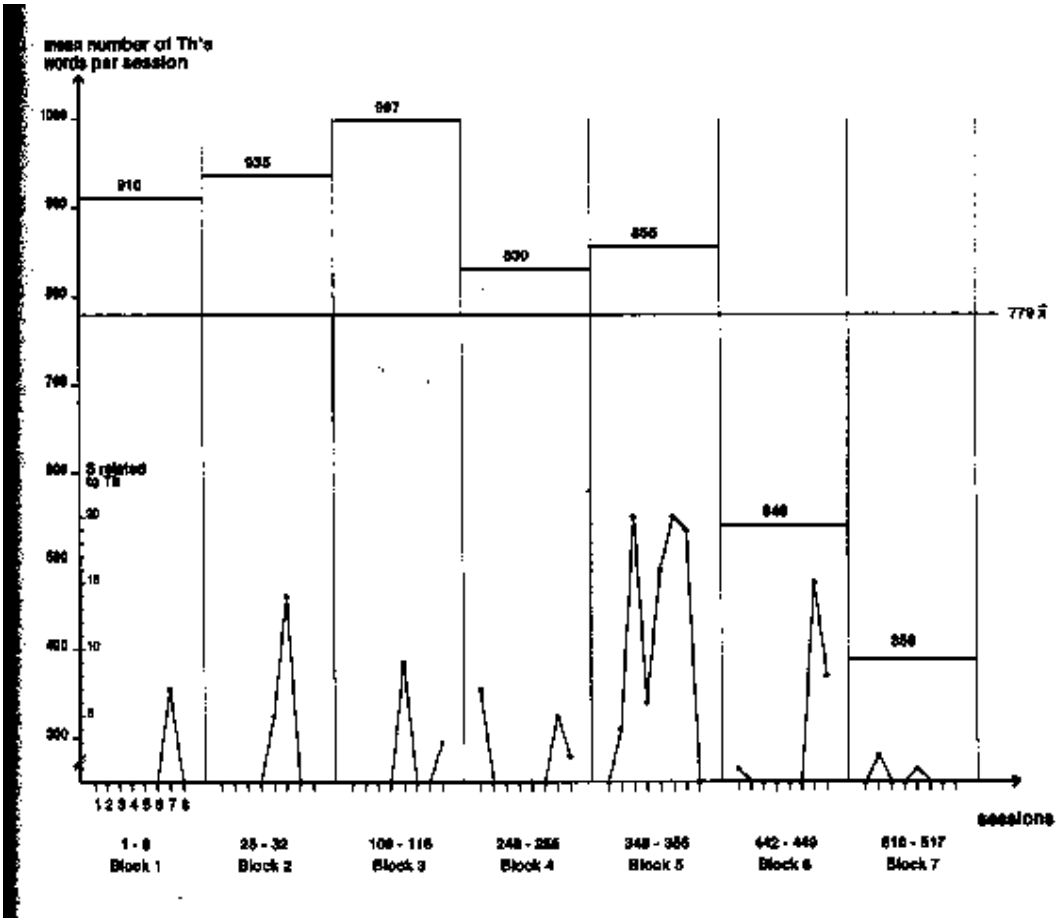

Figure 5 **(a) The Psychoanalyst's Mean Number of Words per Session for Each Block and for the Entire Treatment; (b) Suffering Related to the Therapist (summed values of suffering from sequences which are predominantly or exclusively related to the therapist)**

makes clear that, for the first time in Block 5, the suffering related to the environment evidently replaces the suffering in regard to herself. Until then the patient apparently had been primarily occupied with her own insufficiencies, insecurities and inhibitions. Now she began - as our data suggest - to tackle her environment, even though it was painful for her. And the psychoanalyst became the primary, and, according to the Weiss and Sampson control-mastery theory, *safe*, object for her painful conflicts. The usefulness of this hypothesis will now be examined in the light of a more detailed qualitative consideration of clinical material from Block 5.

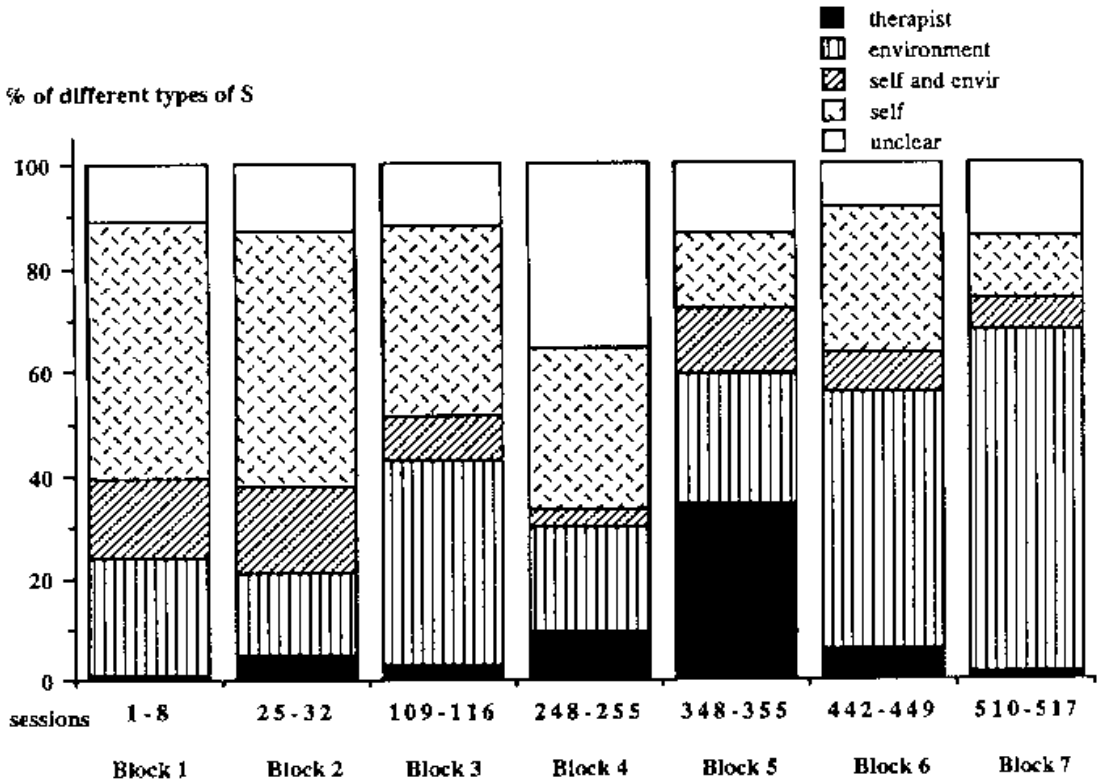

Figure 6 Mean Percentages for Each Block of the Categories: unclear, suffering related to self, suffering related to both self and environment, suffering related to environment, suffering related to therapist (subcategory)

5. Qualitative Results and Discussion

The following clinical descriptions are meant to complete the quantitative results and stick as closely as possible to the text of the verbatim transcripts. Our purpose is to make *plausible* relations among events which seem to be of importance for the psychoanalytic process. Our understanding of and reasoning about the material will proceed primarily along commonsense lines. When we use specifically psychoanalytic interpretations we shall do so explicitly.

The external situation during the sessions in question was the following: at the beginning of this period the psychoanalyst had moved his office. The consistency of the setting was disturbed; a previously

unknown part of the psychoanalyst's personal life became visible to the patient.

In five out of eight sessions of this block the patient manifestly deals with topics of suffering which may be understood as paradigmatic complaints about abstinence. She complains that the psychoanalyst is silent so much, that he does not pick up on her offerings. She regards him as inaccessible and not interested in her. On the other hand there are many other sequences that contain no reference to suffering from the psychoanalyst's abstinence. The complaints in these sequences focus on a number of topics. The therapist's move has created confusion. She feels unprotected from his gaze because there are no curtains to dim the light in the new office. And here he also sits too close behind her. He expects too much from her. He asks too many questions about her holidays. And most of these complaints are based upon the patient's *assumption* about the psychoanalyst rather than on his actual behavior (e.g. he does not express any overt expectation of her, at least not verbally).

The psychoanalyst focuses on the patient's concern about both his distance (too silent, not interested, inaccessible) and his getting too close (sitting too close, seeing her too clearly, intruding on her holidays). And the patient in turn is very eager to explain why she is concerned with his getting too close. She might loose control. Her defects (especially her unwanted hair) would become too obvious. And, above all, physical closeness is forbidden: she tells of a colleague who criticized her for touching someone. In psychoanalytic terms, during this period the patient appears to be dealing with an oedipal conflict if this is defined as a conflict about gender and generational boundaries.

So far the psychoanalyst has been looked at only from the patient's perspective. What did he actually do in this block? An evaluation of his interventions shows the following:

(1) He does not intervene less than in the other treatment blocks in which suffering in regard to the therapist seldom occurs. Remember the quantitative finding that the number of the psychoanalyst's words is higher than his mean for the entire treatment.

(2) In the sessions with a high score for patient's suffering in regard to the therapist most of his interventions are focused on her critical, accusing

and irritated comments about him. He explicitly encourages the patient to complain about him. When the patient's complaints are directed toward a specific behavior he does not attempt to neutralize them, e.g. via a transference interpretation, but confirms their realistic aspects - in the manner suggested by Gill (1982). In one sequence the psychoanalyst even accepts the patient's reproach that he once used the word 'dumb' in connection with her, although this term could not be found in the verbatim transcript.

(3) A smaller group of the interventions seems to connect several of the patient's themes. For instance he links her fear of staying in the session too long with her fear of her boundaries being violated by a forbidden touch. But very few of his interventions are interpretations in a stricter sense, i.e., connections with infantile wishes or hints at (deeply) unconscious content. More often, but only in certain sequences, the psychoanalyst focuses on latent meaning.

(4) Frequently the psychoanalyst intervenes by introducing alternative ideas. For example, he suggests that silence could mean approval, not just criticism, as interpreted by the patient.

In summary one can state that during this treatment period the therapist absolutely avoided defending himself. If he had had a defensive attitude he might have glossed over the patient's criticism and suffering or have doubted their justification. And although he was not abstinent in the sense of formally complying with a rule, he handled the principle of abstinence in a functional way (according to Cremerius 1984 and Thomä and Kächele 1987), i.e., against the background of a case-specific psychodynamic understanding: to be abstinent in regard to *this* patient, during *this* phase of the psychoanalytic process means that the psychoanalyst had to avoid - even indirectly through an interpretation - personally defending himself.

Of course, the way the patient experiences the psychoanalyst's behavior is of crucial importance for the development of the therapeutic process. How then did she respond to this therapist's particular form of abstinence, that is, to his abstaining from being defensive? Fortunately we can get a clear answer to this question by examining the last hour of this block when the patient begins to talk about how she had recently been perceiving the psychoanalyst. She had repeatedly complained about the bright daylight in the new office. But suddenly, since the previous session, curtains have been put up. She realizes that the psychoanalyst must have known that this has been planned but hadn't mentioned it when

she had complained about the lack of curtains. She then becomes aware that his not telling her was just what made it possible for her to clearly experience what it feels like to be subjected to someone looking at her. And she gets some insight into the benefits of the psychoanalyst's having withheld this information. She feels at ease and relieved by his calm reaction to her attacks. She describes the 'impersonal' in the therapeutic relationship as a welcome protection. And this sense of 'impersonality' becomes so strong that she suddenly can no longer remember exactly what her therapist looks like.

Finally, from a psychoanalytic point of view, one can assume that the patient perceived her psychoanalyst's calm reaction as a relief not only in regard to her aggressive attacks but also in regard to her wishes to be close, even if she still experienced these wishes predominantly as anxieties. The analyst's abstinence did not manifest itself as a rigid clinging to a rule, but was based on a correct understanding of her conflicts. Obviously he passed her test, as predicted by Weiss and Sampson's control-mastery theory, by reacting in a calm way both her criticism of him and her fear of being too close. The patient reacted according to the theory's prediction: she talked about her feelings of relief and relaxation. The 'total suffering' is very low in this session and her suffering in regard to the therapist completely disappeared.