to here. On the one hand, the feeling of being helplessly exposed. I was sick after all and didn't have a chance to say that I would like to have someone else take care of me. No trust. Well, here it isn't always that way, only if I try very hard to think about it. Then somewhere I feel a reservation about going so far because I wouldn't be able to defend myself. Of course, my personality and yours are guarantees, but simply by your saying it I make it into a rejection.

A: Yes, because the flowing together expresses a longing, namely to get enrichment by taking as much of my fat as possible, thus if at all possible not only a raise but a million's worth of affection, as an expression of strength and potency.

P: Yes, all of what you just said gives security. But I have to think of the following: Okay, what should I do with this longing for affection if it's impossible for them to merge to the same degree as two pieces of butter? So, get rid of it.

In a later session the patient described the mixing by referring to two bars of chocolate, thus revealing the anal origin of the reference and its different unconscious aspects.

A: Why get rid of it? Who says that it can't become reality and you can't retain something from here?

P: Yes, yes, either everything or nothing.

A: And you cut a piece of fat off my ribs with the knife.

P: [Laughing] Because I always have the tendency, everything or nothing.

A: Well, you've also discovered that you can be very curious in order to get more, everything if possible.

P: What kind of concrete example are you thinking of?

A: Hmm.

P: Because I wanted to know where you are vacationing . . . .

A: Yes, that is the example I was just thinking of, because that was also a matter of burning curiosity. And then you would like to have a steadfast man you can't disparage, who asserts his independence, because otherwise he would be a weakling.

It is always especially impressive and convincing when the patient's and analyst's thoughts coincide. Then, after a pause, the patient spoke about his boss.

P: You used the words "longing for affection." There was another word. "Longing for agreement."

A: Things in common.

P: Yes, yes.

A: Hm.

P: That is something that has worried me my entire life, when I had my first experiences with girls. It was with my wife that it happened for the first time, that I didn't lose all interest the moment my affection was reciprocated. If they became weak, then they lost almost all value.

A: Yes, yes, weak.

P: Or vice versa, if I showed a feeling of affection to someone, whoever it was, and if it weren't reciprocated immediately, I became aggressive. I not only withdrew my exposed feelers but became more withdrawn. It was an incredible humiliation

for me. Just like the fact that the two of us can't simply and completely blend together, like the butter.

A: You mentioned that you used to be more aggressive. At some point there must have been a reversal, to being self-deprecating and self-critical about not being able to finish anything, when you started making yourself the object of accusations.

P: I can now see these two pieces of butter. In religion and in communion you find just the same thing.

A: In communion.

P: In communion, in union, in eating the body, I'm not the only one to have this wish; there are millions. It's simply a part of me because I'm human.

A: Yes.

P: And not because I once knew this teacher.

A: Yes.

P: So it's nothing that I have to continuously struggle against or disparage, nothing that robs me of my value as an individual, it's rather something that belongs to me because I'm just like the rest.

A: Yes.

P: And now you'll say right away that you are also an individual, have feelings just like I do, and it must be possible to make the thing with the butter come true.

A: Yes.

P: On the other hand, ha ha, but just a second, otherwise this will go too far. Of course, you are right. This is so contradictory, just as my mood can sometimes swing within seconds, like a scale trying to get into balance. But my mood doesn't stay in balance. And now I think that if I really manage to go to my boss and talk about money, then maybe he will also think, "Maybe he could do something for nothing once." He will somehow feel disappointed if I demand something from him for what I do, since he's only human. I would have to manage to sacrifice a part of this all-or-nothing standpoint that a hundred minus one is simply equal to zero, but rather that one hundred minus one is still ninety-nine and one hundred minus fifty is still half. Can you understand me? This is so hard for me.

A: Well, yes, a hundred percent is in fact nicer, hm.

P: Yes, but one hundred minus one is still . . .

A: Ninety-nine.

P: And for me ninety-nine turns into one. I'm much more interested in this one part of a hundred than in the other ninety-nine.

A: And everything is invested in this one part, and then you yourself are nothing.

P: Yes, if I can't have everything, then I don't want anything at all. But emotionally I'm still waiting for the bang that happens when I learn something like I have today. Dr. B. used to say, "Then your anxieties will explode like a balloon. Boom, boom. And they're gone." I'm still not finished with it, but it would be lovely if it were possible.

A: I have the feeling that you are happy about the discoveries you've made today, but that you don't really dare to express your pleasure and thus to belittle your

discoveries right away. Perhaps you're also disappointed that I'm not dancing with joy at the profound connections you've discovered.

I later thought about the missing explosion prophesized by his earlier analyst. That such an exaggeration, which made the analyst into a magician performing wonders, unconsciously had to lead to the patient's anal disparagement, which in turn prevented both the explosion and a stepwise improvement from occurring, was shown by the history of this patient's illness.

2.2.4 Erotized Transference

Gertrud X, a 33-year-old woman, was referred to me by her family physician because of frequent depressive episodes, which had already led her to make several attempts to commit suicide. The patient complained also about frequent headaches. In numerous talks her physician had attempted to give her support, but in the meantime her relationship to him had become so tense that he did not feel he was in a position to look after her any longer.

The conflict situation was as follows. The patient was an only child, and she had lost her father in the war when she was 3 years old. Her parents' marriage must have been marked by tension, and her mother had not established any close ties to anyone since then. At first she established contact with her brother's family. The patient also greatly admired her mother's brother, who died in the war when the patient was 5 years old. Her mother's father also played an important role; he was an dominating authoritarian who, just like the rest of the family, was staunchly devout. She portrayed her mother as someone who was rather infantile and dependent on the opinions of others and who attempted to tie the patient to her.

A positive development had taken place about 6 years before the beginning of therapy after the patient had established a friendship with a younger (female) colleague, which made it possible for Gertrud X to put some distance between herself and her mother. Now this colleague was planning to get married and move to another location. The patient felt herself exposed to increasing attempts by her mother to cling to her, and reacted by provoking aggressive clashes. The patient had never entered into closer heterosexual friendships. Her relationships to men were characterized by her effort to find confirmation, yet her frequent provocations put their goodwill to a serious test.

In the initial interview the patient appealed especially to my willingness to help, and in particular knew how to describe in a convincing way a long chain of experiences in which she had lost someone. I offered her therapy, whose goals were to reduce conflict, both in her separation from her mother and in her attitude toward men.

Although Gertud X accepted my offer, to my surprise she expressed doubt from the very beginning about the success of analysis. She expressed skepticism especially regarding my age. She said that she was only able to establish a trusting relationship to older men; I was about the same age as the patient. In view of her aloof reservation I paid especially careful attention in our interaction for signs of a flickering of friendship, a desire for confirmation, or erotic interest. The patient

rejected interpretations in this vein in a standard way, constantly emphasizing that there was no point in me concerning myself with her in this manner. My interpretations only caused the patient to become more cautious. My attempt to break the ice by interpreting deeper unconscious wishes only had the effect of offending the patient, who reacted by becoming depressed, thinking of suicide, and retreating. These alarm signals led me to be very cautious.

Yet despite all the patient's recalcitrant reservation it became impossible to overlook the fact that her interest in me was growing. She was overpunctual in coming to her sessions, concerned herself increasingly with their contents (even though primarily in a critical way), and started using a perfume that made her "present" in my rooms for hours after her appointment.

These changes were indicative of a new topic in our interaction. With the increasing length of therapy the patient's mother became increasingly jealous, in particular because, according to the patient's reports, I frequently functioned as the star witness in their disputes. Her mother called me twice, attempting to gain my support by complaining about her daughter; I rejected this attempt from the very beginning. On the contrary, the patient's independence became a preferred topic. The patient explained in great detail about her mother's countless attempts to interfere and about her infantile nature and jealousy, and came to me for support in her struggle for more independence. In this phase of therapy our interaction was largely free of outright tension.

The first summer break, which lasted several weeks, was a turning point. There was little indication of this change in the period immediately preceding it; the patient's conflicts with her mother had instead been the prime topic. It was not until the last hour before the vacation break that the patient appeared alarmingly depressive and skeptical. Without wanting to, I adopted the role defending the therapy while the patient continued, without interruption, to deny the value of every positive sign. On the evening of the same day the patient phoned me and spoke openly about her intention to commit suicide. She got me involved in a long telephone conversation, in which we went through the contents of the last session once again.

During my vacation Gertrud X turned to her family doctor again and sought support. An intense dispute developed very quickly, whereupon she took an overdose of sleeping pills and had to be admitted. I detected a trace of triumph in her description of these events. Our interaction after the summer break had resembled that at the beginning: the patient had been skeptical and pessimistic with regard to the success of the therapy. Proceeding from her experience in the summer break, she emphasized over and over that there was no point to her having any hope. Sooner or later she would again be alone and without any human support. Invisaging her next attempt to commit suicide, I tried to show the patient my sympathy and explain to her that it would extend to her beyond the end of therapy. Although I recognized the aspect of extortion in her statements, I did not make it a topic because of my fear of further complications.

My own private situation aggravated these conflicts in this phase of therapy. The patient did not have any difficulty finding out that I was in the process of getting a divorce and that my family had moved to another location. This fact was only very briefly mentioned in the therapy, but I noticed that the patient tried to find out more

about my private life by following me in her car. I transformed this fact into the interpretation that the patient had become curious and fantasized about sharing the future with me. As a result of this interpretation, she again attempted to commit suicide by taking sleeping pills; hospital treatment was not necessary, but this event increased my vulnerability to being blackmailed. The patient began to call more frequently after the sessions. Although I regularly referred to the necessity of discussing these things in the next session, I no longer dared to force them to a conclusion and thus over and over again let myself get involved in long disputes on the telephone. This constellation remained stabile for a very long period of time. In the sessions the patient was silent and rejecting and emphasized the hopelessness of the entire situation. I attempted both to encourage her and to confront her latent rejection; in general she reacted by becoming offended and frequently called me after the sessions "in order to get over the weekend." Although I noted that the patient's social conflicts with the outside world settled a litte and that she had fewer conflicts with her supervisor in particular, this had little significance for the therapeutic process. In view of this stalemate I did not dare steer toward ending therapy because there was a very large danger that each announcement of an end would be answered with an attempted suicide.

The culmination and end of this tormentous clash was a call in which the patient said that she had just taken a dose of sleeping pills that was probably lethal. She called me from a telephone booth not far from my office. Rapid action was indicated in this emergency situation. I immediately picked her up with my car and took her to the hospital. This joint trip in my car and handing her over to the emergency care doctor on duty etc. naturally provided her with a large amount of transference satisfaction. For a brief moment it was as if the patient and I were a pair, even if an estranged one. Yet our relationship reached a point here where I had to tell her after her release from the hospital that she could force me into an active act of providing medical help, but that she had thus also lost me as analyst because I could no longer help her in that capacity. Subsequently she tried to make me alter my decision by threatening to commit suicide. Yet my steadfastness at the end of treatment made it possible to find a halfway conciliatory conclusion.

Commentary. The treatment described here resulted from a series of mistakes that are typical for beginners. Yet a beginner's mistakes often reflect an understanding of treatment characteristic of the school of analysis he adheres to. In retrospect it is possible to identify the following undesirable developments:

1. Attempts to master the ongoing crisis situations solely by working with transference and resistance is insufficient if it is not linked to an improvement in the patient's real life situation. The patient had to be reconciled to the possiblity, in fact the probability, that she would never marry; the fact that the analyst wakened unrealistic hopes therefore had to have antitherapeutic consequences. Unreflected rescue fantasies on the part of the therapist had an unfavorable influence in this case.
2. Since the patient had no partner, focussing on unconscious transference wishes had to have an antitherapeutic effect because, once again, the forced reference to transference wishes aroused unrealistic hopes. In the initial phase the therapist fell into the role of seducer, and this role had harmful effects on the rest of the analysis.

3. A topic that went untreated, especially in the first third, was that the patient employed the therapy as a weapon against her mother and that the therapist was led into taking sides. As a consequence, the patient's aggressive impulses, whose development was inevitable after her hopes had been disappointed, were directed onto someone outside therapy, which paved the way for the later, unfavorable collusion.
4. Following her serious threats of committing suicide, the analyst gave the patient more sympathy than can be maintained in an analytic setting. This obstructed the interpretation of her aggressive impulses, especially her using the threat to commit suicide to coerce the analyst. The patient's preexisting tendency to treat the analyst as a real partner was strengthened precisely in this phase of therapy, without patient and analyst jointly reflecting on the role transference played in maintaining her self-esteem. The therapist's family situation, which the patient was somehow aware of, increased her illusory hopes. If an unmarried patient who cannot cope with being alone happens to have a therapist who is the right age, alone, and possibly even unhappy, then the social reality of this constellation is so strong that it is probably extremely unusual for them to be able to focus on the neurotic components of a patient's hopes. Expectations and disappointments that have antitherapeutic consequences are almost inevitably the result.
5. It was almost inevitable that the therapist, under the burden of the disappointments and complications that he at least in part caused, would not be able to resist the pressure of his own feelings of guilt and let himself get tied up in telephone conversations justifying his procedure. In trying to justify himself it was almost a matter of course that the therapist's arguments were dictated by his own interests and not by the patient's needs, which in turn promoted the patient's secret hopes of overcoming the limitations of the therapeutic setting. Indicative of this was the fact that the therapeutic frame only regained its importance the moment the therapist admitted his failure and announced that it meant the termination of therapy.

2.2.5 Negative Transference

Negative transference is a special form of resistance that can destroy the analyst's ability to function. Has therapy reached a standstill? Is the patient one of those people who somewhere in their mind desire change - otherwise they would not come - but who at the same time deny that the analyst has any therapeutic influence? How do the patient and the analyst each cope with a chronic impasse?

The analyst can maintain his interest by attempting to recognize the reasons for the negative attitude that eludes his influence. This can be linked with the analyst's hope of interrupting the repetition and at least transforming the rigid front into a mobile war and outright hostilities. It is not difficult to recognize in this martial metaphor that the analyst suffers from such a paralyzing balance of power. One means of making it easier to bear this powerlessness is to detect the secret satisfactions that the patient derives from being able to maintain and regulate the balance of power. This is linked with the hope that knowledge of the destructive consequences of this pleasurable ability to exercise control can also lead the patient to finding new paths to gain pleasure. Abandoning the usual track and seeking free space is tied to a renunciation of security that no one gladly accepts as long as no new and promising sources of pleasure are apparent and, what is even more important, as long as these new sources do not flow precisely in those moments when people thirst for them.

In the last session I had plainly pointed out to Clara X, a patient with anorexia nervosa, that there was a deep and wide gap separating what she said here and how she acted outside - and in general between her thinking and her actions - and that she separated both spheres of her life from one another. I attempted to impress on her that although she suffered from this dichotomy, she also maintained the power embodied in it and that I could not do anything about it. The sense of what I said was, "You are powerful and I am helpless, and I can feel that your power is a strong force." Outwardly she seemed peaceful, she was a peaceful dictator, and she was not even aware of her awesome strength that made me helpless.

In her first utterance in the following session the patient referred to the blow I had given her when she, referring to the fly swat that was lying around, asked, "Do you kill flies in the winter?" And immediately added, "Do you use it to hit patients?" To my interpretation, "You are thinking about the last session," she immediately responded in a reflective manner, "Yes, it hurt me very much."

P: I understood your *criticism* to mean that although I regret not being able to do anything, I do it willfully, that I insist on my habits in order to keep you from interfering, in order to maintain my independence.

A: But not maliciously. It's difficult not to immediately take my thoughts to be criticism. Otherwise you could view your habits self-critically and perhaps see and sense that there might be other and larger opportunites for satisfaction. But by closing your eyes and retaining something that has become very established, you have very little space left to change something and go your way.

P: My perseverance can be much worse. You should inquire about the question of my weight.

The patient then spoke about the only item that might motivate her to sacrifice her perseverance, namely her desire to have another child, but this desire was immediately blocked by the thought that she would then be the prisoner of motherhood again. I picked up this line of thought:

A: Not to persevere would lead to an ambiguous goal, to becoming a mother again, which you experience to be a prison.

P: But then I would have to deny several characteristics even more fiercely. Then I would have to be feminine and patient, wait at home for my husband, be in a good mood and try to please him, try to be as nice as possible and speak with a gentle, soft voice. But beware! This doesn't include having pleasure from physical movement, and social contacts have to be largely abandoned, and I would have to forget any ambitions to have a carreer. One ambiguous situation takes the place of the other. My deepest longing is [pause] to be accepted all around and to be able to accept myself.

A: In other words, to overcome these contradictions.

P: To overcome them by having a second child is an illusion, I would get just as much negative feedback about not being a good mother and doing everything wrong.

A: I believe that you have a deep longing to overcome these contradictions, but that this feeling is unsettling. You refer to these examples in order to wipe away the shame from your demand for instantaneous nursing. You do everything to avoid this shame, which also prevents you from having more happy moments.

After this interpretation the patient replied that she simply could not see how anything could be changed by talking.

Consideration. I had the feeling I was acting as if I wanted to make something especially appealing for her, as if an angel strengthened my powers of persuasion. I surely had this fantasy because the patient some time ago had copied a painting by the pre-Raphaelite Rosetti, "The Annunciation," and brought it along with the comment that the fragile Maria in the painting, showing signs of cachexia, was probably an "anorexa."

I alluded to this in my next interpretation.

A: I am just like the angel proclaiming the Annunciation, and you are the anorexa Maria who is an unbeliever. An angel helps me be persuasive, but I turn into a devil who deceives, and you are intelligent enough to know, and you do know, that such persuasion lies because the salvation that it promises doesn't last.

Then the patient - as if in prayer and after a longer period of silence - made the following statement:

P: Hum, who took You, oh Virgin, to heaven, praised be the Virgin Mary, blessed art thou, naturally I don't believe, after all I have a heretic as father who is sitting on a cloud in heaven, but not because St. Peter let him in, but because hell was overfilled. You also said, however, that he was too much a heretic and what he said was much too unbelievable.

A: You could give me a chance to let my words resound in your ears as if they were sent by an angel, and above all you could give yourself a chance.

P: But Dear Lord, do I need a second child to get rid of this feeling of being torn apart?

A: No, I don't believe that you need another child to do it. In your own mind you already doubt whether it is worthwhile to have a second child. And then you've got the ambivalence again. The second child is a prison for you. Do you want to get started on your way to prison? Nobody wants to do that. The point is thus to give the persuasion and your own hearing more of a chance when you make a decision that could land you in prison. The point is pleasure, pleasure for its own sake, but you will always be more likely to find it where you find it now, for example, when you eat something at night.

P: [After a pause lasting about 4 minutes] The thought of gaining weight and eating doesn't have anything to do with pleasure or with the feeling of being able to accept myself or of having accepted myself or of being accepted. I can only do it because of the insight that it might be necessary for another child, but not otherwise. When I'm well armed, then I enjoy my inner contradiction as undivided pleasure.

A: That is the goal, the undivided, the unambiguous pleasure, not a divided pleasure.

P: I'm sorry, that is something that does happen, but just for seconds and hardly when the object is bread or food or the classical ways of having a good time. Now I can see a funny image. If the Anorexic lets herself get involved and starts to extend her finger, this unusual hermaphroditic figure there, Gabriel or whoever it is supposed to be on the picture, is left hanging, whether the angel is masculine or feminine? In one hand it has a bough of lillies, in the other the fly

swat, and if it extends its finger out too far, then the finger gets swatted one. Think of the fact that being a mother is a large responsibility.

A: Just don't stretch out your finger too far and hold the lillies under the angel's nose to smell, and then there is the ugly word "anorexic," not very nice, *Hexe* [witch], *anorexe* . What you give yourself, so to speak, in anticipation of the fly swat, of being hit by the fly swat. You used the ugly word.

P: I always do that. I use all the words to describe myself that others have ever used to describe me and that have been offensive. It makes my condition bearable, the age-old technique of anticipating the attack by inflicting it on yourself. A very helpful invention.

The reader should not overlook the fact that Clara X just provided an accurate definition of "identification with the aggressor." Therapeutically it was a disadvantage for this process to repeat itself after my aggressive interpretations and thus to become stronger.

The last part of the hour was concerned with immediate statements.

A: You asked me to be direct and blunt in telling you what is important and not just to say everything indirectly. I believe this is something you're demanding of me and of you yourself too. You want to hear loud and clear what is frank and unambiguous and undivided. You want out of the ambivalence. That is the problem over and over and is especially true today. I almost would like to thank you for giving me the opportunity.

After a long period of silence in the next session the patient said in retrospect, "Yes, after the last session I really had a feeling of unity and satisfaction. If I say anything, it could get broken again."

A: Yes, the topic was permission. And I had the same feeling you do, I even thanked you for it.

P: Although I don't know what you want to thank me for.

A: Yes, it's an expression of my happiness. I had the feeling, yes, . . .[falteringly] that the wide gap separating us, it seemed to me, got smaller.

P: Yes, do you think there's a wide gap?

A: Yes, I see a wide gap between action and behavior, action, behavior and speaking, and talking and thinking.

P: Don't you also have the feeling that when you start talking it starts getting controversial right away again?

A: Yes, that might be, but there are also points of agreement. There were also some in the last session. Thinking, acting, and speaking are not the same, but these spheres don't have to be as far apart as they are at times in your case. There are optimistic signs that more things are converging.

P: [After a two minute pause] Oh well, that's why I don't dare say what's on my mind. I think it might disappoint you again. And now you can say, "But I'm used to it."

A: No, I wouldn't say that - although it's true - I would rather say that it is a hard path, one filled with disappointments. You know that's how it is.

P: What I was thinking about is why I have new disappointments, more than is normal.

A: Perhaps it's related to the fact that things get too hot when they get closer, and that you become unsettled and retreat when you get closer to somebody.

Clara X again turned to the subject of her role as housewife and mother and to the question of a second pregnancy and whether she should, in this regard, force herself to gain weight. She told the story of an infertile woman, and considered herself a failure if she didn't "make" a second child. In the process it became clear that her body feeling had changed in the last few months, probably as a result of the therapy. I agreed with her that I also supported the goal of reaching a changed body feeling and, as a consequence, of her reaching a normal weight. The patient's anorexia had begun soon after her menarche, so that she had become amenorrheic very early. She had conceived her healthy son following a hormone treatment. The patient knew, after I had explained it to her, that her cycle could not set in before she had at least approximately reached a certain weight. The hormonal regulation of the menstrual cycle is so closely correlated to the amount of body fat that the absence or reoccurrence of menstruation can be predicted from a woman's weight. Psychogenic factors play only a minor role in the disappearance and reappearance of the period.

Clara X refused to fulfill the necessary preconditions for having a period, i. e., to return to a normal weight. She said that this held no promise for the future, it didn't motivate her.

A: Why is this way of reaching a new body feeling only sensible if you have another child? In my opinion you would reach normal weight if you had a different feeling toward life, one that you could develop with more pleasure, and maybe here and there with more disappointment. I see other things in addition to a child. I am an advocate of normal weight, but you put me in the wrong category. I'm convinced that you would feel better. If you think you would disappoint me, it's because you've come close to some very hot feelings, to the hot oven itself.

Commentary. The struggle over the symptoms and goal of changing her weight took up too much space. The negative transference was not traced back to the disappointment of the patient's oedipal wish for a child in transference. One allusion in this direction was not developed. The analyst's remark about approaching the hot oven was an allusion to the patient's sexual feelings; she had frequently used this phrase to refer to her sensations and her genitals. Of course, there was another, deeper aspect, so that the analyst's failure might also have been the result of insecurity. The patient's longing for her mother and to become a mother again might have been behind the topic of having a second child and the talk about her body feeling. The patient incorporated this longing in a simile about a good fairy, in whose lap she could bury her head. The patient used the negative transference and negativism to protect herself from the disturbing fusing and, ultimately, also from separation as well as from simple disappointments and rejections.

After reading this report, Clara X supplemented it with the following dialogue with a fictive reader:

Reader : I was very interested to read what your analyst wrote and thought it was fairly reasonable. What do you have to say about it from your point of view?

Clara X : When I glanced through the text for the first time, very quickly and feverishly, I asked myself whom he was talking about. Am I supposed to be Mrs. X? Did he ever tell me that? I found some expressions and details that could only stem from my own analysis, but I had simply forgotten many things.

Reader : Well, forgotten?

Clara X : The passage from my analysis that it refers to was a long time ago. Besides, I think this Mrs. X is most unpleasant, even repulsive. I can see her in front of me on the couch - I am sitting behind her - like a fat black dung beetle incessantly paddling in the air with her legs and rasping, "I can't get any where, oh, I can't, I can't!"

Reader : A dung beetle on its back is really helpless.

Clara X : Yes, but I'm afraid that if beetle Mrs. X is offered a straw to climb in order to turn over, she would only growl, "I don't like straw! Either I get an orchid or I stay where I am!"

Reader : By using this image - it comes from Kafka, doesn't it - you repeat what your analyst referred to as "negativism beyond my influence." You have even taken his seat. Is what he said about you really correct?

Clara X : I have the feeling it is. It's probably much too true, and it makes me feel ashamed. According to my idea of what I would like to be like, I move forward on my own two legs. Just why was I that stubborn in analysis?

Reader : You don't want any help, not even a straw.

Clara X : That's nothing new to me! I want to justify myself; I want to pluck apart what disturbed me, why I acted this way and accepted so little of the help that was offered to me. But it doesn't lead to anything but a repetition of the moaning that I've already gone through in therapy.

Reader : Tell me anyway what you have to moan about.

Clara X : I've always felt deeply disappointed. I longed for something closer, more direct, for aggressive physical contact, as it were. I'm much too experienced in throwing words around. Despite my own longing, I can use language to perfection to keep my partner at a distance. I was raised with words. My parents talked more than touched. My mother said herself that she wasn't able to really enjoy her children until she was able to talk to them: "I can't and couldn't do very much with little children who crawl on the floor, babble, slobber, smear their food, whom you let ride on your knees, and with whom you cuddle and be silly." The climate in our home was not cold, but cool, like the days in early spring. You could smell the promise of sunshine and violets in the air, but you still shivered and needed a sweater . . . .

Reader : And this promise naturally wakens an immense longing.

Clara X : Precisely. The merry month should come finally. And instead, the next cloud, the next hail storm. Parents demand that a child be reasonable, control himself, be understanding. They appeal to his pride that he is already big . . . .I recreated this state in therapy. And suffered from it. Incidentally, I've acted the same way toward my son. He was able to talk very early. When he would come into the kitchen when he was nearly two, to be close to me, I had the urge to interrupt my work and pick him up. And what did I do instead? I *told* him that he could play with the pots.

Reader : Can't you also overcome this distance by speaking?

Clara X : Fortunately I know I can. Sometimes. I distinguish between language and talk. For example, you can say "the language of anger" or "the language of love," but not "the talk of love." At the most we talk *about* love. But it's worthless straw, while language . . . .

Reader : is the grain that bread is made of.

Clara X : You understand me. When two people speak with one another, something really happens. During therapy I lost much valuable time talking *about* facts, going in circles, about some symptoms. I'm afraid I sometimes led the analyst around by the nose, unconsciously, and he trotted around behind me, going in the same circles.

Reader : Do you think so? At least he must have had a lot of patience.

Clara X : Yes. And I could hardly imagine when the talks were so unproductive that he might also be paralyzed. I admit that I was happy that I was able to affect him, hurt him. But a child only perceives its own - presumed - helplessness. He once even called me a tyrant, while trying to clarify a resistance. *That* hurt, and I'll never forget it. I was outraged, and while going home I recited to myself the opening lines of Schiller's *Die Bürgschaft* , "To Dionysus, the tyrant, crept the demon, carrying a dagger . . . ."

Reader : Something like that can get things moving again, can't it?

Clara X : Moving - yes! I was hoping just that would happen when I tried to arrange situations in which he and I would do something together. I'm disappointed that I didn't learn to be more spontaneous. For example, I suggested that we spend one session walking.

Reader : What came of the walk?

Clara X : We didn't get beyond discussing it. He didn't think the suggestion was entirely absurd, unacceptable, or childish. He left it open - then I gave up the idea myself. My motivation was gone. The motivation and the pleasure. I'm disappointed that I didn't learn to be more spontaneous.

Reader : But despite everything, you liked going to therapy?

Clara X : Yes. After all, I felt I was being given more attention and understanding than by the people allegedly close to me, the ones I had ties to in everyday life. My resistance was more; it was a sign of my constant devotion, if not to say a declaration of love to my analyst. Unconsciously I was saying, "Look, I'm retaining a couple of defects so that I need you. Because I know that it's good for you, like for everyone, to be wanted. I bring my sorrows, my inner images (and sometimes even real pictures), and my money to you regularly and punctually. I do my part that you have a task to do and can earn a livelihood. And at the same time I watch out that I don't claim too much of you, don't take too much of your time and strength, because I only make limited use of your advice on the outside."

Reader : Hum. Sounds a little megalomaniac, but seems convincing to me.

Clara X: That's why I find the expression "negative transference" insufficient. My attitude was fed in part by feelings that I felt to be positive. When my mother used to say, "I don't have to worry about my daughter; she just runs along, she is stable, thank God," then my little ears took it to be strong praise. I thought that my analyst would also have to positively acknowledge my inclination to only accept a very limited degree of help.

Reader : I just had a thought. If somebody prejudiced against psychoanalytic treatment is listening to us and collecting counterarguments, then this is a real treat. The therapeutic relationship that maintains itself. The client conserves her symptoms because the couch is so nice and familiar to her!

Clara X : Sure. I know such people. Let them listen until their ears ring. They only hear what they want to. But I know that I have changed. There's been a radical change in the circumstances of my life, as a result of my own action. With the emotional support I had in therapy, I was able to untie the knot, something that seemed impossible years ago and that I tried to escape from by dissolving into nothingness. It's possible that that untying this knot was the only task I saw throughout all the years of analysis. The other kinds of problems were also important, but ultimately maybe secondary.
Reader : That sounds positive. But may I nevertheless make a critical comment?
Clara X : I know that you're just as crazy as I am.
Reader : Huh?
Clara X : Somebody who tacks a "but" onto every positive statement! Shoot!
Reader : Among the other, allegedly secondary kinds of problems are your eating habits, weight, looks, health, body feeling, ability to tolerate the closeness of others, no, to perceive this closeness as satisfactory and not to always run away . . . .Aren't you cheating yourself tremendously when you refer to everything as secondary?
Clara X : Heavens. I don't consider myself cured. But I don't blame it on my therapy, and it doesn't make me feel inferior. I know that I'm in danger, and I like to balance my way along the edge. But maybe I will be able to handle it better in the future. In the meantime I'm having enough fun in life not to "beat it" voluntarily.
Consideration. It was impossible, retrospectively, to overcome the deficiency that Clara X complained about, and the question whether the therapy would have been more successful if . . . must therefore remain unanswered. This "if" can be tied to many conditional clauses. Should I have stood up immediately and gone for a walk with the patient? And what would have to have happened during the walk to create the new beginning in the sense of the spontaneity that Clara X was longing for? Once, without any previous announcement, Clara X invited me to breakfast, which she had brought along and spread out on the table in my office. I was naturally surprised but not irritated, and behaved, at least according to my perception, completely naturally. I had already had breakfast, and so I drank a cup of coffee. Clara X had fruit and a whole grain cereal. What she had expected of this arrangement stayed unclear, and in retrospect it was not a success.

Commentary. Since subsequent reflection about which real or symbolic wish fulfillment would have facilitated a new beginning for Clara X is idle speculation, we will mention a few of the general points that guided the analytic strategies. It is advisable to take complaints and accusations seriously in a comprehensive sense. This widens the scope of psychoanalysis without leading to transgressions that are ethically dubious and technically fatal. In the standard technique the limits were surely drawn too tightly, a fact which was partly a side-effect of Ferenczi's alarming experiments. Aside from flexibility, however, the analyst must be aware that a patient's complaints and accusations about deprivations and deficits in his relationship to the analyst fulfill a function that originates in neurotic dissatisfaction. If the analyst assumes that defects and deficits definitely result from what happens to someone in childhood and in the course of their life, then there is little chance for change. Strictly speaking, these events cannot be put right in retrospect. The professional means of psychotherapists, whatever their provenance, would in any case be subject to narrow limits. Anna Freud (1976, p. 263) took this position, that namely an individual can only change what

it itself has done, but not what was done to it. This argument pays too little consideration to the fact that the incapacity to act constitutes neurotic suffering. A patient's accusations about not being offered enough in therapy are assertions that also serve to protect himself against not having to take the risk of fulfilling the potential for his own thoughts and actions. The analyst was obviously not successful in sufficiently freeing Clara X from her self-induced limitations to enable her to reduce her complaints about deficits in present and previous interpersonal relationships. Although individuals with anorexia nervosa deny that they suffer from self-induced hunger, the condition continues to maintain and reinforce a deficit state. Kafka's *Hunger Artist* complained that a fundamental deficit in maternal love was the cause of his fatal illness. After the artist died of starvation, Kafka has a panther take his place in the cage. The short story concludes with the panther being shown to the audience in place of the artist. It is not an easy task to reconcile a patient with the pantherlike components of his own self.

2.3 Significance of the Life History

2.3.1 Rediscovery of the Father

Twenty years ago Friedrich Y suffered numerous periods of serious depression; the symptoms were so serious at that time that psychotherapy was not even considered. After an initial outpatient therapy with an antidepressive, lithium was administered as prophylactic medication, which has continued until the present day. Although psychotic mood swings had not become manifest in the meantime, Friedrich Y reported that he fell from states of high spirits into black holes.

He had postponed his desire to seek psychoanalytic treatment for a long time, and could now for the first time take the liberty of having one and was also willing to wait a long time for it. He sought therapeutic help because he had felt "walled in" for years. He described his condition with the image that he lived under a layer of concrete that he has to break through every morning after waking up; he reasoned that this condition stemmed from the years of treatment with the lithium medication. The indications for psychoanalysis were the depressive disturbances of the patient's ability to work and of his interpersonal relationships, which were very comprehensible psychodynamically and were probably due to neurotic conflicts.

After one and one-half years of analysis the patient had made great progress, particularly in his capacity to assert himself at work. As a consequnce of these changes, which made a great impression on him, he wanted to make the attempt to get along without taking the prophylactic medication of lithium. The question of the medication's somatic and psychological side effects had to be taken into consideration in making this decision. Schou (1986) reported that patients occasionally describe a modification of their personality as a result of lithium treatment. After considering the entire course of Friedrich Y's illness, his psychiatrist and I made the decision that the lithium medication could be gradually reduced and eventually discontinued.

The following sequence describes a phase from this period of time in which my worries and anxieties in view of the responsibility I had nolens volens accepted can also be seen.

Friedrich Y demonstrated again today very clearly that he had made great progress. Yet I was preoccupied by how little he knew about his father, a fact we had already spoken about several times. His memories of his father, who had died when the patient was 13 years old, hardly went further back than to the age of 7 or 8. This period of his childhood development appeared blurred. Although he knew a lot about the time he had spent with his mother, with regard to his father he could only remember a few Sunday walks and that his father had worked in his workshop "as if he were crazy." The shop was in their house, and his father, a Swabian craftsman, retreated there to avoid his wife, whose ideals of order and obedience ruled upstairs.

As a boy the patient had usually not been allowed into the shop and had been very distant to his father. He got all the more under the thumb of his pious mother, under whose upbringing two older sisters were already becoming depressive. The same thing happened to him; he experienced states of severe depression when he left home to begin studying at the university.

With this previous history in mind, I attempted to make him aware of the distance between us by telling him that he described exciting developments taking place outside and I could watch with great pleasure how he was unfolding, but that I noticed, alluding to transference, that he hardly perceived my workshop. He would barge into the room, lie down on the couch, take his glasses off, and not see anything else of the momentary situation.

He confirmed this, laughing. Just today he had noticed this as he took his glasses off. Moreover, there had been a time when he had trained himself to look out of focus, in order to be able to concentrate fully on his inner images and thoughts. When I emphasized his pretending to be blind, he interrupted me.

P: This is like being in front of a pane of frosted glass, glass like that in the door to father's workshop.
A: Yes, that's a remarkable parallel. But it is also surprising that we still know so little about you and your father after more than two years, as if his death had completely obliterated him, and that we know little about what you perceive here.
P: [A short period of silence] That's true. I'm very happy about the good progress I'm making, but I really don't exactly know how it takes place, how it functions, I don't know, it's pretty nebulous.
A: It probably has to be kept nebulous in order to avoid conflicts with me.

In one of the following sessions he spent more time talking about his father and the remarkable phenomenon that he had such a limited picture of him even though his father had worked at home as a craftsman for 10 years. He had grown up with the feeling of always standing outside the door. He had probably been disappointed that his father could never get his way against his mother. This time he mentioned not only his mother, but his father's mother, his grandmother. She was a woman in love with life and apparently enjoyed retirement; she came to them every day for her meals and spoiled the children with chocolate - which his father approved of but his mother criticized. His father apparently enjoyed the fact that the children were happy and being spoiled by their grandmother, who had grown mild in old age.

The patient had had a daydream after his father's death. In it he had seen an image of his father sitting in heaven and observed him masturbating. When he mentioned this image for the first time, it seemed as if his father had had a stern and evil look on his face. In today's session he attempted to differentiate, saying that it could be that the stern and evil aspects had been his mother and that his father had looked at him in a different way - as if he had felt a bond to him that was rooted in what his mother would never have accepted.

A: So it's conceivable that this image of your father in heaven portrays a connection, that something has stayed alive between the two of you and that you have bridged death in this way.
P: Yes, I wasn't able to mourn at all, I wasn't able to cry. Somehow it was as if I didn't have any use for it. I stood there in front of the door to the workshop and imagined that he was very far away.

The patient continued this line of thought, saying that this daydream might portray the wish to have received more encouragement from his father. He linked this to the fact that his mother had not permitted him to get a driver's license and that he had not had his way until he was away at the university.

At this juncture I pointed out to the patient that he had recently begun to furtively look around my room more and more, but had avoided me. I also pointed out that the treatment would be concluded sometime and that he then would again be in a situation like that when things between him and his father had not been out in the open. At this the patient became disturbed.

P: That's something I'd rather not think about yet; there are a few things I have to find out before I can go.
A: So that you won't only have stood outside the workshop door.

He then started to cry. I was surprised by his strong outburst of feelings because he had not been able to mourn. He is one of those people who rarely cry. Such moments of loosening up provide great relief, particularly in depressive personalities.

After the patient's crying had subsided somewhat, he said, "Those are moments when I have the feeling that there is never enough time. I can sense it: Our time is up again today." Although this was true, I had the impression that the patient also used the time limit to restrict himself and to keep from having any pleasurable fantasies about uniting with me. Therefore I said, "Well, I always have ten seconds time for a bold thought if you dare to tell me one." At this he laughed in a very relaxed way, sat up, and enjoyed staying seated for a moment before he stood up and left the room.

While entering the room for the next session, the patient said, "Today I'm going to be very demanding." It was two minutes before the beginning of the session. The door was ajar, and I was sitting at my desk. He did not want to lie down immediately and sat on the couch, his legs spread apart. I found it strange to sit at my desk while he was sitting on the couch, and said, pointing to the two armchairs, "Then it might be more comfortable to sit over there." "Yes," he said, "today I want to take a good look at you. I have the feeling I don't know you well enough. I realized it recently when we met in town."

We continued on the topic of observing something, of looking very carefully. He didn't pick it up himself, but left it to me to say, "In that regard you have been very restrained." Yes, he said, he had never exactly asked himself whether this was a

Freudian or a Jungian analysis. He mentioned that a friend of his had gone to a Jungian. The therapy was over now, and they were going sailing together. The question of whether something similar could happen to us was in the air.

A: And now you had to take a good look. Isn't that so? You think if I were a Freudian, then something of the sort probably could not happen.

P: No, I don't know enough about it at all. At the university I did read *The Interpretation of Dreams* once, but since then I haven't wanted to know anything about it. It's always bothered me when my friends turn to theoretical writings during a personal crisis. Yet, after all, [laughing] you probably have written something at some time, and I could go look for it.

A: Yes, you could.

Then he recalled that he had driven to his home town last Sunday and visited an old friend of his father. He had asked the old man, who was 80 years old, to tell him something about his father. He hadn't spoken to the man for 25 years. He learned once again that his father had been injured in an accident and that he had gone about his work despite having great pain. The pain was caused by cancer, which was diagnosed when Friedrich Y was 6-7 years old; his father died when he was 13. Friedrich Y mentioned further that the Sunday walks had ceased when he was 6 or 7. After that his father had worked all the time, even on Sundays.

Subsequently he remembered a dream about an acquaintance with whom he had business contacts. This man had recently fallen from a fruit tree and was now tied to a wheelchair. In the dream he had thrown the man out of his wheelchair and rolled around with him on the ground, developing a feeling of tenderness in the process.

He was amazed at this because he otherwise had always had arguments and disagreements with this acquaintance. But he had the feeling that it had somehow done him good to reach out once. I linked this to his father and to the feeling that he had brought to this session, namely of being demanding. He laughed. He recalled that he currently did not need much sleep, that he woke up at 5:30 but did not dare to get up because his wife might wake up.

A: Yes, then your mother is sitting there in the room again and watching that you don't demand anything of your father, that means, that you don't go out jogging in the woods early in the morning when you wake up so early.

He thought about whether it had anything to do with the fact that his dose of lithium was already reduced to one tablet a day. Although he still needed a midday nap, he had the feeling that he needed less sleep at night and was strong enough to uproot trees.

Considering the responsibility that I shared for discontinuing the lithium medication, I inquired about his psychiatric consultations and the nature of his high spirits. On further reflection I came to view my concern in the framework of a countertransference reaction. I had sensed in this way that the patient was worried about whether he might act destructively when in closer contact, whether he might develop too much aggressiveness, whether he, in the cheerful mood accompanying his progress, might turn everything topsy-turvy. Not only his wife would be a victim of this expansiveness, but I as well. I therefore made the interpretation that he was on the lookout for limits and restrictions.

From the beginning of the following session Friedrich Y was busy telling me that he had had a celebration on the weekend and was very satisfied with it, as he had been able to develop his professional role. The next night he had had a dream in which he saw himself hiking with his father and going into a shower room in a youth hostel, and that naked women had also been there, which came as a surprise to him. While he was still telling me about it, it became clear that he had enjoyed the view in the dream. Without directly associating to elements of the dream, he continued that he thought over and over again about his father being married twice although he hardly knew anything about his first wife. He had never been able to imagine that, in his father's second marriage, his father and mother ever had anything to do with one another. At his birth his father had already been 40. Laughing, he noted that this "already 40" was an unusual way of expressing premature aging and, in matter of fact hardly justified.

He continued thinking about his father, and now he also recalled that he had learned something from his father, specifically how to look at trees, to look at them like people. In contrast, his mother had insisted that he learn the names of plants and that he know the exact details of all the flowers. This was his mother's world. His father was much more alive when they walked through the woods. He said that his father had also shown him how to make small water wheels out of bark and twigs and that he could still do it, which he did with great enthusiasm.

After the image of his father had been blurred by the pane of frosted glass for a long time, it now seemed to brighten. This happened in direct correspondence to the increasing normalization of his interest in me (i. e., as an individual) and to the revitalization of childhood memories that now surfaced and became accessible to him.

I ended the session with the interpretation that in the dream he had apparently been able to express his wish that his father open his world of women to him. He might, as a boy, have felt that his father did not want to let him into it.

The patient started the following session by saying that he had finally been able to discuss various problems with a colleague. He had expressed his complaints and reservations and dissociated himself, although he had noticed over and over again that he was concerned not to cause the colleague very much suffering.

He then remembered that while coming to the session he had thought about the title he would give his biography if he were to write one. The first detail he recalled was that as a child he had once released the hand brake of a hay wagon, which landed in a pile of manure. "Thus at some time," he said, "I must have been more able to do something like that, until I pulled the brake again. For twenty years I've been braking all the time."

I picked up his comment about being braked and his cautious attempt to release the hand brake and said, "Yes, you've recently made various attempts to release your brake, as well as to make some critical remarks here." This was a reference to the various attempts he had made to take a close look at me, and I had both many positive aspects and some critical ones in mind. To my surprise the patient picked up this line of thought:

P: Yes, for a long time now I've noticed out of the corner of my eye a microphone on the chair in front of you. I've asked myself whether you were planning to

make a recording or whether you were even making a recording now. [Tape recordings were not made of this patient; this report is based on detailed notes taken during the sessions.]

A: Even though reason tells you that I wouldn't make any recordings here without your express approval, there seems to be a latent possibility now, a pleasurable idea that you could criticize me very intensely if I did such a thing behind your back.

P: Even though I don't believe you're capable of doing it, it would give me the opportunity here to start a real attack on you.

A: To become fierce.

P: Yes, to take the offensive. Incidentally, I wouldn't mind at all if you made tape recordings here. I can imagine that it's interesting for you.

Proceeding from this brief exchange, the patient returned to the topic of his profession and clearly indicated that he could be more outgoing in some gatherings. He could risk saying things in groups that he otherwise would only have secretly said to the colleague sitting next to him.

A: Yes, you're taking the initiative. You would like to open yourself to others.

P: Yes, I've probably kept many things to myself for too long. And even when I told my wife something, it wasn't enough. Something was incomplete.

The dialogue then returned to the therapeutic situation. The patient said once again, "Looking around in this room and perceiving personal things, it's a very difficult process for me."

Commentary. The course of this therapy raises a number of questions that deserve brief mention. The reader will have noticed the lack of speculation regarding the psychogenesis of the patient's illness as it manifested itself twenty years ago. It can nevertheless be clearly seen in the analyst's countertransference that he was nagged by substantial concerns about whether, after working through the clearly neurotic depressive conflicts, the anticipated release of expansive energy might lead to a destabilization of those sectors of the patient's personality that in psychoanalytic theories are associated with the genesis of psychotic conditions, in particular with manic ones (Abraham 1924; M. Klein 1935; Jacobson 1953, 1971). To understand the dynamics of this case, other components, especially the effects of the long-term adminstration of lithium on the patient's personality, a subject that has previously received little study, have to be taken into consideration (Rüger 1976, 1986; Danckwardt 1978; Schou 1986). Medication that works psychotropically inevitably has a psychodynamic effect in addition to its pharmacologic one. Lithium became, for this patient, the epitome of the prohibitive maternal principle. He plunged from typical adolescent hypomanic experiences, which for him were overpowering, and the medication provided the protective shield that he did not dare to question. With regard to technique, it was therefore important for the analyst, together with the patient, not to focus primarily on discontinuing the lithium treatment, but rather to initially focus on working on the factors disturbing the patient's capacity to work that were linked to his difficulties with his father.

2.3.2 Brother Envy

The psychoanalytic situation stimulates a patient's needs that are rooted in the mother-infant relationship. This relationship, i. e., the mother-child template, constitutes the silent background that makes it inevitable that third parties - e.g., other patients - will at some time be experienced as trouble makers and rivals.

For Käthe X an unexpected pregnancy precipitated intense feelings, which may have stemmed from earlier moments when she had experienced envy and jealousy. Since the patient had a negative attitude toward being pregnant, the first signs of a pregnancy led her to pay increased attention to her own body and to show more interest in women who were pregnant or had just given birth. In the session of analysis described here a presumed childhood experience, which might have only been based on a single fictive memory, was linked to an stress situation she had experienced and to an antagonistic constellation in the therapeutic relationship.

At the beginning of the hour Käthe X described a visit she had paid to a colleague who had just given birth to a son. During the visit she had suddenly noticed her period had come. In her words, "I visit her in the hospital, and then this starts." When the young mother was supposed to nurse her child, Käthe X prodded a colleague who had come along into watching with her,

P: "Let's watch, I want to see this." I simply overpowered her.

A: Take a close look, just like you like to do.

Commentary. This remark was directed at one of the patient's strengths, which she had acquired in her defensive struggle against closeness and desires to fuse. She was particularly gifted in perceiving the personal details that create distance.

P: The colleague I visited is otherwise relatively thin. Now she's got real breasts. Makes her look good. I told my other colleagues about it. The baby is nice and has blue eyes. The others said, "Now it's your turn to have one."

The patient hesitated and became unsettled, so I said:

A: It makes you feel funny, completely different.

P: Yes, I'm all confused. That it starts bleeding now, funny, just like in menstruation.

Then she remembered an acquaintance who had had a miscarriage in the third month. I commented that the impressions she had had during the visit had confused her.

P: I've been to the hospital quite often. Actually, it didn't seem strange to me.

A: This time the situation was different, and you believe you're pregnant. It touches you very personally. The bleeding would mean that you aren't pregnant after all, a kind of negative decision.

Consideration. I hypothesized that there were psychic reasons that the patient had not become preganant previously, yet she herself did not raise the topic.

P: Could be that I've deceived myself. The situation in the hospital room, the solemn mood. It was a dear child. [Pause] The father was also nice. The mother was a little pale. That's not really an impression that scares me.

Since the patient withdrew affectively from the current scene-which made a strong impression on me, inasmuch as I was familiar with the patient's life history - I decided to take an active step to tackle her avoidance and affective reattribution ("solemn mood") and asked a question linking the situation in the hospital with an experience

in her past when the birth of her brother had forced her out of her parents' apartment when she was just 2 years old.

A: When Karl, your brother, was born, how must it have been then?
P: It happened at home. I heard it. It wasn't a difficult birth.
A: What does a 2-year-old hear?
P: No idea. I can't remember Karl until we had to go to the children's hospital a few months after he was born. That's the first thing I recall. I can still remember exactly how father pulled me on my sled to the hospital. Karl was in the hospital at the time.

Commentary. This early memory can be considered a relationship paradigm, in the sense described by Mayman and Faris (1960). This paradigm, on which Stiemerling (1974) has published a quantitative study of 500 people, represents the loss of the mother and an intimate relationship to the father.

A: Why was Karl in the hospital?
P: Don't know. Never interested me.
A: This time you were interested in your colleague and her baby. Why now?
P: Yes, I wanted to see the baby. Yes, what was the reason? I don't even have close contact to the colleague. I was interested in the baby and how the mother looks, how she has changed.
A: Just like we're interested in the changes that have recently begun to take place in your body.
P: Yes, yes. How she holds the baby in her arms. She is usually so unfeminine.
A: Well, if she manages to change, then . . . .

The patient interrupted me and continued my own line of thought.

P: Don't know what's wrong now. [Paused about one minute] Now I remember that I talked with colleagues yesterday about cats. We used to have cats. And a pregnant cat is always coming to me now. She's bound to have her kittens at our house. What should I do? A colleague killed a young cat once, simply flushed it down the toilette. And now I'm beginning to feel very funny.

She was freezing, something that always happened when she had to confront stressful subjects that overwhelmed her resistance.

P: I recall that my mother once used the expression for a miscarriage, to flush it down the toilette.
A: It's hard to bear the thought.
P: Yes, my mother had her miscarriage when a letter made it impossible for her to overlook father's adultery. When mother told me, I thought to myself that she had killed the baby.

Commentary. Although this statement by the patient contains a highly ambivalent identification with her mother as her father's lover (inasmuch as the father involved the patient in allusions of an incestuous relationship), it also contains an identification with the aborted baby. She experienced herself to be the aborted baby, which also represented her wish that her brother had been aborted.

A: And something similar is in the offing for you, as if viewing the nursing mother made you aware of something that is completely unthinkable. The sight of Karl at your mother's breast, "If I could just get rid of him!" And your first association corresponds nicely. Karl was gone again and you were satisfied.
P: [Laughing] Yes, yes, that was the right place for him.

After thinking for a moment she again began to speak about her mother's miscarriage.

P: I regretted it. I would have liked to have seen it.
A: Since you couldn't prevent it, you could at least have seen it. What did the intruder look like? How did your mother look? Looking has become one of your strong points.
P: Has it? Do you think so?

The patient was touched by my reference to the fact that her "looking" was rooted in conflict. In my next intervention I therefore referred to a characteristic habit that the patient had often mentioned. She customarily arrived early, in order to see the previous patient leaving my office.

A: The way you look around my office, to see if everything is still in the same place or if I've changed something or removed anything.
P: [Correcting me] Yes, but I don't do it any more, it's different now. Today I've only looked at the potted plant.

The plant, a hibiscus, is on a toy box that I only use occasionally. In the subsequent long period of silence I felt I could sense how she gazed around the office. Innerly I agreed with the patient that what she had said was very accurate, namely that she no longer felt the need, out of mistrust, to inspect the room and its contents for changes; in the meantime she had come to feel comfortable. Then she said matter of factly, "Interesting, the things a toy box can be used for!" Then she recalled a television film in which a boy was featured in two scenes playing with such a toy box: in one he flushed a baby down the toilette, in the other he let a crocodile eat it.

The thought of it made her shiver. She thought it was very bad, the poor baby. I chose, in contrast, to emphasize the aggressive element: "It upsets you to have to observe how this boy can openly give in to his impulses. That he simply eliminates the bothersome baby." The patient responded, "The boy was entirely aware of his rage at his mother, which was very intense." At the same time she made a powerful gesture, clasping her hands and rubbing them together.

P:I'm actually not as angry at my mother as I used to be, and have noticed that my husband and I almost rival for my mother's attention - which really amazes me.

She said this slightly mockingly, surprised because it used to seem completely inconceivable to her, although she had always clearly recognized that she envied her brother at how he managed to gain mother's favor. Mother gave him beautiful things, while she herself only got some money. She always gave Karl the things he had wished. But with her? She could tell her mother for days what she wanted, but it was of no use; her mother never remembered anything. "It's clear," she said, "Joseph [her husband] has taken Karl's place. I notice that I become envious of my husband and how my mother likes him."

Käthe X now summarized how her mother and husband agreed that she should be very happy to have managed to get somebody like him. Her mother simply had not given her enough attention.

A: Yes, we are concerned about whether the same feeling always returns, the feeling namely that somebody else gets my full support, and not you, and you have to make do with money.
P: I was already well on my way to seeing things here just like with my mother, to have just the same experiences.

She seemed to turn cold from inside and began to shiver.

P: When I imagine that the woman who's here before me always marches out with a happy look on her face, that would bother me very much. Then I would think that things are much better between you and her than between us.

Käthe X attributed, in transference, different roles to the previous patient, which were expressions of sibling rivalry. The conflict culminated in the patient identifying the other patient with her brother, which meant that the other patient would have to leave as soon as she felt better. The following interpretation picked up this line of thought: Her envy of the other patient, who should be sent away, would also be directed at herself if she openly displayed something positive.

A: This idea is a great burden on you. You can't permit yourself to be happy here, to make any progress, or at least only in a disguised way. I'm not supposed to notice that you're improving.
P: Yes, that's correct. My progress, I show it ouside. You can't see it then, and I can still be happy about it.
A: There's no danger in showing it to others.
P: But I also show it here. Because I'm happy when things change. But perhaps a little more carefully, cautiously.

In conclusion we will now discuss the patient's feeling of *envy for her brother* in more detail. If we raise the question as to why the patient envied her brother, we strike upon the feeling she repeatedly had as a child, of being excluded from the primary family, a feeling she had in connection with the birth of her brother. Because she had cried and whined a lot even as an infant, after the birth of her brother when she was two she was quartered out of her parents' apartment to her grandparents, who lived in the same house. The family's circumstances lead one to assume that she was an unwanted child and that the birth of her brother was linked to some extent with a normalization. It was thus natural to assume that the patient had received too little motherly attention instead of that she had a hypothetical envy for the "breast," and to assume that in the following years she had identified with this deficit in a way that made her angry and stubborn, as justified by her mother's behavior. There are, in fact, deficit experiences that can be strengthened or weakened by subsequent fantasies. This tension also

characterizes the basic pattern of envy and jealousy that M. Klein studied retrospectively and linked to a two- or three-person relationship.

Envy is basically directed at the productive strength: that which the envied breast has to offer is unconsciously taken as the prototype of the capacity to produce, because the breast and the milk that it provides are viewed as the source of life. (M. Klein 1962, p. 185)

As a result of infant research, the chronology of the manifestation of envy and jealousy is a matter of more controversy today, although in a different sense, than at the time of the great controversies between A. Freud and M. Klein (Steiner 1985). Micropsychological studies of the interaction between mother and child make it dubious that the process of splitting, which was linked to the handy metaphors of the "good" and "bad" breast, can be considered the cause of envy.

In contrast to the assumption that splitting involves very early intrapsychic processes, Stern's (1985, p. 252) results indicate that splitting is tied to later symbolic operations. Stern's criticism emphasizes the clinical relevance of splitting processes but severs them from their hypothetical anchoring in early infancy.

The frequently recurring experiences that occurred throughout the childhood of Käthe X led to an extension of the basic pattern: "If I am kind and good, they will keep me; if I am bad and stubborn, then they will drop me." Although a large number of such splitting processes - into good and bad - can be demonstrated in the case of this patient, they must be viewed as the outcome of a development in the course of which recurrent experiences led to the stabilization of this early fundamental experience. The modification of this unconscious schema in the transference situation - as the patient's reaction to another patient she considered in even greater need of assistance and with whom she could unconsciously identify - was an indication of the increase in underlying security that she had already gained in analysis. Rosenfeld (1987, p. 266) emphasized in a posthumously published work that envy is gradually reduced when the patient feels accepted by the analyst. He criticized, in hindsight, the typical Kleinian interpretations of envy, which lead to a dead end. Stereotype interpretations of envy make the patient feel humiliated, resulting in an antitherapeutic *circulus vitiosus* . If, in contrast, the patient feels that he has room for thinking and developing, his envy gradually decreases. Since Rosenfeld was a leading representative of the Kleinian approach, his late change of opinion might be of consequence for all of psychoanalysis.

2.4 Transference and Identification

2.4.1 The Analyst As Object and As Subject

Freud's demand that "the patient should be educated to liberate and fulfil his own nature, not to resemble ourselves" (1919a, p.165) seems to contradict the large, decisive therapeutic significance of the patient's identification with the analyst. At a symposium on the termination of analyses, Hoffer (1950) declared the patient's capacity to identify with the psychoanalyst's functions to be the essential component of the therapeutic process and its success. This topic is thus of fundamental importance for an understanding of the therapeutic process and for the tension between the poles characterized in the following quotations:

We serve the patient in various functions, as an authority and as substitute for his parents, as a teacher and educator . . . However much that analyst may be tempted to become a teacher, model and ideal for other people and to create men in his own image, he should not forget that that is not his task in the analytic relationship, and indeed that he will be disloyal to his task if he allows himself to be led on by his inclincations. (Freud 1940a, pp.175, 181)

Yet this raises a number of questions. What does the patient identify with? What are the consequences of the psychoanalytic theory of identification for the optimization of therapy in

the sense of facilitating the patient's task of grasping the analyst's functions? What does the psychoanalyst contribute, and how? Is it possible, with regard to the patient's experiencing, to distinguish the functions from the person embodying them? What is the relationship between identification and the demand that the transference neurosis be resolved at the end of analysis?

Identifications with persons from the patient's past are repeated with the object of transference. For various reasons it is useful to distinguish between the analyst's roles as transference object and as a subject. Significant persons from the past become inner "object representations" and ally themselves with "self representations." These inner images and the effects they have on experiencing and behavior form the starting point of the process that Freud (1900a) referred to as the reestablishment of "perceptual identity." This affective-cognitive process leads to the rearrangement of current relations according to old patterns. It follows from this that the patient, on the basis of his unconscious disposition, also attributes roles to the doctor. In the constellation of transference neurosis the analyst can feel the strong pressure that the patient exerts to compel the analyst to accept a role. The patient would like to get to know the psychoanalyst in order to be able to identify himself with him, e. g., as an idealized object. The other person's subjectivity is not taken into consideration in these unconsciously governed and powerful attempts to reestablish a perceptual identity; the other person is made into an "object." By going along with this, the psychoanalyst can recognize the discrepancy between what is attributed to him and what he is. In this way he acquires the knowledge that makes it easier for him to make transference interpretations, as described particularly by F. Morgenthaler (1978). As a result of transference interpretations the past becomes present, opening new opportunities and perspectives.

Qualifying the psychoanalyst as a "new object" thus in our view does not go far enough (Loewald 1960). Although, according to psychoanalytic theory and terminology, the "object" comprehends the "subject," the development of a psychoanalytic "personology" (a two- or more-person psychology) requires that the subjective nature of individuals be fully acknowledged. The analyst fulfills his therapeutic function as a genuine subject and only in part by letting himself be made into an object.

The attempt to avoid directly influencing the patient has, in connection with Freud's mirror metaphor, contributed to the fact that the role identificatory processes play in therapy has been neglected although they have great significance for a cure. We want to modify rigidified and sedimented "object identifications" by helping the patient make new experiences. The subject pursuing this goal, i. e., the analyst, must be acceptable to the patient; he should not stand out among the "average expected environments" in the sense described by Hartmann (1939), in order not to precipitate xenophobic reactions. However since the special status of the psychoanalytic dyad differs substantially from routinized communication, in which only clichés are exchanged and which is itself a kind of mirroring of a rigidified state, the situation is novel, characterized by a quality of strangeness.

Although the transference neurotic repetition - itself strongly dependent on the situative conditions created by the psychoanalyst - determines the form and content of observable phenomena, the identification with the psychoanalyst's functions provides insight into previously unknown, unconscious connections and new experiences. Sterba (1940, originally published in 1929) emphasized the therapeutic significance of identification in an early article which, in contrast to his later publication (1934) on therapeutic ego splitting, has remained relatively unknown.

The analyst assists the ego, attacked by the id, offering it the possibility of an identification which satisfies the reality testing needs of the ego. This identification of the reality testing parts of the patient's ego is made possible by the fact that the analyst continuously observes and interprets to the patient the psychological situation without prejudice.

The invitation to this identification comes from the analyst. From the beginning of treatment, comments are made by the analyst about the work they will have to accomplish in common during the cure. Many phrases such as, "Let us recall what you dreamed, or thought, or did there," used by the analyst contain this invitation to identification with him as it is implied every time the analyst uses "we" to refer to the patient and himself. This identification with the analyst is based first on the patient's wish for recovery and second on the positive transference . . . .This identification is based finally on a narcissistic satisfaction resulting from *his participation in the intellectual work of gaining insight* during the analysis. (Sterba 1940, p. 371, emphasis added)

In this passage Sterba came close to recognizing the important fact that the identification can also be directed at the joint work and not just at an object. Thus the form of communication that can lead the patient out of the neurosis is itself one of the major issues.

Although the intensified formation of "we-bonds" is to a certain extent not unproblematic, because it can have a seductive effect or make contradiction and independence more difficult, we nevertheless believe that the "standard technique's" understanding of psychoanalytic rules has impeded the identification with the psychoanalyst's functions and the formation of we-bonds as called for by Sterba. The primary unity of person and function is associated with complications, which in our opinion can be resolved in the course of treatment, e.g., in identification leading to the adoption of self-reflection. The opposite attempt, namely to carry the incognito to an extreme and provide the therapeutic functions impersonally, fails for anthropological and psychoanalytic-psychogenetic reasons.

The fact that we put things in a new context and thus give them a new meaning always implies that we inform the patient of our views and divulge ourselves personally. Since, from a psychoanalytic perspective, an individual's personal identity develops both from within to without and from without to within, there are often limits on how much external influence can be exerted, and not only for practical reasons. Although we reject a purely social psychological explanation of identity development (from without to within), its theses, as argued for example by Luckmann, have serious consequences for our understanding of interpersonal mirroring.

An individual does not experience himself in an unmediated way. Only the environment can experience an individual in an unmediated way, only the environment gives itself to consciousness directly. An individual experiences others in social relationships. These others are given, unmediated, by their physical presence. The physical presence of fellow humans (or more generally, of others) is taken as a field for expressing their conscious processes. Yet insofar as the other's experiences are directed back at him, "the individual is mirrored in his fellow humans." In social relationships, which take place in a common environment, the individual experiences himself via his fellow humans. The capacity for interactive mirroring is the fundamental condition for the individual human being to form a personal identity. (Luckmann 1979, p. 299)

This understanding of mirroring makes it possible to grasp Freud's mirror metaphor in the sense of mediated self-reflection (see Vol.1, Sect. 8.4).

Yet there are a number of questions regarding the modified mirror metaphor that cannot go unmentioned even if answering them goes beyond the framework of the cases discussed in the following sections. The form of communication - therapeutically helpful and leading to changes - that is conceptualized as "mediated self-reflection" is inadequate both theoretically and practically because more is involved than the perception of previously unconscious "contents" and the emotions linked with them that are conveyed to the patient. Discovery and rediscovery take place within the framework of a special form of communication that makes it possible for the patient to find a new relationship to himself. The nature of the relationship that the psychoanalyst exhibits toward unconscious material - and this implies *his* relationship to himself, as elaborated by Tugendhat (1979) - becomes the model for the process of transformation that also changes the patient's relationship to himself.

2.4.2 Identification with the Analyst's Functions

Amalie X came to psychoanalysis because the severe restrictions she felt on her self-esteem had reached the level of depression in the last few years. Her entire life history since puberty and her social role as a woman had suffered from the severe strain resulting from her hirsutism. Although it had been possible for her to hide her stigma - the virile growth of hair all over her body - from others, the cosmetic aids she used had not raised her self-esteem or eliminated her extreme social insecurity (Goffman 1974). Her feeling of being stigmatized and her neurotic symptoms, which had already been manifest before puberty, strengthened each other in a vicious circle; scruples from compulsion neurosis and different symptoms of anxiety neurosis impeded her personal relationships and, most importantly, kept the patient from forming closer heterosexual friendships.

The analyst offered this woman, who was hard working in her career, cultivated, single, and quite feminine despite her stigma, treatment because he was relatively sure and confident that it would be possible to change the significations she attributed to her stigma. In general terms, he proceeded from the position that our body is not our only destiny and that the attitude which significant others and we ourselves have to our bodies can also be decisive. Freud's (1912d, p. 189) paraphrase of Napolean's expression to the effect that our anatomy is our destiny must be modified as a consequence of psychoanalytic insights into the psychogenesis of sexual identity. Sexual role and core identity originate under the influence of psychosocial factors on the basis of one's somatic sex (see Lichtenstein 1961; Stoller 1968, 1975; Kubie 1974).

Clinical experience justified the following assumptions. A virile stigma strengthens penis envy and reactivates oedipal conflicts. If the patient's wish to be a man had materialized, her hermaphroditic body scheme would have become free of conflict. The question "Am I a man or a woman?" would then have been answered; her insecurity regarding her identity, which was continuously reinforced by her stigma, would have been eliminated; and self image and physical reality would then have been in agreement. It was impossible for her to maintain her unconscious fantasy, however, in view of physical reality. A virile stigma does not make a man of a woman. Regressive solutions such as reaching an inner security despite her masculine stigma by identifiying herself with her mother revitalized old mother-daughter conflicts and led to a variety of defensive processes. All of her affective and cognitive processes were marked by ambivalence, so that she had difficulty, for example, deciding between different colors when shopping because she linked them with the qualitites of masculine or feminine.

When structuring the psychoanalytic situation and dealing with such problems, the analyst must pay extra attention to not letting the asymmetry of the relationship excessively strengthen the patient's feeling of being different. This is important because the idea of being different - that is, the question of similarity and difference, of identity and nonidentitiy - forms the general framework within which unconscious problems appear. In this case the analyst and patient succeeded relatively quickly in establishing a good working relationship, creating the preconditions for recognizing the internalization of earlier forms of interaction with primary reference persons - parents and teachers - during the development of the transference neurosis. The correction that was achieved can be seen in the changes in her self-esteem, in her increased security, and in the disappearance of her symptoms (see Neudert et al. 1987).

The two excerpts of treatment given below are linked, despite the time that elapsed between them, by the fact that each is concerned with enabling the patient to make new identifications as a result of the analysis of transference. The analyst's "head" became the surrogate of old, unconscious "objects," and its contents the representative of new opportunities. The representation on the "object," which is simultaneously self-representation, made it possible to establish a distance because the analyst made his head available and kept it too. Thus he became a model for closeness and distance. This example clearly demonstrates the therapeutic effect that insight into the connections between the analyst's perceptions and thoughts can have.

We have selected this case because in our opinion it is suited to provide several lines of support to our argument. Although the head acquired sexual importance as a result of the process of unconscious displacement, this displacement did not alter anything regarding the primacy of intellectual communication between the patient and the analyst about what was sought hidden inside the head. The search for knowledge was directed at sexuality. This secret and well-guarded (repressed) treasure was assumed to be in the head (as the object of transference) because of the unconscious displacement. The rediscovery of "displacement" brought something to light that was "new" to the patient.

The ideas that formed the background for my interpretations are given in addition to the abridged verbatim dialogue. These "Considerations" were subsequently added to the interpretations and the patient's responses. It is obvious that I was led not only by the ideas described here when I arrived at my interpretations. However interpretations may be created, any interpretation actually made to the patient must be aligned along "cognitive" criteria, as demanded by Arlow (1979). My comments refer to the "cognitively" and "rationally" groundable "end products" - my interpretations - and neglect their genesis and the intuitive, unconscious components in their genesis. The source of each of my analytic thoughts thus remains open. If we assume that the analyst's perceptive apparatus is steered by his theoretical knowledge, which may have become preconscious, then it is very difficult to trace the genesis of interpretations back to their "beginnings." For example, theoretical knowledge about displacement also facilitates preconscious perception; it pervades the analyst's intuition and blends with the countertransference (in a wider sense).

The patient suffered from severe feelings of guilt, which were actualized in her relationship to me. The Biblical law of an eye for an eye and a tooth for a tooth was reinforced in her experiencing because of her sexual desires. Her life historical role model for the contents of her transference neurosis was a fantasized incestuous relationship to her brother. The increase in inner tension led the patient to reconsider the idea of dedicating her life to the church as a missionary or to contemplate committing suicide. (As a young girl she had wanted to become a nun and nurse but given up this idea after a trial period because the pious confinement became too much for her. Leaving also helped her establish some distance to the strict Biblical commandments.) Now she wielded her "old" Bible against me, "in a fight to the finish." This fight took place at different levels, and the patient invented a series of similes for them. She had the feeling that the analyst's dogma, the "Freud Bible," could not be reconciled with her Christian Bible. Both bibles, however, contained a prohibition of sexual relations with the anaylst.

The patient struggled for her independence and needs, which she defended against both of these bibles. She developed an intense defense against my interpretations, and she had the feeling that I knew in advance exactly "what's going to happen." She felt humiliated because her detours and distractions had been detected. She had the intense desire to mean something to me and to live in me; she thought about giving me an old, lovely, and wonderful clock that would strike every hour for me (and for her).

In this phase of treatment one topic took on special significance and intensity; this was her interest for my head. What had she learned from measuring my head? In a similar situation Amalie X had once said that for a long time she had thought that I was looking for confirmation of what was already there - in books, in my thoughts, in my head. She wished that something completely new would come out. She herself looked for interpretations and made an effort to understand my ideas.

The patient mentioned her strict boss, who had unjustly criticized her and for whom she was no match.

A: You presume that I'm sitting behind you and saying "wrong, wrong."

Consideration. This transference interpretation was based on the following assumption. The patient attributed me a "superego function." This interpretation took the burden off her and gave her the courage to rebel (the patient had recognized long before that I was different and would not criticize her, but she was not sure and could not believe it because she still had considerable unconscious aggressions against old objects). I assumed that she had much more intense transference feelings and that both the patient and I could tolerate an increase in tension. I repeated her concern that I could not bear it and finally formulated the following statement: "Thus it's a kind of a fight to the finish, with a knife" (not specifying who has the knife). I meant for this allusion to phallic symbolism to stimulate her unconscious desires. It was an overdose! The patient reacted by withdrawing. Assumption: self-punishment.

P: Sometimes I have the feeling that I would like to rush at you, grab your neck, and hold you tight. Then I think, "He can't take it and will suddenly fall over dead.

A: That I can't take it.

The patient varied this topic, expressing her overall concern about asking too much of me and of my not being able to take the struggle.

A: It's a kind of a fight to the finish, with a knife.

P: Probably.

She then reflected that she had always, throughout the years, given up prematurely, before the struggle had really begun, and withdrawn.

P: And I don't doubt any more that it was right for me to withdraw. After such a long time I have the urge to give up again.

A: Withdrawal and self-sacrafice in the service of the mission instead of struggling to the end.

P: Exactly, nerve racking.

Consideration. She was very anxious about losing her object.

A: Then I would have the guarantee of being preserved. Then you would have broken off my test prematurely.

We continued on the topic of what I can take and whether I let myself be carried along by her "delusion." The patient had previously made comparisons to a tree,

asking whether she could could take anything from it, and what it would be. I returned to this image and raised the question of what she wanted to take along by breaking off branches.

Consideration. Tree of knowledge - aggression.

P: It's your neck, it's your head. I'm often preoccupied with your head.

A: Does it stay on? You're often preoccupied with my head?

P: Yes, yes, incredibly often. From the beginning I've measured it in every direction.

A: Hum, it is . . . .

P: It's peculiar, from the back to the front and from the bottom. I believe I'm practicing a real cult with your head. This is just too funny. With other people I'm more likely to see what they have on, just instinctively, without having to study them.

Consideration. Create shared things as primary identification. [This topic was discussed for a long period of time, with some pauses and "hums" by the analyst.]

P: It's simply too much for me. I sometimes ask myself afterwards why I didn't see it, it's such a simple connection. I am incredibly interested in your head. Naturally, what's inside too. No, not just to take it along, but to get inside your head, yes above all, to get inside.

Consideration. The partial withdrawal of the object increased her unconscious phallic aggressiveness.

The patient spoke so softly that I did not even understand "get inside" at first, mistaking it for "put inside." The patient corrected me and added a peculiar image, "Yes, it's so hard to say in front of 100 eyes."

P: Get inside, the point is to get inside and to get something out.

I saw this getting inside and taking something out in connection with the subject of fighting. It was possible to put the sexual symbolism resulting from the displacement from the bottom to the top to therapeutic use by referring to a story that the patient had told in an earlier session. A woman she knew had prevented her boyfriend from having intercourse with her and had masturbated him, which she had described by analogy to head hunter jargon as "head shrinking." The unconscious castration intention dictated by her penis envy created profound sexual anxiety and was paralleled by general and specific defloration anxieties. These anxieties led in turn to frustration, but one which she herself had instinctively caused, as a neurotic self-perpetuating cycle. The rejection of her sexual and erotic desires that now occurred unconsciously strengthened the aggressive components of her wanting to have and possess (penis desire and penis envy).

A: That you want to have the knife in order to be able to force your way in, in order to get more out.

After we exchanged a few more thoughts, I gave an explanation, saying that there was something very concrete behind our concern with the topics of getting inside, head, and the fight to the end with a knife.

A: The woman you mentioned didn't speak of head shrinkers for nothing.

P: That's just the reason I broke off this line of thought. [For about ten minutes the patient had switched to a completely different subject.]

After expressing her insight into her resistance to an intensification of transference, she again evaded the topic. She interrupted the intensification, making numerous critical comments.

P: Because at the moment it can be so stupid, so distant. Yes, my wishes and desires are the point, but it's tricky, and I get real mad, and when head and head shrinking are now . . . .

She laughed, immediately expressed her regret, and was silent. I attempted to encourage her.

A: You know what's in your head.

P: Right now I'm not at all at home in mine. How do I know what will happen tomorrow. I have to think back. I was just on dogma and your head, and if you want to go down . . .[to a shrunken head]. It's really grotesque.

Consideration. I first mentioned the shrunken heads because I assumed that the patient would be more cooperative if the envious object relationship could be replaced by a pleasurable one.

Then the patient came to speak of external things. She decribed how she saw me and how she saw herself, independent of the head, which then again became the focus of attention in a general sense.

A: By thinking about the head you're attempting to find out what you are and what I am.

P: I sometimes measure your head as if I wanted to bend your brain.

The patient then described the associations she had once had when she had seen my picture printed somewhere.

P: I discovered something completely different at the time. There was an incredible amount of envy of your head. An incredible amount. Now I'm getting somewhere at any rate. Whenever I think of the dagger and of some lovely dream.

Consideration. The patient obviously felt caught. She felt humiliated by her own association, as if she had guessed my assumption as to what the envy might refer to. In this case I would have rushed ahead of her, so to speak.

A: Humiliating, apparently to you, as if I already knew which category to put it in when you express envy, as if I already knew what you are envious of.

P: That came just now because you had referred to the shrunken heads, which I didn't even make. But what fascinated me is this fight to the finish, for the knife, to get to the hard part . . . .Yes, I was afraid that you couldn't take it. My fear that you can't take it is very old. My father could never take anything. You wouldn't believe how bland I think my father is. He couldn't take anything.

Consideration. A surprising turn. The patient's insecurity and her anxiety about taking hold developed "unspecifically" on her father.

A: It's all the more important whether my head is hard. That increases the hardness when you take hold.

P: Yes, you can take hold harder . . .and can - simply - fight better.

The patient then made numerous comments to the effect of how important it was that I did not let myself be capsized, and she returned to her envy. Then she mentioned her university studies again, and how she used to "measure" the heads of the others. Then she introduced a new thought.

P: I want to cut a little hole in your head and put in some of my thoughts.

Consideration. An objectivistic image of "intellectual" exchange as a displacement?

The patient's idea about the two-sided nature of the exchange led me to recognize another aspect of this fight. It was also an expression of how important it was to me that she remain a part of the world (and in contact with me), and digress neither into masochistic self-sacrifice nor into suicide.

P: That came to me recently. Couldn't I exchange a little of your dogma for mine. The thought of such an exchange made it easier for me to say all of this about your head.

A: That you continue coming here so that you can continue filling my head with your thoughts.

Consideration. Fertilization in numerous senses - balance and acknowledgment of reciprocity.

P: Oh yes, and mentioning really productive ideas.

The patient returned to the thoughts and fantasies she had had before the session, about how she had been torn back and forth. Whether she had a future at all, and whether she shouldn't withdraw in some way or other and put an end to it all.

At the beginning I had attempted to relieve her intense feelings of guilt with regard to her destructiveness. I picked up the idea once again that her thoughts about my stability were in proportion to her degree of aggressiveness. The patient could only gain security and further unfold her destructiveness if she found strong, unshakable stability. The topic of dogmatism probably belonged in this context. Although she criticized it - both her own Bible and my presumed belief in the Freud bible - it also provided her security, and for this reason the dogmatism could not be too rigorous or pronounced.

A: Naturally you wouldn't like a small hole; you would like to put in a lot, not a little.

The idea of a small or large hole was your shy attempt to test my head's stability. My subsequent interpretation was that the patient could also see more through a larger hole and could touch it. She picked up this idea:

P: I would even like to be able to go for a walk in your head.

She elaborated on this idea and emphasized that even earlier, i. e., before that day's session, she had often thought to herself how nice it would be to relax in me, to have a bench in my head. Very peacefully she mentioned that I could say, when looking back on my life when I die, that I had had a lovely, quiet, and peaceful place to work.

Consideration. Quiet and peacefulness clearly had a regressive quality, namely of completely avoiding the struggle for life.

The patient now viewed her entering the motherhouse as if a door had been wide open and she had turned away from life. She then drew a parallel to the beginning of the session, when the door was open.

P: I really didn't have to drill my way in. Yes, there I could leave the stuggle outside, I could also leave you outside, and you could keep your dogmas.

A: Hum.

P: And then I wouldn't fight with you.

A: Yes, but then you and your dogma would not be afraid of mine. In that setting of peace and quiet everything would remain unchanged, but the fact that you interfere in my thoughts and enter my head shows that you do want to change something, that you can and want to change something.

About five minutes into the next session, the patient returned to my head and measuring it and to the fact that it had disturbed her that I had started talking about the shrunken heads.

P: I told you so. Why do you simply want to slip down from the head?

She then described how she had hardly arrived at home before she recalled the thoughts she had had when she had said hello but then had completely forgotten during the session.

P: To me, he [the analyst] looks as if he is in his prime, and then I thought about the genitals and the shrunken heads. [But she quickly pushed this thought aside, and it was completely gone.] When you started with the shrunken heads, I thought, "Where has he got that again?"

The next topic was the question of my security and my dogmatism, and it was clear that the patient had taken a comment I had once completely undogmatically made about Freud and Jung (I have forgotten what it was) to be dogmatic. She then thought about living a full life, about the moment when everything stopped for her and she became "ascetic," and about whether everything could be revived. Then she again mentioned fighting and my head.

P: I was really afraid of tearing it off. And today I think that it's so stiff and straight, and I think to myself, "I somehow can't really get into my head. I'm not at home. Then how should I get into yours?"

The patient then began to speak about an aunt who was sometimes so very hard that you might think you were facing a wall. She then continued about how hard and how soft she would like her head to be. Her fantasies revolved, on the one hand, around quiet and security; on the other hand, she was concerned about what might be hidden in her head and the danger of it consuming her.

Consideration. This obviously involved a regressive movement. The patient could not find any quiet and relaxation because her sexual desires were linked with pregenital fantasies, which returned in projected form because they were in danger of being consumed. These components were given their clearest, and in a certain sense also their ultimate, expression in an Indian story the patient later associated, in which mothers gave pleasure to their little sons by sucking on their penises but bit them off in the process.

The comparisons of the heads and their contents always revolved around the question of whether they went together or not.

P: The question of how you have your thoughts and how I have mine . . . .Thoughts stand for many things . . . .

A: How they meet, how they rub off on one another, how far they penetrate, how friendly or unfriendly they are.

P: Yes, exactly.

A: Hum, well.

P: You said that a little too smooth.

The patient thought about all the things that scared her and returned again to the shrunken heads.

P: There I feel too tied to sexuality. The jump was too big.

The topic was continued in the question of her speed and of the consideration I pay to her and her speed.

P: But it is true; naturally it wasn't just your head but your penis too.

Amalie X was now in a position, with phases of increasing and receding anxiety, to distinguish between pleasure from discovering intellectual connections and sexual pleasure. The couch became her mental location of sexual union, and her resting in my head the symbol of pregenital harmony and ultimately the location of shared elements and insight. This aspect became even clearer a little later.

With regard to the patient's symptoms, the topic of the sessions was characterized by her anxiety about having injured herself, which was a reaction to a harmless cystitis. The patient suffered from a constant urge to urinate, which she assumed might be the result of having injured herself while masturbating. With the aid of anatomy books, she had tried to imagine her genital region. She localized her complaints to her entire abdomen. She imagined that she had destroyed a muscle by pushing and rubbing it, similar to how the sphincter muscle of the bladder can be damaged during difficult births. The patient was greatly disturbed by this anxiety, and her sleep and capacity to work were also disturbed. She was afraid that someone might notice a wet spot on her pants. Destructive fantasies predominated in her masturbation.

Despite her growing complaints the patient showed trust. She expected a clear answer about whether it was anatomically possible for her to have injured herself while masturbating. My assurance that this was not the case reduced her anxiety and temporarily provided her with great relief but also with the feeling of having blackmailed me or of having "somehow seduced me." This was to be a source of "new dangers." Blackmail, confession, and seduction became mixed. She was afraid that I would "lead her somewhere where everything was permitted," as if there were no place for guilt in my point of view. The patient alternated between two images; in one she viewed me as the seducer, in the other as the judge of public morals. Retreating to pious religiosity seemed to her the way to escape the threatening boundlessness in herself, which would muddle and destroy everything. Yet her religiosity still meant little to her, especially since she had loosened her ties to the church prior to analysis because she had not felt any relief of her distress but repeatedly felt new stress from the commandments.

In this phase there was a decisive turn in the relation between transference and doctor-patient relationship, which resulted from the fact that I had offered an explanation for my technique. Amalie X took this as a sign of my trust. This facilitated her identification with my function as analyst of providing insights. My willingness to inform her of my thoughts, which appeared to her as a special treasure, raised both the relationship and the transference to a new level. Having a view and being able to gain insights, i. e., being less excluded, made her aggressive intruding into my "head," her drilling a hole, superfluous, or in other words brought us closer together and let her participate at a friendly, pleasurable, playful level.

It is nothing special for me to offer a patient insight into my psychoanalytic thinking. In my view it is a completely banal situation, which however might provide the patient an entirely new experience. In a displaced transference to her supervisor she exhibited an "immense respect," as shown by her boss' lack of time, which did not permit her to clarify a small dispute in another talk.

The patient apparently experienced the trust I showed as an sign of great freedom, as if I had freed myself from some inhibition. Then we worked through the fact that she had known for a long time what my opinion about important items in her experiencing was and that she was in fact entitled to intrude and know.

The patient mentioned a problem with her boss and made it clear that she felt freer toward him. She attributed her success in an exaggerted way to psychoanalysis and to me. Then we turned to the question of encouragement and I said that the wish she expressed for encouragement deprived her of being able to enjoy her own success. The session continued about the excessive respect she still had.

A: That is getting quite a bit smaller by itself.

P: I still have a terrible fear of being thrown out.

(For a long period of time the patient had regularly left my office a few minutes before the end of the session, creating a minisymptom. The numerous determinants of this behavior were never a particular topic of concern. The patient's behavior changed by itself step by step. Among other things, the patient wanted to avoid being sent away, which could "annul" an entire meeting.)

To my surprise the patient asked, "Have you noticed that you've just given me an explanation for your technique, something you rarely do?" In response to a question, I find out that the patient was impressed by my statement that something decreases of its own accord. (In retrospect, I thus did give her encouragement, namely that many things happen on their own and not everything has to be fought for.) The patient then spoke for a long time about how unusually positive she had experienced my statement to be and that she viewed it as an sign of my freedom.

P: Don't you like the freedom that I attribute to you?

I showed my surprise at her belief that she was not supposed to intrude in my thoughts and learn the reasons for my statements and ideas, although she had known this for a long time.

P: But that I could say it, that is what I found incredibly new.

A: Then it is almost as if my saying that you may know something that is completely natural and that you have known for a long time was a sign of approval.

P: There was more to it, namely the image you've always had for me, simply that you protect your treasure. [She laughed.] I've always had the feeling . . .head, book, and all the things, and when you open your own head, then I don't have to drill, and that is simply something completely different. It's just an openness or freedom that exudes from you. A proof of trust, I think, when you say, "I do it for this and that reason . . . .I think it is this or that." It seems to be different if you say it or if I say it to you.

With regard to the open book it must be added that the patient in the meantime had read a publication of mine and a second one I had jointly authored with my wife. The patient had somehow attributed commandments prohibiting the acquisition of knowledge to the "Freud bible," and she was apparently surprised that I viewed her curiosity as something natural, just like her gathering of information about my family background. And with regard to my Christian Bible, even before beginning analysis she had had a vague idea about my far-reaching family ties.

New and more intense transference fantasies developed with the increase in the patient's trust and her identification with my function as analyst in helping her achieve

insights. A continuous working relationship was thus assured, which was symbolized by the "stable, reliable face," by the "I-am-there-face" of the psychoanalyst, and by his "warm hands."