Helmut Thomä at work with an obsessive-compulsive patient,

supervised publicly by Merton M. Gill on April, 30th 1982

Introduction

This draft has three parts.

Part 1) Summary of Arthur's history and symptomatology

Part 2) Some parts of session 61 and 62 based on transcripts are summarized

Part 3) Merton Gill's supervision is completely documented

The draft has to be polished. The introduction has to be augmented. Problems of psychoanalytic treatment of obsessive-compulsive disorders have to be briefly discussed. A good reference to that topic is Psychoanalytic Inquiry vol. 21 (2) 2001 (issue editor: R. Curtis Bristol).

Arthur Y had suffered from an obsessive-compulsive disorder for nearly 30 years when he decided to make a fourth attempt at therapy, which proved to be successful. As the analyst providing treatment in this case, 1 was more than just a close contemporary of the patient. In this therapy I was able to reconstruct some of the history of the psychoanalytic technique, as it was reflected in this patient's experiences. To renounce the anonymity that I neither can nor wish to maintain in this case, in hindsight I can state that I rediscovered some of my own development in the therapeutic technique of well-known colleagues who were involved in the previous therapies. More important was the fact that many of the stories the patient told me made me recall the experiences I had had when I was young. Many of my own experiences and events in my childhood were reanimated in this therapy. There are many faces to the 'relationship' between agent and victim.

Symptoms

Throughout his life the patient had tried desperately to overcome the irreconcilable contradictions inside him. Yet despite his strong anxieties of possibly committing a murder and defense rites that took the form of compulsive thoughts and acts, he was successful in his profession. He just managed to keep his dependence on alcohol under control; every day he lived for the soothing effect it had on him in the evening.

One far-reaching therapeutic insight must still be mentioned. He asked if fulfilling all the commands, in whichever form, that might come from an absolute ruler and whose common denominator for the patient was the fact that they were directed against pleasure and sexuality would lead to him being and staying the only and beloved son. These projections of power and impotence and his use of simultaneous and rapidly changing identifications to participate in them went far back, leading beyond the pathological resolution of oedipal conflicts.

It is known that such idealizations and prejudices can be linked with different meanings. Since masochistic self-denigration, e. g., ”I am a pile of shit,” are constantly linked with more or less unconscious anal-sadistic ideas of grandeur, diagnostically the one is implied by the other. Compulsive rites that lead to a temporary soothing of anxiety can take on numerous forms.

In object relations theories, i. e., from the perspective of the interdependence of inner and outer, the contents of value systems and the absolute division into good and evil are given the significance that Freud (1923b) attributed to the ego’s object identifications:

Familial Background

Many typical Nazi ideas were handed down in the patient’s family just as they were in many others between 1933 and 1945. The racist division of people into Aryan and non- Aryan and into Germans and Jews was the foundation on which the idealizations and prejudices – which were linked with the drama of family life in a

unique way, reaching down to the individual member of the family and into life in the small village – were erected. Both of the patient's parents were enthusiastic supporters of Hitler, who was also the patient's ideal until late in his adolescence, i. e., until early in the 1950s. The patient's father was a prosperous mill owner and the second person, coming only after the major local landowner, in a small village in southern Germany that did not have any Jewish inhabitants. He served in the army from 1939 on until he was reported missing in action. He was declared dead many years later. The patient's mother, who bore four children for "the Führer and the volk," held particularly high expectations for her eldest son, the patient. After the war she was insecure and not up to the demanding work of running the mill. She was a chronic depressive, ultimately committing suicide. The patient had three siblings, a brother born in 1939 and two sisters, born in 1940 and 1942. The familial background affected the formation of the patient's ego ideal, as a con- sequence of which the first-born son did not fulfill the expectations his parents had placed in him. According to the patient, it was rather inconceivable for his mother to have been proud of her oldest son. His memories did not take him far enough back for them to give him a feeling of happiness at having once been the object of admiration. His development did not at all correspond to the ideal for a German boy in the 1930s. Until far into the analysis the patient viewed himself and the world through his mother's eyes, as he described it.

Traumatization in childhood

After the birth of his brother, his mother had treated him like a cry baby, and everyday in kindergarten he acted correspondingly – his reaction to his brother's birth was to dirty his pants every day. Since he was not allowed to stay home, walking to kindergarten and especially back home again became a source of torment and humiliation for him. He would be hosed off in the room where the wash was done and where butchering was also done. The totality of his traumatic experiences erased any positive feelings toward life that the patient might have had, since it is, after all, hard to believe that his mother's eye never shined when she looked at her oldest son, to use Kohut's metaphor.

The repeated traumatic experiences the patient had from dirtying his pants included

the disparagement of being called a weakling and everything else other than being ”tough as leather, hard as Krupp steel, and fast as a greyhound,” to use a popular phrase of the time. He was not one of the boys who were big, strong, and good looking – the type he was afraid of in kindergarten as well as later on.

His annihiliation anxieties, which he retained throughout his life, were so extreme that it took a long time before the patient was even in a position to consider the possibility that he might have aggressions of his own and that he might project them onto others. He was free of anxiety, however, regarding the idea that a fast, painless death might rescue him from life. The patient, who was raised an atheist, drew the religious contents of his compulsive thoughts from the years he spent in a boarding school. There his idea of God was also shaped by a sadistic teacher and a homosexual one; the latter looked after the sick children in particular. Although the patient did not submit to either of them, and was not used and abused ”to the end,” whatever that meant, his feeling of distress increased because of his longing for a father. The mixture of homosexuality and sadomasochism was so virulent that he had his first compulsive idea after reading a detective story, namely of committing the crime in the story himself – by killing the sadistic teacher with poison. In his panic he threw the book into the toilet. By getting rid of the corpus delicti that had given him the idea, the anxiety disappeared.

The patient’s mother brought him home from the boarding school to become an apprentice in the family mill. An uncle had filled in as miller while the family waited for the missing father to return. The family did not believe that he was dead, and the mother and grandmother lived in the illusion and hope that they could keep the mill running until he returned, even though the mill did not produce a profit. The uncle, who had an affair with the patient’s mother, and a business manager pocketed money from the mill, and after they left the patient attempted to keep it running, until he closed it down shortly before it would have gone bankrupt; this left him with substantial debts, which he was able to pay off by selling property. Since then Arthur Y worked in a related field as a salesman, where he worked his way up through hard work. Yet the success he ’had in his career increased his self-esteem just as little as the fact that he had established a family of his own and could have been proud of the

fact that he had managed to find a – both attractive and intelligent – wife he had liked especially well ever since they had first met, and to have three teenage children who were developing well.

Former treatments

It is surprising that Arthur Y was able to hide his condition from those around him and that not even his closest relatives knew that he suffered from an abundance of anxieties and compulsive ideas. He feared that he might end the way his mother did and felt responsible for her suicide because he had no longer been able to take her complaining and had flown into a fit of rage the day before her death. He thought that by committing suicide he would keep much worse events from happening, such as *be*ing isolated in a prison or an insane asylum after a sex crime. Such compulsive ideas first surfaced when he was 20 years old, when he became optimistic that his later wife might return his affection. At that time Arthur Y secretly submitted to inpatient psychiatric treatment, which did not bring any improvement. Later, in the course of two long analytic psychotherapies, he gained some insights; these were then deepened durinq a classical psychoanalysis that lasted nearly 600 hours.

Although the patient suffered from strong fluctuations of the symptoms of his anxiety and compulsions, he was able to continue to work without therapy. His expertise in his field and his excellent ability to empathize with his customers enabled him to be fit and alert at the right moment even though he was rarely free of compulsive thoughts, Simply the sight of something red, a sishing noise, or the sound of certain vowels could precipitate severe anxieties and the compulsion to avoid them. The fatal illness of his younger brother led to a worsening of his symptoms and to his decision to consult me.

Preliminary evaluation

Arthur had consulted me once before, long ago. All that he could recall from the first consultation in the late 1960s was my accent. At that time I had referred him to a colleague for the psychoanalysis mentioned above, since I had anticipated moving to

another city. The patient, after completing his therapy, had happened to accept an offer for a good position in the same area I had moved to, so that it seemed logical for him to consult me again some 10 years later. Arthur Y's professional success and the stability of his family did not diminish his feeling of negative self-esteem and submission toward the compulsion that overpowered him. It was only in abstract terms that he imagined he had retained some of his own will and skills. Yet when I asked him toward the beginning of the analysis what it would be like to be free of all anxiety, he promptly answered, "Then I would be intolerably arrogant." By means of his ego splitting he had retained more than just his unconscious arrogance. Existing side by side in him were incompatible identifications with victims and with henchmen. In the course of the years the contents of these identifications – the objects in Freud's 'object identification" – grew and grew. As a victim he identified with the Jews who had been the object of scorn and destined for annihilation, and sadistically he identified unconsciously with heroes and their medals.

The consequences of the patient's experiences in adolescence were more far reaching than to simply determine the contents of his central anxieties and compulsive thoughts. Both the polarization of his inner self that had already been initiated and the splitting in accordance with the ideology instilled in him at home were reinforced at the boarding school by two teachers, who were the exponents of love and hate. These two teachers embodied homosexual and sadomasochistic expectations and fears in a planner that precluded any transformation in him. Just the opposite was the case; there was a stabilization of the existing structures at this time, although there is a high potential for transformation at this age (Freud 1905d).
The patient experienced – in the one teacher's attempts to gain his affections and in his observations of the punishments the other teacher inflicted – his own disturbing desires in the discord between pleasure and unpleasure. One scene from analysis is instructive in this context. It took a long time for the patient to feel comfortable on the couch and secure enough to use the blanket, without automatically becoming homosexual or having the feeling that the rumpled blanket, which he did not fold neatly at the end of sessions, disturbed my orderliness; he initially feared that I would therefore have enough of him and terminate the therapy. It is hardly necessary to mention that the idea of stopping was the patient's attempt to protect each of us from

even worse events. Every time the patient reached a new balance, he attempted to assert his identity resistance, to use Erikson's terminology. Erikson has described identity resistance in the following way:

> Identity resistance is, in its milder and more usual forms, the patient's fear that the analyst, because of his particular personality, background, or philosophy, may carelessly or deliberately destroy the weak core of the patient's identity and impose instead his own. I would not hesitate to say that some the much-discussed unsolved transference neuroses in patients, as well as in candidates in training, is the direct result of the fact that the identity resistance often is, at best, analyzed only quite unsystematically. (Erikson 1968, p. 214)

The patient became more courageous, even though he continued to display the pleasure he found in his power by reverting to masochistic and self-destructive forms and by participating unconsciously in sadistic acts.

The constellation at the outbreak of his illness – at the moment he was loved and had achieved an unimagined success – belongs in a general sense to the typology of those who founder on success (Freud 1916d). Since then the patient's life had been marked by his unrelentless effort to attain narcissistic perfection, whether in business or family matters. His altruistic self-sacrificing behavior was the source of both his happiness and his enormous proneness for feeling offended, which continuously activated unconscious sadomasochistic identifications.

Although the patient had long freed himself of the Nazi ideology, the polarized system of values that had been instilled in him continued to be decisive for his self-esteem. He had an almost unlimited willingness to be self-sacrificing for his family. When he was offended, he regularly turned his aggression against himself. In business matters he also achieved his successes more as a result of his empathy with the customer or, one might say, his identification with the victim he has to sell his goods.

In conclusion, I would like to emphasize a topic mentioned above, namely the problem of the origin of alternating object identifications and their splitting, to use Freud's language. In a more general sense the issue is the relationship between

contents and their psychopathological *forms.* It is obvious that elements other than the influence exerted by the Nazi ideology affected this patient's identificatory processes and that they were largely incompatible. Yet it is just as clear that the primary identifications and the preoedipal and oedipal conflicts played an independent role. Multiple personalities and thoughts about a double and the alter ego were in existence long before this patient sought his ego-ideal in Hitler. I could easily describe the patient's desperate and vain attempts to overcome his psychic conflict between the representatives of his identifications in terms of Stevenson's story about Dr. Jekyll and Mr. Hyde (see Rothstein 1983, p. 45), yet this would underestimate the significance that the *summation* of effects of mutually incompatible contents of identifications have on a pathological outcome, i. e., on pathological forms. On the other hand, taking only the early defense processes such as projective and introjective identification into consideration would also underestimate their significance because this would disregard the role of the series of traumatic experiences a patient has had for years. This is the reason I pointed out above that the internalization (i. e., the formation of "inner objects") involves *identifications with interactive processes.*

English Translation and Summary of Some Passages of Session 61

The summary is given of those parts of the verbatim transcripts which are not literally translated.

The patient has seen in the building, on his way to my office, an exposition about the former Hochschule für Gestaltung, among other things about a questionnaire "Which car would you prefer?". He then speaks for some time about the time after World War II and his enthusiasm at that time for a certain type of car, while he or his family could afford only a small car. He adds that young people nowadays will probably no longer fill in such questionnaires and ends his introductory thoughts with the sentence: "My intensive impression from a while ago is ebbing now, as though somebody told me: What do you want to express here by this, it is not really important."

Thereupon my first interpretation: You had felt with the patient who has to fill in the

questionnaire, and You saw yourself as one who fills it in or perhaps would have filled it in as he was expected to do, but who at present would consider this to be an obtrusiveness. Whose business is it, after all, what type of car I prefer, or what has it to do with the decision whether I am admitted up there as a student, a patient, or a human being? (The questionnaire to be filled in at that time for the Hochschule für Gestaltung was a questionnaire to screen applicants for their admission as students.)

Reaction P 23*:* Well, it really has something to do with it.
I remember that I also talked about cars with Dr. B and Dr. C, and Dr. B, for instance, spoke rather disparagingly of Mercedes cars. Dr. C, too, but I have the impression that this does not lead to anything here.

Then the patient says: ”This has just occupied my mind inbetween. Actually I wanted to continue with the subject of the last session in which I talked about alcohol and that I have myself thorouqhly examined every two years. On that occasion the doctor told me better to be careful with my liver. She allowed me two glasses of wine, but on the average I have been taking three glasses, also since I have been coming here, but they don’t affect my efficiency at all, I can afford them, I seem to be in control of myself in spite of them.”-.We then talk about his health and his negligible overweight.

Interpretation T 46: The main problem seems to be that you
can really relax only if you calm your guilty conscience, and when you are sitting there like that you become excited because you get a guilty conscience to do nothing, to sit down and dream (T 50, repeated con- firmation by patient in this context) and just to do nothing or to do something else than what can be seen.

T 54: When one is sitting there, one does not do anything.
P S7: As Brecht put it, dangle one’s soul.
T 58: So there is a constructive side to this…
P 59: Doing nothing.
T 60: To the so-called doing nothing.
P 61, 63, 65: Some further examples of this.

P 79: He summarizes that when he sits down to read he has a feeling of irritation in his body to his very finger- tips. ”And I think that reminds me of my mother, of the state in which she was, in which she was just sit- ting around. It was quite dreadful.”

T 82: When she was sitting there in a state of depression. Not only of depression, says the patient. I’11 try to describe: She was sitting there and was doing nothing at all, neither physically nor psychically, and was crying over her incapacity to do anything, etc.
P 98: For always when I have no program
T 99: Then it is as if you were your mother, you become like mother.
T 101: T intensifies his interpretation. Then you have very much the impression, you feel as if you were similarly empty and paralyzed.
P 102: Confirmation: Yes, exactly, that’s exactly how it is.
Patient describes (106) his program on Sunday.
P 107: She actually was as lonely as somebody who has been sent to the moon. She was never drunk, but sometimes she got a beer already in the morning. Then she was sitting around. Once he observed her as she urinated out of the house, near the garage. His anxiety to become like his mother, crazy.
T 112: Mental decay. If you are sitting there, you experience yourself as mentally not productive, but on the way to inactivity, emptiness, the way on which your mother got.
P 114: I never dared to ask my former analysts what such a depression actually is and how it can come about that from anxiety I always discover parallels to me. But I believe that now I am stable enough to ask this question. Depression really is a big medley, isn’t it, the patient says and speaks some more about it.
T 124: A lot of things must come together, one and the other, the environment, too. For instance, that the grandmother relieved her of everything and you also relieved her of everything.
T 134: It was probably also important that she was quite alone, that she could not see much sense in life any longer, without husband, this perhaps led to an early senile change. One can never tell afterwards.
P summarizes: Yes, that can be said in the case of my mother,
a lot of things came together.

T 148: And then the increasing resignation that everything becomes independent, goes on almost automatically.
P 149: That is something that frightens me. When you say
those words, something that becomes independent and then goes on automatically, it touches me on a very sensitive spot.
Some explanation on the subject of automatic processes. T (summarizing finally): You want to know whether you are different from the mother, whether in your case it's different. Then T comes to talk about the patient's real misery at that time, that he was not allowed to sit down because of the bad economic situation. He had to run about and always pretend to be doing something.
P: Yes, even if it was of no use whatsoever.
T 193: Yes, and when you were thinking you appeared to be doing nothing, and secondly, not only did you not do anything, but what is worse, you were on the same way as your mother, for heaven's sake, not become like her. (T 193) Thereupon
P 194: Yes. To come back to the different car types I somehow adopted from my mother the adherence to or the importance of status symbols, for a car was and still is to a certain degree an instrument to demonstrate power and money.
P 196: Dr. B somehow made a fool of herself when she at least that was my impression – sniffed at the Mercedes. (She had a Lancia.) Perhaps she thought that being a psychotherapist one cannot drive a Mercedes, and with Dr. C I had the same impression, and I think he told me once that it was only to show one's potency, and the Peugeot in which he drove around was by no means – but now I am somehow not objective again.
P 219: It is actually his private matter what car he buys.
T 220: It is also your private matter that you (the analyst laughs) are allowed to be not objective.
P: I am thinking all the time of something else, too. And he mentions that there is only one session left before the vacation break. He has not got any tablets for three months and remembers the dispute about the tablets.
P 228: I think I am sure that I don't need any, but one
thing has become important for me during the last few days, namely whether I could get your vacation address again.
P 230: Well, somehow a piece of – I don't like the word, but I had it on the tip of my

tongue – umbilical cord.
P 235: It helped me a lot to know that I had those tablets, and on this occasion I might again lash out at Dr. C. If he had prescribed me such tablets, it would probably have been positive for me. They may as well be in my cupboard if I don't need them, and they don't do any harm, but he won't let me have the prescription by any means.– When I phoned him before Christmas he growled at me that prescribing tablets was not his business.
T 236: And before you had got Dr. C's vacation address, and later on you didn't get it any more, you were deprived of it somehow abruptly.
P 237: And that was exactly the wrong thing.
P 239: By the way, the first time Dr. C really urged the address on me, I wouldn't have thought of asking for the vacation address. Suddenly he said, "Here is my address." I think I looked at him rather stupidly. And when I really would have needed it, I did not get it any longer. You don't need it any longer – and I actually did not dare and did not contradict him to say that I did not think so at all.
T 256: The question now seems to be whether I say, "This time not, the last time yes."
After some exchange of ideas I tell the patient that it is not possible to phone me in the vacations, that I can get a message through my secretary.
P 271: He mentions himself his curiosity. And one needs some distance before one can express it.
P 275: Perhaps you go hiking if you cannot be phoned.
The patient likes going to the mountains and hiking.
P 275: Therefore, because you like hiking and it would be a nice community.
T 278: And a more positive community than the one of sitting depressedly in the armchair. Another community than the one you are afraid of: When I am sitting there, I'11 become like the mother.
T refers to the curiosity (285).
P: Yes, and I once talked to you about a long-distance hiking path, and I had the impression that you knew something about it, that it starts from Oberstdorf.
P 290: A reaction which actually nobody could have minded would have been: Do you know that path? I actually did not dare to ask at that time.
P 294: Even today it's not easy for me.

P 296: And I think I know the reason. I probably would not have got an answer from Dr. A, B and C,
P 298: but the counter-question, ”Well, why does that interest you?” And if such counter-questions are posed to you for some time, you no longer feel like asking.
T: I don’t know him myself, I know something about him.
P 310: I really made it easy for my former psychoanalysts. I just come to think of a snail which puts out its feelers. If you touch the feelers only a little bit, it will retire into its shell. That’s just the way I behaved for many years. And something else comes to my mind, a dog, a big dog which snarls (314), one doesn’t touch it easily, or else it might bite off a finger.
T 320: In that case the dog is probably rather the weird
psychotherapist who mustn’t be irritated, that’s the way I understand it, who has to be treated at a distance.

From Session 62

In the introduction questions regarding discretion in connection with the tape recording are dealt with, as the patient. for different good reasons has to attach special importance to the demand that nobody should have access to the verbatim transcripts without the analyst’s knowledge.

In P 55 the patient refers to his absurd anxieties that on every occasion he might be caught at something.
T 56: Takes up the subject. Apart from the normal dangers, the usual dangers, you see, for inner reasons, everywhere a danger twice as great.
T 60: You see more dangers or greater dangers, for inner reasons. And T goes back to the last session.
T 62: To refer to an example at the end of the last session: You noticed that some psychoanalysts are not so pleased with certain questions, that they don’t like questions. You noticed that very correctly.
T 64: And it is very important for you to find out what might irritate me. That’s an important thing, and the danger involved cannot be the little danger that this or that may not be suitable, but that he becomes a dog which is lurking. And if you touch it with your finger, what will happen? Will it snap and bite the finger off? That is to say,

the danger of your irritating someone a little becomes immense, he be- comes a bulldog which bites your finger off.
P 65: Now I remember exactly. I wanted to express it in a different way, although what you say is correct. But at the end of the last session I had something else in mind. I thought I had rather been like a snail, so docile that when you slightly touch its feelers it retires at once.
p 67: Instead of having been like a dog which would have barked sometimes.
T 68: Yes, and then it was the finger of the man, of the psychotherapist.
P 69: Yes, that's what I really meant, although the other thing is also correct.
T 70: So these are the two sides.
P 71: And I have also got an example for it.
P 73: I remember exactly now, we talked about the long- distance hiking path and when I talked about it you took the subject up and asked whether it started from Oberstdorf. And the last time when I talked about it you said, "Well, every Suabian will know Oberstdorf." And it is quite typical that I accepted this, although I at once thought that the point in question was not really Oberstdorf, but the hiking path which of course is not so well known, but I did not say anything.
P 75: There was a red light somewhere, that's enough, don't ask more.
T 76: Or you'11 bite his finger off and he will become angry, and then you retire like a snail.
P 77: Then I retire, but there remains a sting within me.
T 78: But I believe that this is a very important realization to which you have come, and I would like to have a closer look whether this is correct.
P 79: I am surprised that you give the matter such importance, because we have been talking about it for months.
P 81: You said it was a very important realization. You
emphasized especially that you were interested, but on the other hand we have been talking about it for months.
T 82: Oh yes, it's not a new realization. I wanted to say something about a detail. Two things become clearer by your impressive images of the snail and the dog and the biting, namely why you retire like a snail if at the same time you are not a snail but a biting dog, and that means that there is not only curiosity, but it changes into obtrusiveness, in a strong desire to know, to bite, so snap, to know exactly, and this

is connected with the anxiety that you might hurt and that the other therefore evades. Actually I also evaded, I did not say that I knew the hiking path. You experienced this as receding because there had been too much curiosity in your question. I made the subject more general, it's true. Hiking path 5 does not start in 0.

P 83: It starts in K.

T 84: Many start in 0, I did not start in 0 and I did not take hiking path 5, but I know something about it from others. With this example I can show something which is perhaps important because it shows why it is advisable in certain circumstances not to just answer questions. Nith this example we can make clear the things that are involved, namely curiosity, obtrusiveness, intensive obtrusiveness, taking away something from the other, etc.

P 85: Yes, of course, if certain questions are answered at once, the thinking process comes to an end for the time being.

T 86: Yes. Besides it is true, of course, that psychotherapists do not answer certain questions and evade not only because of this, but for other reasons, personal reasons, and to notice this is irritating, in that case you feel a strong irritation, that's what I wanted to show, perhaps stronger than it really is, and that involves that, for inner reasons, you experience a very strong danger to be obtrusive. The inner reasons, that was the important point for me, are connected e.g. with curiosity changing over to' biting questions, sarcasm, insistence, insistent questions, etc. There are some images, ask a hole into somebody's belly. The questions are aimed directly at the belly.

P 87: He holes me is what they say nowadays. Do you want to refer to some kind of sexuality with this?

P 89: Then my guess was right, for I remember this from earlier occasions, it actually always annoyed me.

P 91: The wording strikes me, to ask a hole in the belly is strange, really, for where do we find a hole in the belly.

T 92: It is all the limbs on growing up, head and neck, the penis, the limbs and the whole body, in any case curiosity directed to things regarding the body, also to finding out something about somebody, penetrate, penetrate into somebody's head, what is looked for there and where the anxieties of being hurt are to be found, that is a subject on which I cannot say anything now. I would therefore rather be reserved,

but it was meant to be an allusion.
P 93: In this connection something comes to my mind which alarmed me. It occurred to me when I heard the word penetrate. It was in December or November last year, i.e. when my crisis was beginning. There was a preview of a detective film in which a man, obviously a sex criminal, attacked a woman and very slowly pushed a knife into her heart. It was an abominable scene, I am still puzzled or actually disgusted when I only think of it. What irritated me most was that the man did it so slowly. I wanted to discuss this with you a long time ago, the question why it frightened and repelled me so much, I found it disgusting.
T 94: Well, I can explain it with the example, because you are more curious than you think you are allowed to be, that means you are a snail which very quickly retired its curiosity feelers. Curiosity has become connected with penetration and forbidden things, and this has summed up, summed up and summed up and summed up. Wherever something penetrates, it is a knife that penetrates, you are affected, not because you can do something like that, but because with this image the penetration, especially into another person, is re- presented insistently. And therefore there is nothing harmless for you, e.g. harmless curiosity. When I somehow evaded on that occasion, it signalized to you: Aha, I got punished, obviously I was bad, I was obtrusive.
P 95: I have got another example for it: You told me you could not be phoned in your vacation, and I might really content myself with this, but I am always thinking what you might do. But as to the direct question, ”What are you going to do?”, I dare to ask it only now in this connection, when it does not come directly from me.

Merton Gills evaluation of session 61 and 62 of Arthur’s analysis at a meeting of the Psychoanalytic Institute in Ulm 30.4.1982

I want to begin by expressing my admiration and respect for Dr. Thomä, for what he is willing to do. He is willing to submit his work to criticism, possible criticism at any rate.
I would wish that more people in positions of authority like himself would be willing to do that. I have both complimentary things to say and some critical things to say. But I am very pleased to be able to say that my overall assessment of these sessions is a very positive one. It is the kind of work I would take pride in myself.

At the same time I should like to make it perfectly clear that criticisms have to be put into the perspective of the nature of the examination of an analytic session. I think perhaps I can make that clear to you in the quickest and most vivid way by telling you that when my colleague Dr. Hoffman and I decided that we wanted to put out a a monograph which would include annotated recorded transcribed sessions, we wanted to include a perfect one, too, and we never found it.
We could never find one that we did not have fairly serious criticisms to make, and that's the nature of the beast, and I want you to understand, therefore, what I have to say in that context. None of you could possibly present a session of yours that would not be subject to criticism, nor could I, and I know that from experience.
You know that in championship chess there is a timer, and you have to make your move within a certain time.' Well, I spent all day studying these two sessions, but when Dr. Thomä was sitting in the chair of the analyst he didn't have all day, he had to react in a certain time. You have to understand, therefore, the subsequent examination of a session in those terms. Furthermore, the complexity of human reaction, is such that it is always possible to see more. In fact it would be very strange if one didn't, and I think it would only be a manifestation of the rigidity of the examiner if the examiner was unable to find more on a second look.
So I hope that you will understand that in whatever perspective I say or whatever kinds of suggestions I make, I am perfectly well aware of the fact that quite other suggestions could be made, and even contrary ones in some instance, but that that does not mean that it is a question of this is right and that is wrong, but each has its place. There are, nevertheless, our patterns of the importance and hierarchies, etc.
Now the question is what is the best way to deal with this material, and I don't really know obviously, but I'11 tell you what I am going to do. I have written a kind of a running account of the content and of the sequence of the two sessions. You`ll get some feel for what I like and what I don't like, I'll try not to do that too much. Andthen, after I have done that, I am going to go over eight or ten points which I believe are important points that this material demonstrates, and obviously I will be making those points in the light of my own views about technique. One more word perhaps about perspective, that is about this case in particular. This is a case of a man, who has had at least three previous therapies, and one of them was supposed to be a formal analysis, and these previous therapies fairly clearly did not help him very much. He

therefore proposes a very interesting challenge to the analytic method. Why was he not helped in previous analyses? Is it because he cannot be helped by analysis? Or is it because the analyses were not done in a way that would be helpful to him? And just as an overall summary statement I will say at the very beginning that there is plenty of evidence in my opinion that he was not helped by analysis because the analyses were not done as I think and as I believe Dr. Thomä thinks they should be done. And I think there is already very good evidence that Dr. Thomä is handling this man in a way which is very different from how he was handled before and that it is already showing very important changes and indications. The particular sessions that I have are 61 and 62.

Helmut Thomä: Just to make it quite clear, I handle the
case differently from the way I would have treated the patient formerly, that is, I could have been the therapist of all three previous analyses. So could I. But neither Dr. Thomä nor I would have conducted nor do we conduct an analysis now the way we would have then. And from that point of view, if I may say so, I think you have something special to learn from Dr. Thomä and myself, because through painful experience we have come to see that the way many analyses are conducted is not good. I hope you don't consider this to be too grandiose a thing to say, but I believe that Dr. Thomä and I have an understanding of something, which is an improvement, a significant improvement of the way analysis is conducted by many people. It is very hard to know how many, but certainly from the literature the evidence is clear. So this patient is an excellent challenge from that point of view and at the same time something of a disadvantage, because with regard to the transference he is in a position to split the transference and expresses negative transference towards the former therapists, which is going to make it all the more difficult, I think, for the negative transference to be expressed in relationship to Dr. Thomä.

To go now then to the sequence of material. First hour 61. I will try to be fairly quick about it, but keep it in mind if you have some question later. He came and the first thing he says is that he carne a little bit earlier and he saw a questionnaire on the notice board, a questionnaire which was given, when this was a school of design, to prospective students of the school to determine whether they would be suitable to be taken as students in this school, and one of the questions was: What kind of automobile do you prefer? He talks about that for a while and then he says he

doesn't think that it's important to be talking about this subject, and Dr. Thomä says, "Ah, but it is important" and he explains that this has to do with the patient's character and that the patient realizes that had he been given such a questionnaire he would have dutifully answered it like a good boy. But nowadays, young people are different, and the patient would regard that kind of a question as an impertinent intrusion. What business is it of anybody to ask you, what kind of a car do you prefer? And furthermore, what has that got to do with whether you could be a suitable student in a school of design or not? So Dr. Thomä interprets that the patient is putting himself in the place of a prospective student who will have to answer this questionnaire and that he wishes that he would be more like a young person who could say, "I am not going to answer your damned questionnaire and it is not your business anyhow."

Then the patient tells about a doctor who said that he was in fairly good health, but there was something not quite right with his liver and that he should drink no more than two glasses of wine an evening. However, the patient is quite honest and admits that he drinks three glasses of wine. There is some discussion of how the patient uses wine to relax himself, and then it becomes a discussion of his guilt over, I would say, his passivity, of sitting still and doing nothing. Then there is a discussion about the patient's mother who apparently was a depressed woman, possibly quite seriously depressed, who used to sit around all day long doing nothing but drinking beer, and the patient has a great fear that he might become like her.
In connection with discussing his mother's depression he returns to the issue of his relationship to therapists, and he says that he didn't dare ask questions of his former therapists, though he would have liked to have asked questions about depression. Then Dr. Thomä and the patient have a rather lengthy discussion about depression, and in the course of that discussion Dr. Thomä discusses what kinds of things lead to depression and that there can be such a thing as an automatic, more or less automatic progression, so depression results from many different factors, and the patient becomes somewhat frightened during this discussion, because he fairly clearly feels that maybe he is in some kind of a state which will automatically proceed and he will become somewhat like his mother. Dr. Thomä interprets that the patient has a fear that he will identify himself with his mother and become like her.

The discussion changes to a discussion of automobiles. They return to automobiles, and the patient discusses an automobile as a status symbol.
That opens the way for the patient to engage in some criticism of his former therapists. One of his former therapists criticized the Mercedes. He criticized the Mercedes I think fairly clearly with the implication that some people think you have to have a Mercedes because that's an expensive and important automobile. I think that his criticism of his former therapists has to do with their belittling tne significance of automobiles and speaking as if to them it is not necessary to have an important automobile.
In fact, at one point he says the therapist appeared somewhat comical in his eyes for talking this way about automobiles. In his youth he was very interested in automobiles and even had automobiles as pin-ups over his bed, the way some young men have pin-ups of girls in various state of undress, and he had pin-ups of luxurious automobiles.
- We are coming to the end of the hour, and the patient mentions and I believe that this is an important issue with regard to these two sessions – that this is the second last hour before the vacation, the lengthy four week summer vacation.

That enables him to criticize his former therapists even more, because his former therapist, one of the therapists, once before a vacation gave the patient his address where he was going to be on his vacation, and the patient hadn't even asked for the address. Then, on a subsequent occasion, the patient had asked this same therapist for some pills, and the therapist had angrily rejected the request for pills saying, ”What do you think, I am not that kind of a doctor who prescribes pills,” which the patient clearly found a serious inconsistency in the doctor's behavior. If he is willing to tell him where he is going on a vacation, why isn't he willing to give him pills? And now Dr. Thomä makes

”You are afraid that perhaps I will be inconsistent like that previous doctor was and now I will not give you my address when I am going on vacation.” And it is clear that on a previous occasion Dr. Thomä did give the patient his address when he went away, and now the patient is afraid that Dr. Thomä this time will not give it to him. So they discuss their issue, and Dr. Thomä tells him that he cannot be reached by

telephone, but that he can always get a message through to him through his secretary.

The patient then begins to express increasing curiosity about Dr. Thomä's vacation. Where will he go, what will he do, will he hike perhaps? To him that is a logical thought, because why can't Dr. Thomä be reached on his vacation? He is not going to be in a hotel where there are telephones, perhaps he will be hiking some place where there are no telephones. Yes, it is a logical possibility. And that reminds him of something that becomes very important in the session, it reminds him of a previous occasion when they talked about hiking, he and Dr. Thomä.

And the patient remembers that at that time he did not dare to ask Dr. Thomä certain questions about whether he knows exactly where that path is, whether he ever actually hiked on that path. In short, there was a discussion in which Dr. Thomä did reveal that he knows something' about the path, because the path is not far from here. The point was, what about that path? That becomes exceedingly important in an interpretation that Dr. Thomä will make. The patient discusses anxiety about asking things from his former analysts, and then, in a very interesting way, the patient compares himself to a snail. He compares himself to a snail that as soon as something touches the feelers he pulls back into himself.
Then another picture comes into his mind, the picture of a dog, a snarly dog who you have to be careful of, because if you extend your finger, he will bite. The implication is not very clear, I think he says he wishes to be like such a dog and not like such a snail, but I am not sure whether that comes up in that session, but it does in the next one. At any rate, Dr. Thomä makes an interpretation that the patient apparently feels that a therapist is like a dog, one of these snarly dogs that you have to be very careful of, because if you irritate him he will bite. And there the session ends.

Now we come to the next session. It opens with a rather long discussion about the tape recording and the patient's anxiety about the fact that information about him will become known to people who shouldn't have such information. And the way that that comes about is that it so happens that his wife knows a certain person who knows a certain person who she has reason to believe works in this clinic, and she or he only

knows that person's first name. And he uses that first name and asks Dr. Thomä, "Is there a person here by, that name?" and Dr. Thomä says, "Yes, there is a person here by that name, and ...", and then there is a long discussion about whether the records are available to that person and whether the records are being adequately guarded to preserve the patients confidentiality, and then there is some discussion about where the records are kept and who may have access to them, and does Dr. Thomä give permission first. And there is a reference to the patient saying that he thinks that Dr. Thomä told him once that he would keep his records locked up in his personal office. And Dr. Thomä responds in a way that makes the patient think that Dr. Thomä thinks he never said that, and the patient says that, and Dr. Thomä says, "No, there was a misunderstanding, I thought you meant the case record and not the verbatim transcript", and in various ways

Dr. Thomä attempts to reassure him that he is not in danger of material that would be embarrassing to him becoming avail- able to people who shouldn't have such material. And in that same connection there is an interesting discussion of the patient's explaining how, in some detail that I don't under- stand, but it is not important here, he doesn't pay his bill, from his own bank, because he doesn't want somebody to be in a position to guess that if he pays such a bill every month to a psychotherapist he must be a patient.
Dr. Thomä reassures him in one way or another, but then makes the point that the patient I think I am right about this – has undue anxiety about various things, an unnecessary degree of anxiety. And then Dr. Thomä brings up the example of the dog from the preceding session, and he interprets that the patient is unduly concerned about the possibility of irritating somebody else. And in that connection Dr. Thomä repeats the interpretation that the patient thinks of the therapist as a dog who mustn't be irritated. And the patient says, "Yes, what you say is true. But, you know, what I really meant was that I want to be a dog, too, and maybe I am afraid that I am like a dog, that I am a person who bites too soon, too. In other words, I have two images of myself: I am not just a snail, I am also such a dog, I am afraid of that."
Then the patient returns to the matter of this path I told you about, this hiking path, and he says to Dr. Thomä what I said a few moments ago, "You know, your answer was a little beside the point. It wasn't just the question of

it was a question of that particular path." "Every Schwabe knows Oberstdorf" is very important, because
Dr. Thomä is going to use it in an interpretation which in my opinion is an excellent interpretation that I am going to want to focus on as an illustration of an excellent interpretation. That's why this point has to be clear in detail that if the patient was talking about the path and Dr. Thomä talked about Oberstdorf. He was in a way not speaking directly to the issue that the patient was raising, he was therefore avoiding. Nov the patient says, in effect, "That was somewhat beside the point." So he is in effect accusing Dr. Thomä of having avoided something, and the patient himself, I think, recognizes that his avoidance was based on his anxiety: he didn't want to irritate Dr. Thomä with too sharp and pointed and insistent a question. Had he done so, he would have said then to Dr. Thomä, "But you know, that's not the point, I'm asking you about that path." Now Dr. Thomä says, "That's a very important point. We must discuss it more." And the patient says, "I am surprised by what you say. We have been talking about this for months."

Dr. Thomä deals with that by saying, yes, he knows that, but he wants more detail about the issue. And again he makes the interpretation that the patient is afraid that he will hurt the other person with his questions, so that the other person will withdraw. And now comes the interpretation that I consider to be an excellent interpretation. Dr. Thomä interprets the patient's experience of the relationship as plausible. You remember my fuss about the importance of interpreting the patient's experience as plausible? Here is an illustration, because Dr. Thomä says, "When I avoided answering directly about the path, you experienced that as my irritation that you were being too direct with me, and I receded from you. That was your experience."

Now there has been all this discussion about the patient's fear that if he asks questions too directly he will irritate the person who he is asking questions, and that person will withdraw from him. Now Dr. Thomä says,

Dr. Thomä is interpreting an interaction that took place between himself and the patient. He is interpreting the patient's experience as plausible and valid. - I am going to continue with this point: What would another analyst do of the kind that Dr. Thomä

and I object to? The important point is that Dr. Thomä is taking a very different position from the one which I described.
His position is: and I have behaved towards you in a way that validates your anxiety. It's not just your father or your mother or whoever – I behaved in a way that gave you reason to fear that I would be irritated.
Then an interesting thing happens: Dr. Thomä says

and he says there is this issue of the patient's anxiety that the analyst will be irritated, and Dr. Thomä says that analysts sometimes for personal reasons do become irritated. Then he interprets that the patient's curiosity doesn't simply remain curiosity, but it becomes an insistent and biting and penetrating curiosity, which I have something more to say about. And now the patient says, "Do you mean something sexual?" And Dr. Thomä says, "Yes, I had something sexual in mind, but it's not entirely clear and I think it would be better ..." – These are not your exact words, but the idea is: I don't want to say any more about that now, on another occasion perhaps we will talk more about it.

Now comes a fascinating phenomenon because the patient suddenly has a memory. And the memory is of the time last winter when he became very anxious again, which led him to come to Dr. Thomä to ask for further treatment, though he had had these three previous treatments. And what is it that he remembers? He remembers a movie he saw that was very disturbing to him. In this movie there was a criminal who put a knife into a woman's heart. But what was especially disturbing to the patient was not just that he put a knife into somebody's heart, but that he put it in very slowly. That was very disturbing. And the patient says he doesn't understand why that was so disturbing to him.

Then comes an interesting discussion about "Spätzle"[1], which I think I understood, I'll try, maybe you'll find it amusing. Dr. Thomä really makes a fairly long remark using the example of Spätzle.

[1] "Spätzle" are a kind of noodles, typical for southern Germany.

everybody likes Spätzle in his own particular way and nobody can tell anybody else how he should eat them and that Dr. Thomä feels that there is a very important point here. Well, I should have said there is discussed in a number of times in these two sessions the patient's wish to have a kind of a harmonious union with Dr. Thomä, which Dr. Thomä very explicitly contrasts to the patient's relationship with his mother which was a union, but a painful and disagreeable union. And Dr. Thomä interprets that the patient would like to have a harmonious union, and hiking is talked about from that point of view, that they both like to hike, etc. And at this point Dr. Thomä makes a point of sort of the dialectic in human life between harmony with another person and individuality being one's own person. And Dr. Thomä, if I read it correctly, also said, "And this is one reason that I hold myself back somewhat, because you need your own individuality, too, and you shouldn't eat Spätzle necessarily the way I eat it." Is that right?

And then they say good-bye, and that's it'

I make now twelve points as a kind of summary.

1) There is a good example of an interpretation of manifest con tent that is not about the relationship in transference terms. I have already given you the example. It was when the patient was talking about this other therapist who gave him something, but then refused to give him something that Dr. Thomä made the interpretation, "And you are afraid that I will be the same. I gave you something, and now I won't give you something." In the coding scheme, for those of you who are interested, that's an XR, because X is a material about the other doctor, which is not about the relationship, and Dr. Thomä makes the interpretation in the relationship, so it's an XR.

2) There is another very interesting illustration here of the way in which an interpersonal interaction has to be understood from both sides with each character playing both roles. What I mean to say about that is that if the patient describes being a snail and being a dog, you mustn't be satisfied with asking yourself, "Who is the snail: and who is the dog?", because you are a snail and a dog, and he is a snail and a dog, too. They are both both. And although at any particular time you may decide that a particular interpretation one side or the other seems to take precedence, you have to make sure to remember that both can be both, and the patient could look upon Dr. Thomä as a barking dog, a biting dog, but he could also think that he is a frightened snail who withdraws when somebody asks a direct question. It could relate

to the very same issue that he could consider not only that Dr. Thomä was irritated, but that Dr. Thomä perhaps avoids direct exchanges as was shown by that kind of an illustration.. And you also have to remember then in your account of transference you have to be careful to be willing to take both sides. We have to be very careful because we would rather think of ourselves, would we not, as dogs who can bite than as snails who are frightened? So that we are inclined to pick up the one that we would rather believe. But in this instance, I think, it is a tribute to the atmosphere that Dr. Thomä has established in this analysis that the patient was able to say in the next session, after Dr. Thomä repeated even, ”I am the dog”, the patient said, ”No, I am afraid I am the dog.” Because, after all, that makes Dr. Thomä the snail, too. So I think it is important and, as I say, a tribute to the therapy that Dr. Thomä can see both.

3) This comes up, I think, in especially interesting ways with regard to sex, because every therapist, whatever sex he is, has to be prepared to be perceived as the other sex, and if a man has insecurity about himself as a man, so that when he becomes a woman in the transference he can’t see it, then the therapy is in trouble. And if a woman therapist is insecure about her femininity so that when she becomes a man in the transference and she can’t see it, then the therapy is in trouble. That’s why we need to be fairly comfortable with a whole range of types of feelings, even to be able to identify in a series where you are the other sex.

4) There was an interesting illustration of where, I think, Dr. Thomä’ did not see that he is both, and I will attempt to use it also for what I think is an important illustration of another point, and that is to say the immediacy with which an exchange that has taken place between patient and therapist may be expressed in the transference, and I refer to the knife. You remember that Dr. Thomä’s interpretation, although as I told you, it was a little bit ambiguous as to who was the knife, his interpretation nevertheless took the form of the patient’s curiosity being the knife, that it is the patient who is penetrating somebody else, presumably in this instance he is penetrating Dr. Thomä, with all the sexual implication that that has, which incidentally leads to another point I will come to in a moment.

– But first to the knife: I believe that at that instance where the patient had this memory of the movie, of a man pulling a knife, you remember how?, slowly into

some- one's heart, that there was a reference to Dr. Thomä as the knife who is doing that.

Just before that, Dr. Thomä had made an interpretation about curiosity, and the patient had said, "You mean something sexual?", and Dr. Thomä said, "Yes, but I am not going to discuss that now." That's the slow knife that's coming in. "I'11 give you just a hint now, later I'11 make another little push, and later another little push" – that's my hypothesis that at that very moment the patient's image, yes, it referred to his own curiosity, I don't deny that, but I think it will also say "And you are pushing the knife in slowly, too, doctor? You are saving these sexual interpretations?" etc. That interpretation could have been made, too. Both sides could have been made.
5) But the other point I wanted to make is a compliment to Dr. Thomä, because I think many analysts at that point would have been tempted to make a sexual interpretation and to go into sexual material. I forget, one or the other of them actually said, "These are penetrating questions" into a person's head, you know, and into a person's heart. I mean how is it possible for an analyst to use such talk without thinking about sexual intercourse, something penetrating something else and something coming in slowly, etc. etc. The very word penetration is used, etc. But it would be wrong to make sexual interpretations of that kind at this point. That in my opinion would he a flight from the transference which is being expressed in these – those who think sexual interpretation should be made call it superficial. I say: No, that's not superficial. What's important is not some fancy idea about sexuality, what's important is something that has emotional significance right now. And I think that if Dr. Thomä had made a sexual interpretation at that point, the patient might very well have experienced it a sexual penetration Dr. Thomä was making on him, but it would not have advanced the therapy. On the contrary, it would have frightened him, I think, away from his beginning exploration of whether he dares talk about Dr..Thomä, what does he like, how does he eat his Spätzle and where is he going on his vacation, etc. I am not objecting that Dr. Thomä had something sexual in mind and I am glad that when the patient said, "Have you something sexual in mind?", He said, "Yes." I don't even object to the fact that he said, "I don't think it will be useful to discuss it now, we will take it up" – that's not my point.

6) My point is to be aware of the interaction that is taking place and to bring it into your interpretations.
The main message that I would wish to communicate to you if there is only one main point that I can get across, what it is that I want to say, and this is it: The idea and this bears on that central question in my judgement of what is this way of doing psychoanalysis that in Dr. Thomä's opinion and mine is a better way than the old way. Because the old way attempts to keep as great a distance as possible between the patient and the analyst. To keep the transference uncontaminated is the alleged reason. You mustn't do anything, because if you do something you contaminate the transference and we want to get the pure transference, so we know that this came solely from the past, etc. That is nonsense, be- cause the whole idea of that is based on the implication that it is possible in a human interaction to do nothing. It is not possible to do nothing. You are always doing something, and if you just sit there and don't say a word for a month, you are doing something. The existence of the analytic situation is a doing something. The point is not to do nothing, because you can't do nothing, you are always doing something. The point is to be aware of the implications for the patient's experience of whatever it is that you are doing. And that changes the whole atmosphere of an analysis. It is no longer a situation in which a person fights to do nothing, it's much more relaxed, because he does this, he does that – so what if he reassures the patient? Is the heaven going to fall? No. But he should be aware of the implication of reassurance. Do you know what Dr. Thomä did with this patient that he is analyzing? Do you know what terrible thing he did? He gave him pills. It's a good thing he is already a training analyst, because if he wasn't a training analyst and anybody would find out that he gave an analytic patient pills he never would become a training analyst.

That is the central point that there is always activity. For instance, Dr. Thomä does a good deal of reassuring of this patient, rather more, I think, than was necessary. And I will come to what I consider to be a possible hypothesis that explains that.

7) Why did the patient become frightened when he thought that Dr. Thomä might actually tell him where he would go on his vacation? I think that there is a good deal of material earlier in the session – maybe it's in the first session – that bears on that.

Because when the patient was discussing his mother's depression he said that he thought that other people were to blame, at least in part, were guilty for his mother's depression because they did too much for her. They took care of her in everything, so that made it all the more possible for her to just sit. Now you remember that this patient is afraid that he will become identified with his mother and become too passive. I think that he has some anxiety that Dr. Thomä may do too much for him and in that way rob him of his individuality, which I think is one of the reasons that Dr. Thomä emphasized the individuality as much as he did. I think that the patient is afraid that he has presented himself to Dr. Thomä in such a way that considering the fact that Dr. Thomä already did give him a fair amount of reassurance, did tell him that he can get in touch with him through his secretary, that he is afraid that maybe Dr. Thomä will do too much and not realize that he is capable of taking care of himself and he doesn't need so much, and will overwhelm him by giving him too much – I think that may have had something to do with his getting so frightened at that point. And therefore intuitively and correctly Dr. Thomä did not tell him anymore, and I am glad that he didn't.

But again, to go back to my previous point: Do I think that if Dr. Thomä had told him, the analysis would have been ruined?

No, but then Dr. Thomä would have had to be very alert to the fact that the patient would experience it this way and make that interpretation. I think it is going to turn out after we learn more about this way of doing analysis we are going to be astonished at what will be possible to do and still have an analytic situation if we make it explicit and interpret the patient's experience. I am not saying you can do anything. You can't have intercourse with the patient, that's too avid an analysis, which is the example. No, it still matters what you do. There is a certain degree of relative impersonality that has to be maintained in an analysis, but where is that point? Who knows? And is it necessarily the same for every analyst? No. Then is it necessarily the same for every analyst-patient pair? No. This is where a degree of flexibility in analytic technique in my opinion comes in, and once again I repeat, though you may be getting bored with it, it is not what is done, but whether what is done can be brought into the transference by way of interpretation.

8)There are some interesting illustrations in these sessions of validation of interpretation. *First of all, there is the whole fact that* the patient becomes

progressively bolder as the sessions go on. He becomes sharper and sharper with his questions. He has the nerve to say to the analyst 'You know, that wasn't the point, doctor, about Oberstdorf, it was about the path." And he also has the nerve to say, "I had the feeling that you are manipulating me and that you are a trickster." It takes some nerve to say that to an analyst. And I think you see an interesting progression in these two sessions of an increasing capacity to be direct, and I think this is a validation of the interpretations about the patient's anxiety about being direct. Not only that, but there are a number of instances in these two sessions where the therapist makes an interpretation and the patient says, "I'll give you another example." I don't remember at once what they were, but such illustrations occur. That means that something has been said that was meaningful.
9) It's also true that that could be a compliance, and there are evidences of compliance here. For instance, I think an interesting one that occurs to me is the explanation about why sometimes it is better not to answer questions because that stops the thinking process, and the patient says, "Oh, yes, doctor, yes, that stops the thinking process." I think the patient is simply being compliant because the doctor has said that.

10) I have a couple more points which I will allude to. There is a very important issue in these two hours that is touched upon in only a glancing way that I think would bear some very interesting and detailed discussion. I cannot say anything about it very useful, except to draw your attention to the issue. The fact that these are two hours just before a vacation I think for most analysts would mean that the whole issue of separation and loss would inevitably be the major theme of these two sessions, but it doesn't seem to be. What seems to be the major theme of these two sessions is anxiety about curiosity that will be interpreted as aggressive. That seems to be at least stated in a manifest form. What the whole thing is about, anxiety about activity, passivity, aggression, I don't know. Where is the separation issue'? Obviously it's here in that whole business of "Can I get in touch with you during the vacation?" It's there, but surely it has been made more explicitly as subject of examination. My hypothesis is that in a way that I would need more time to study and think about, the interaction that is taking place between them is a disguised gratification of the patient's anxiety about the separation, that possibly even this discussion about

harmonious union – and I think that has something to do with why at the very end Dr. Thomä made that remark about individuation and separation etc.
So that would be a very important issue to consider here, but it also leads to, I think, a very important consideration with regard to technique and brings me back to one of the things I said at the very beginning with regard to the nature of the analytic situation.
11) If somebody would re-examine these two sessions from the point of view of the conviction that the separation and loss issue is the main issue, I suspect he could build a very logical, reasonable case to make his point. So what does that mean? That these are terrible two hours because the main issue wasn't dealt with? No, it means, in English we say, there is more than one way to skin a cat. If the issue of separation is important, it will come again, it will be dealt with, there are different ways to go about it, and if any analyst tells you that he knows what is the right theme that should have been taken up in these particular two hours, don't believe him. That's his idea, and there are other ideas, too.

12) I think the last point I am going to make has to do with what I think is a very interesting countertransference issue here, having to do with this whole issue of technique that Dr. Thomä and I, if I may speak of us as in harmonious union in that respect, stand for. Helmut Thomä: I know that. I hadn't known it at the time of these sessions, by the way.) By the way, this is a very important point to make, and I. am glad that you make it explicit. These things that I am telling you are more or less in some of the things that I have written, in the book, the Monograph on the Analysis of Transference, not nearly as clearly as I am telling them to you now, because they have become clearer to me in the course of the last year or two since the book was finished. But Dr. Thomä conducted these sessions, and Dr. Thomä's whole way of doing analysis is before he knew my ideas. Therefore I think it is absolutely correct to say that he came to them independently. He is not simply doing something he learnt from Dr. Gill**.** Nevertheless, it is very nice to find out now, to find somebody who is in harmonious union with one, too, because we all have our problems about separation and individuation and unity etc. But at the same time, having had the experiences that we , have had, Dr. Thomä and I – and it's in my work, too, I can show it to you – have anxiety about what we are doing, because we have Gewissensbisse about

what those other analysts are going to say about us, about these terrible things that we do. And I think that that grips into our work every now and again. I think, for example, that it plays some role in your making this explanation about the virtue of not answering questions, as if you are saying, ”I know that other way of doing things, too, I know about that, too.” And I think, although I am not sure, that it also has something to do with the reassurance that you are giving the patient. And I think it has some- thing to do with this final speech about individuation and separation, because it’s a peculiar trend of reversal. You explain to the patient why you are holding yourself somewhat separate from him. When analysis is done the other way, the analyst doesn’t feel any need for that, he doesn’t feel any need to explain why he holds himself separate, because he considers that to be the proper technique, that he is behaving the way he should. I think in a very complex way that I cannot explain to you now, but that I am simply offering for your and Dr. Thomä’s consideration, the change in technique is finding subtle expressions both in what one does and in what one doesn’t do. In a way, Dr. Thomä feels guilty not only because he isn’t being distant enough, he also feels guilty for being too distant. Too distant – and he is explaining to t-he patient why he is. You understand that in his fight, in that Kampf gegen the old way of doing things he also feels some guilt that he isn’t doing it even more, and he is therefore explaining to the patient why that is so.

In answering a question Dr. Gill concludes: I don’t know whether I would have or would not. And the important thing is not whether it was done or was not done I am trying to understand why it was done, that’s all. This is one more elaboration of my statement that to me the crucial thing is to be aware of the nature of the interaction. And to be aware of the nature of the interaction one has to pay attention not only to the patient’s experience, but to one’s own experience. And I am saying that when Dr. Thomä and I conduct. an analysis I think for us the whole issue of technique and whether we are employing correct technique or not plays a very important role in our feelings, and I am only saying we should be aware of that, because it will probably affect certain interpretations and interactions that we will have with the patient. To me, the issue is not ”Should he have done that, would I have done that”, it is only to try to explain that every analyst enters every analytic situation with his own personality and his own ideas about what is an analysis, and his own ideas about

technique. And I am saying that since for me and Dr. Thomä the whole issue of what is correct analytic technique is a very important one, for all the personal meaning that it has in terms of our relationship to our colleagues, and in terms of our ideas about whether we are making a contribution, and in terms of our ’anxiety about whether we will be listened to, etc. etc. etc. that we should be aware of that. When we begin to look for our counter- transference, we should realize that the likelihood is that that will be an issue in our countertransference. And so will it be for you, too. Those of you who are being trained in this Institute presumably are being taught certain ideas that some of your colleagues in other institutes, possibly in Vienna, I don’t know, are told is not proper. How will you deal with that?