Helmut Thomä Horst Kächele

PSYCHOANALYTIC PRACTICE

2 Clinical Studies

With the Collaboration of

Stephan Ahrens Andreas Bilger Manfred Cierpka
Walter Goudsmit Roderich Hohage Michael Hölzer
Juan Pablo Jiménez Lotte Köhler Martin Löw-Beer
Robert Marten Joachim Scharfenberg Rainer Schors
Wolfgang Steffens Imre Szecsödy Brigitte Thomä

Angelika Wenzel

Translated by M. Wilson

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Professor emeritus Dr. Helmut Thomä
Wilhelm-Leuchner-Str. 11, 7900 Ulm
Federal Republic of Germany

Professor Dr. Horst Kächele
Abteilung Psychotherapie der Universität Ulm
Am Hochsträss 8, 7900 Ulm
Federal Republic of Germany

Translator:

Dr. Michael Wilson
Max-Wolf-Straße 16, 6900 Heidelberg
Federal Republic of Germany

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Preface

We are pleased to present the second volume of our study on *Psychoanalytic Practice* , which we entitle *Clinical Studies* . Together, the two volumes fulfill the functions usually expected of a textbook on theory and technique. In fact, some reviewers have asked why such a title was not chosen. One of the reasons for our narrower choice was that our primary concern is focused on those aspects of psychoanalytic theory that are relevant to treatment.

The first volume, entitled *Principles* , has evoked much interest within and outside the professional community, creating high expectations toward its clinical counterpart. After all, psychoanalytic principles must demonstrate their value and efficacy in treatment, i. e., in achieving changes in symptoms and their underlying structures. This is apparent in the clinical studies contained in this book, and in the process of compiling them the senior author has had the opportunity to take stock of his long professional career.

We have willingly let others closely examine how we work, and one consequence of this has been a growing exchange with other psychoanalysts and with scientists from other disciplines and from numerous countries. This cooperation has enriched the contents of this volume. Although not mentioned specifically in the text, both our collaborators from Ulm and our colleagues from other locations have provided drafts of passages and left it to our discretion to use them as we saw fit. Although it would theoretically have been possible to attribute authorship to those who drafted specific sections, our coworkers have agreed to references to their names being omitted in the text as part of our efforts to prepare a uniform and coherent volume.

Our special thanks for their unusual willingness to place their specific knowledge at our disposal for inclusion in this book go to the following psychoanalysts who are not members of our Ulm group: Stephan Ahrens (Hamburg) enriched our knowledge on the state of discussion about alexthymia; Walter Goudsmit (Groningen) reported on his years of experience in treating delinquents; Lotte Köhler (Munich) examined our view of countertransference from the perspective of self psychology; Imre Szecsödy (Stockholm) described and applied his model of supervision. Our conviction that interdisciplinary cooperation has a positive effect on clinical work is demonstrated by several passages of text contributed by scientists from other disciplines. Martin Löw-Beer's (Frankfurt) philosophical comments have extended our understanding of the "good hour" (see Sect. 10.2); Joachim Scharfenberg (Kiel) provided annotations from a theological perspective to a dialogue in which the analyst was confronted with religious problems (see Sect. 10.3.2); and Angelika Wenzel's (Karlsruhe) linguistic interpretations demonstrate how our clinical understanding can profit from the application of other methods to psychoanalytic texts (see Sect. 7.5.2). We are more than merely personally grateful for such contributions because they emphasize how fruitful interdisciplinary cooperation can be.

Of particular value have been the critical comments that numerous colleagues have provided to the drafts of various chapters or sections of the manuscript. Although we are very aware of our sole responsibility for the text we present here, we would like to extend our gratitude to Jürgen Aschoff, Helmut Baitsch, Hermann Beland, Claus Bischoff, Werner Bohleber, Helga Breuninger, Marianne Buchheim, Peter Buchheim, Johannes Cremerius, Joachim Danckwardt, Ulrich Ehebald, Franz Rudolf Faber, Heinz Henseler, Reimer Karstens, Otto F. Kernberg, Joachim P. Kerz, Gisela Klann-Delius, Lisbeth Klöß-Rotmann, Rolf Klüwer, Marianne Leuzinger-Bohleber, Wolfgang Lipp, Adolf-Ernst Meyer, Emma Moersch, Michael Rotmann, Ulrich Rüger, Walter Schmitthenner, Erich Schneider, Almuth Sellschopp, and Ilka von Zeppelin.

We are grateful to the members of the staff of the Department of Psychotherapy in Ulm, whose constant support enabled us to complete the manuscript in a relatively brief period of time. We are also grateful to the staff at Springer-Verlag, who ensured that the preparation of the book proceeded smoothly.

We are especially indebted to our translators, in the case of this English edition to Michael Wilson, who mastered this formidable task authoritatively but sensitively. Our discussions with him (and the translators into other languages) exposed a number of ambiguities and obscurities in the original German text, which we believe have been resolved in this English edition.

We are, finally, most indebted to our patients. It is in the nature of things that advances in psychoanalytic technique are linked to an interpersonal process. The examples that can be found in this book document the significance that we attribute to the critical collaboration of our patients. We hope that this book's descriptions of our clinical experience in psychoanalysis will benefit future patients and be a helpful stimulus to their therapists.

Ulm, May 1991 Helmut Thomä, Horst Kächele

Introduction

Becoming a psychoanalyst is a unique learning process of getting acquainted with Freud's work and the development of psychoanalytic theories and techniques. Especially for German psychoanalysts, it is fraught with unusual difficulties. This issue must be considered in the context of how each generation attains its own professional identity. Unfortunately, each subsequent generation of psychoanalysts achieves independence much too late. The reasons for this delay can be found both in the overwhelming stature of Freud and in the idiosyncrasies of psychoanalytic training (Thomä, 1991).

In the first volume of our study we have presented our theoretical positions, taking our guiding idea from Balint's two- and three-person psychology, which focuses on what the analyst contributes to the therapeutic process. For reasons rooted in our biographies and because of the general and the specifically German problems we discuss in Vol. 1, our scientific efforts in pursuing our goals have proceeded slowly and hesitatingly. This is especially true for the senior author, who had to travel a long path before reaching his present understanding of psychoanalysis, expressed in these two books. It was Merton Gill who gave him the final stimulus to undertake a critical survey of the theory and practice of psychoanalysis and to contemplate its future.

We can legitimately claim to have set a good example in at least one regard, namely by having made psychoanalytic dialogues - and thus how we really work - accessible to psychoanalysts and other scientists. One consequence of anchoring case reports in audio recordings and transcriptions of sessions is that the therapist exposes himself to the criticism of his colleagues in a unique manner.

The physician's obligation to secure confidentiality requires that we be extraordinarily cautious. In attempting to resolve the problems related to making dialogues accessible to assessment by others, we have left no stone unturned in extending the example Freud suggested for protecting a patient's anonymity, altering everything that might enable a patient to be identified. Such coding, however, cannot go so far as to make it impossible for the patient to recognize himself, should some coincidence lead him to read this book. Yet we also consider it possible that a former patient described here might have some difficulty in recognizing himself. A peculiar type of estrangement results, first, from the alterations we have made in external features and, second, from the one-sided description - restricted to specific problems - of a patient which those around him are very often not aware of. This estrangement is very welcome to us in connection with the issue of confidentiality.

We refer, furthermore, to biographical data - which we "code" in the sense that we replace them with analogous phenomena - only insofar as they are relevant for comprehending events in therapy. One widespread mistake is to believe that in analysis the entire individual becomes visible. In fact, the weak spots, the problems, and the suffering are at the center of the analytic encounter. The other, conflict-free sides of the individual's life are neglected because they do not constitute the primary object of therapy. Although this omission creates a distorted image of the analysand's personality, this one-sided and frequently negative image that a patient presents is welcome from the perspective of facilitating anonymity.

We have spent much thought on the nature of the codes we should employ. No one method is entirely satisfactory. To use a code name based on some prominent feature would attribute particular importance to one aspect. On the other hand, we did not want to use numbers for identifying patients. As pseudonyms we have consequently decided to use (arbitrarily chosen) Christian names together with an X for women and a Y for men, borrowed from the terminology for the chromosomes responsible for determining female and male gender. The anatomical difference between the sexes constitutes the inherent and biological foundation of the life histories of men and of women, regardless of the significance of psychosocial factors for sex role and sense of identitiy. This code thus reflects the tension

between the uniqueness of each individual's life and the biological basis of the two sexes. Dimorphism is, after all, the basis for each individual's gender role even if the plasticity of human psychosexuality goes as far as the desire to change the sexual role in the case of transsexualism. We hope that our readers will accept our coding system, the purpose of which is to facilitate the use of the index of patients.

This volume could never have been written without the permission of our patients for us to record therapeutic dialogues and to evaluate and publish them in a form in which their identity is protected. The consent of many patients is linked to their hope that the thorough discussion of problems of analytic technique will benefit other patients. Several patients have provided commentaries to the sections of text related to themselves; we are especially grateful to them.

This willingness to cooperate constitutes a rewarding change in the social and cultural climate, to which psychoanalysis has also contributed. Although Freud may have had good reason to assume that the patients he treated "would not have spoken if it had occurred to them that their admissions might possibly be put to scientific uses" (Freud 1905 e, p. 8), over the past decades many patients have shown us that this is no longer true. It is beyond doubt that psychoanalysis is going through a phase of demystification. It is no coincidence that at the same time that patients are reporting about their analyses autobiographically, the general public is eagerly devouring everything that earlier analysands have to report about Freud's therapies. The literature on the latter is growing and demonstrates that Freud was not a Freudian. Intellectual and social conditions have changed so much in the past decades that analysands - whether patients or prospective analysts - are reporting about their therapies in one form or another. The "other side" is thus finally getting their hearing. We psychoanalysts would be taking the easy way out if we were to dismiss such autobiographic fragments, the quality of writing in which varies considerably, as being the result of negative transference that was not worked through or of exhibitionism and narcissism.

Most reservations against the use of tape recordings and the evaluation of transcripts do not stem from patients but rather from analysts. The fact that research into psychoanalysis must pay special attention to what the therapist has contributed to the course and outcome has gained widespread acceptance. The stress that results from the clinical and scientific discussion does not affect the anonymous patient but rather the analyst, whose name cannot be kept a secret in professional circles.

Such personally motivated reservations, however, cannot alter the fact that the changes mentioned above make it easier for the present generation of psychoanalysts to fulfill obligations toward both the individual patient and research. According to Freud, all patients should profit from the benefits of enlightenment and scientifically grounded generalizations:

> Thus it becomes the physician's duty to publish what he believes he knows of the causes and structure of hysteria, and it becomes a disgraceful piece of cowardice on his part to neglect doing so, as long as he can avoid causing direct personal injury to the single patient concerned. (Freud 1905 e, p. 8)

In this context, personal injury refers to damage that could result from flaws in the coding of confidential material.

Medical confidentiality and coding have often made it impossible for us to provide precise details about a case history. Readers will nonetheless be able to recognize that the majority of our patients suffered from severe chronic symptoms and that we have chosen these cases from a wide spectrum. Somatic symptoms are frequently a concomitant manifestation of psychic suffering. Numerous examples stem from the psychoanalysis of patients with psychosomatic illnesses; we believe we have convincingly demonstrated that psychic factors were a relevant etiological factor.

The critical reappraisal of his psychoanalytic thinking has led to changes in the *practice* of the senior author over the past decades. We include here case histories and reports from over a period of more than thirty years. In many cases we were able to examine the effectiveness of psychoanalyses in long-term follow-up studies.

In one of his aphorisms, Wittgenstein (1984, p. 149) emphasized the significance of examples. It reads about as follows: Rules are not adequate to determine practice; examples are also necessary. Our rules leave backdoors open, and practice has to speak for itself.

Psychoanalytic practice has numerous faces, and we have attempted to portray them by referring to typical examples. Detailed studies from close up illustrate the respective focus of the dialogue, while a bird's eye view is necessary to gain an overview of therapies of long duration. A theoretical framework is necessary to provide orientation, enabling one to see phenomena, hear words, read texts, and comprehend the connections between human experiencing and thinking. On a larger scale, we have presented our theoretical models in the companion volume on *Principles.* On a smaller scale, we provide the reader theoretical information in the passages entitled "Consideration" and "Commentary" that are interspersed in the dialogues in this book. These passages reflect different degrees of distance to the verbal exchanges and facilitate the comprehension of the focus of the respective dialogue. Important in this regard is that the considerations are from the perspective of the treating analyst, and are thus set in the same type of print as the dialogues themselves, while the commentaries are from our own and a more distant point of view. As many of the cases presented here were treated by the authors, the considerations and commentaries might in fact have originated in the same person, although at different times and distances to the actual moment of the therapeutic situation. This is especially true for the senior author and his role as commentator of his own clinical work, which has extended over a long period of time.

Located at another level of abstraction are references to etiologic psychoanalytic theories in general and in particular. They have been included in this volume to facilitate the classification of examples. These supplementary theoretical comments, together with the wide diagnostic spectrum from which we have chosen typical cases, are the reason for the considerable size of this volume.

As a guide for the reader we would like to add that, with the exception of Chaps. 1, 9, and 10, the topics of the chapters in both volumes are the same. The volumes on theory and practice have been so organized that we provide a systematic exposition of theory in the same chapter and section in Vol. 1 as we discuss therapy and technical aspects in this volume. This parallel structure facilitates switching from one volume to another to take both practical and theoretical aspects into consideration. For instance, a case history of a chronic anorexic illustrating the therapeutic management of identity resistance is given in Sect. 4.6, and a theoretical discussion of identity resistance is the topic of Sect. 4.6 in Vol. 1.

The decision to publish a two-volume text and to follow the same organization in this book on clinical practice is, however, linked with the disadvantage that the discussion of phenomena that belong together in the psychoanalytic situation is torn apart. Transference and resistance, for example, often alternate rapidly and are interrelated. Yet it is necessary to identify an object, i. e., call it by its name, in order to discuss it. We provide a theoretical and conceptual clarification of issues in the first volume; here we describe examples of this or that form of transference or of resistance. The detailed subdivision of each chapter supplies a general frame of reference, and the index contains a large number of entries, facilitating the location of connections between different phenomena described in the text.

We have selected typical examples from the analyses of 37 patients, 20 men and 17 women. Following this introduction is a list of the code names that we have assigned to these patients. The topics and section numbers printed in italics refer to passages in which we provide information to general questions concerning the course of a patient's illness and treatment. The therapeutic processes of 14 patients are documented in this book. For the other cases the courses are implicit and the reader can reconstruct some of them; the presentation of these cases serves primarily to explicate important analytic concepts.

We provide information as to frequency of sessions, the length of treatment, and the setting if this has special significance or if topics related to the initiation and termination of therapy are being discussed.

In the dialogues and comments made from the perspective of the analyst providing treatment, *I* is used for the analyst. Of course, in reality this "I" does not always refer to one and the same analyst. Otherwise we refer to analysts or therapists in general.

We employ the terms "analysis," "psychoanalysis," and "therapy" as synonyms. Many of our patients do not distinguish between therapy and analysis, and some even retain their naivety in this regard. In Vol. 1 we have entered into the discussion of the differences in the wide spectrum defined by the assumptions and rules of psychoanalytic theory. Here the point is to reconstruct the lines actually followed in psychoanalytic therapies, an allusion to Freud's publication entitled "Lines of Advance in Psycho-analytic Therapy" (1919 a).

In this book we retain the use of the generic masculine in general discussions, although we obviously direct our comments to patients and psychoanalysts of both sexes. We speak to the former as individual persons who are suffering, and to the latter as those who, on the basis of their professional competence, contribute substantially to the improvement and cure of patients.

Index of Patient's Code Names

In the Introduction we discuss the general principles of coding confidential material. The following is a list of the issues discussed for each patient. The references to sections containing a summary or information about the genesis of the illness are printed in italics. Reading the respective sections in succession can provide insights into the course of treatment.

Amalie X

2.4.2 Identification with the Analyst's Functions
7.2 Free Association
7.7 Anonymity and Naturalness
7.8.1 Examples of Audio Tape Recordings
9.11.2 Changes

Beatrice X

8.3 Interpretations
9.2 Anxiety Hysteria

Clara X

2.2.5 Negative Transference
4.6 Resistance and the Security Principle
7.5.1 Psychoanalytic Aspects of Metaphors
8.1.2 Remembering and Retaining
8.5.3 Splitting of transference
8.6 Interruptions

Dorothea X

8.5.5 Commonplace Mistakes
9.4 Depression

Erna X

2.1.1 Promoting the Helping Alliance
2.2.1 Mild Positive Transference
7.4 Questions and Answers
7.5.1 Psychoanalytic Aspects of Metaphors
7.7 Anonymity and Naturalness

Franziska X

2.2.2 Strong Positive Transference
7.2 Free Association
7.8.1 Examples of Audio Tape Recordings

Gertrud X

2.2.4 Erotized Transference

Henriette X

9.5 Anorexia Nervosa

Ingrid X

8.4 Acting Out

Käthe X

2.3.2 Brother Envy

Linda X

3.4.2 Aggressive Countertransference

Maria X

4.4 Stagnation and the Decision to Change Analysts

Nora X

4.1 Disavowal of Affects

Rose X

3.4.1 Erotized Countertransference

Susanne X

6.2.1 Social Class

Ursula X

8.1.3 Anniversary Reactions

Veronica X

3.7 Projective Identification

Arthur Y

2.1.3 Common Ground and Independence
2.2.3 Fusion Desires
3.5 Irony
3.6 Narcissistic Mirroring and Selfobject
4.5 Closeness and Homosexuality
6.4 Third-Party Payment
6.5 Reviewing and Transference
7.1 Dialogue
7.4 Questions and Answers
7.5.2 Linguistic Interpretations of Metaphors
7.8.1 Examples of Audio Tape Recordings
8.1.1 Scheduling
8.2 Life, Illness, and Time: Reconstructing Three Histories
8.5.2 Denial of Castration Anxiety
10.1.1 Consultation
10.2 Theoretical Remarks About a "Good Session"
10.3.1 The Image of God as Projection

Bernhard Y

9.6 Neurodermatitis

Christian Y

4.3 Unpleasure as Id Resistance
7.2 Free Associations
9.3 Anxiety Neurosis
9.3.1 Separation Anxiety
9.3.2 Termination Phase
9.3.3 Confirmation and Self-Esteem

Daniel Y

2.1.2 Support and Interpretation

Erich Y

3.2 Complementary Countertransference
3.3 Retrospective Attribution and Fantasizing
5.1.1 Dysmorphophobia and Spasmodic Torticollis
5.2 A Dream Sequence
5.3 Dream About the Symptom
5.4 Thoughts About Psychogenesis

Friedrich Y

2.3.1 Rediscovery of the Father
9.11.1 Patients' Retrospection

Gustav Y

4.2 Pseudoautonomy
7.5.1 Psychoanalytic Aspects of Metaphors

Heinrich Y

7.8.1 Examples of Audio Tape Recordings
8.5.4 Mother Fixation

Ignaz Y

3.1 Concordant Countertransference
7.3 Evenly Suspended Attention

Johann Y

3.7 Projective Identification

Kurt Y

7.8.1 Examples of Audio Tape Recordings
9.11.3 Separation

Ludwig Y

6.1 An Initial Interview

Martin Y

6.3 The Patient's Family

Norbert Y

7.6 Value Freedom and Neutrality

Otto Y

6.2.3 Adolescence

Peter Y

8.5.1 Repetition of Trauma

Rudolf Y

7.8.1 Examples of Audio Tape Recordings

Simon Y

6.2.2 Delinquency

Theodor Y

8.4 Acting Out

Victor Y

6.2.1 Social Class