7 Rules

Introduction

Psychoanalytic rules have multiple functions, a fact that is a consequence of the tasks and goals of the psychoanalytic dialogue, as we have explained in Vol.1 (Sect. 7.1). This is the reason that the corresponding chapter in Vol.1 is focused on the thesis that the efficacy of each rule has to be proven for each and every patient. The rules are put to a test when the analyst pursues the question of whether the system of rules provides a given patient the best possible conditions for therapeutic change. The issue of the utility of rules is a good starting point for using them in a flexible manner, i. e., one in which they are applied in a manner appropriate to the individual patient, and for guiding the dialogue toward therapeutic goals. Since the rules are subordinate to the dialogue, we assign the latter a prime place in this chapter (Sect. 7.1).

Since the other chapters contain many examples of free association (Sect. 7.2), we restrict ourselves here to excerpts from the initial phases of therapy. The same is true of evenly suspended attention (Sect. 7.3); we describe its fluctuations retrospectively.

A flexible application of the counterquestion rule is possible within the system of rules if the analyst responds to the questions the patient inevitably asks instead of following the rule stereotypically. We criticized this stereotypical application in Vol.1, and in Sect. 7.4 we give examples of a flexible application of this rule.

The study of metaphors and the changes they undergo in the psychoanalytic process is especially fertile. Since their significance in the language used in therapy can hardly be exaggerated, we cover the psychoanalytic aspects of metaphors in a separate section (Sect. 7.5.1). The linguistic examination of a psychoanalytic dialogue in Sect. 7.5.2 gives special consideration to metaphors and impressively demonstrates that scientists who come from other fields and study analytic texts independently are able to extend our knowledge significantly. They provide insights into the style of the language that are generally inaccessible to the treating analyst.

The two sections on value-free attitude and neutrality (Sect. 7.6) and on anonymity and naturalness (Sect. 7.7) deal with interrelated problems that were not given adequate consideration in Vol.1. Examples from case histories demonstrate that the resolution of these problems is of great therapeutic relevance.

Many of our examples are based on transcripts of tape-recorded analyses. We have included a larger number of examples in this chapter that demonstrate the influence of tape recording on transference and resistance. Following the general discussion of this topic in Sect. 1.4, we have good reason to include these instructive examples in precisely this chapter on rules. Our purpose is to demonstrate that the psychoanalytic situation is influenced in numerous ways. The introduction of a technical aid must be examined particularly critically, just as are the consequences that rules have on the dialogue; in Sect. 7.8 we give thorough consideration to this topic, including the counterarguments that have been raised.

This volume would not have been written without this innovation. The especially instructive experience we have had has convinced us that the influence this technical aid exerts on the patient-analyst relationship can be considered just as critically - i. e., analyzed - as that of any other variable. The manner in which analysts describe a phenoneon as having been analyzed refers to a genuine quality of the psychoanalytic method, namely that both the influence of the analyst and the setting are made the object of joint considerations.

7.1 Dialogue

The psychoanalytic interview is often compared to classical dialogues. It is therefore natural for us to reconsider the origin of the word "dialogue." Its roots, just like those of the word "dialectic," go back to the Greek *dialegesthai* : to dissect, consider, and consult, or in its transitive use, to discuss something with others. Originally, "dialectic" characterized dialogue as consultation. *Dialegesthai* meant to come together and consult. According to Plato, the dialectician was the one who knew how to ask questions and to answer them. Where, furthermore, the consultation in the dialogue is subject to rules, the word "dialectic" is employed "to refer to the use of such rules or to an institutionalized dialogical practice" (Mittelstrass 1984, p. 14). It is not unusual for the style of the Socratic dialogues, whose goal is summarized by the famous sentence "I know that I know nothing," to be viewed as an ideal. Socrates' students suffered from the superiority of their ironic teacher; Alcibiades is said, for example, to have called out: "What else do I have to endure from this person! He wants to show me his superiority everywhere." Socrates referred to his method as *maieutic* . His comparison with the art of midwifery, his mother's profession, is taken up by some psychotherapists who compare their work with the Socratic maieutic. The metaphor of midwifery is occasionally used for psychotherapy to emphasize the new beginning that self-knowledge leading to change is an important element of. The use of metaphors, however, must take into account any dissimilarities, which motivates us to emphasize the autonomy of the psychoanalytic method.

The style of dialogue handed down from Plato shows Socrates to be a midwife who knew precisely where he had to apply the forceps and who always anticipated which ideas he was really helping to attain life: his questions inevitably determined his students' answers. Socrates produced his own philosophical child. He did not shy from incorporating Sophist devices into his dialectics. If a psychoanalyst were to pose questions the way Socrates did and direct the patient's answers by means of his style of dialogue, then he would be accused of manipulation. In the psychoanalytic maieutic the patient sets the pace of the events. He has the initiative and both the first and last word, however important the psychoanalyst's contribution to the search for liberating solutions to problems may be. An issue in therapy from the beginning to the end is the creation of the best possible conditions for helping the patient achieve change.

It is doubtful, for example, whether Alcibiades, if he had been a patient, would have rapidly regained his composure after admitting his complete ignorance and having his self-security destroyed. Every act of subjugation provokes much aggression, and it in turn can lead to acts of depressive self-humiliation if it is directed against the individual himself. In *psychoanalytic* dialogues the issue is to create the best possible conditions for the patient's spontaneity, and to enable him to act on a trial basis in a manner that itself is indicative of the change he desires. The analyst must subordinate his role to this goal.

To arrive at (self) awareness and reasoned actions is the ideal of the psychoanalytic dialogue, which is rooted deep in the intellectual history of the West. Thus it is no exaggeration to view Plato's idea of anamnesis, or recollection, as a predecessor of Freud's emphasis on remembering as a part of psychoanalytic insight. Freud described psychoanalytic treatment as a special form of dialogical practice:

> Nothing takes place in a psycho-analytic treatment but an interchange of words between the patient and the analyst. The patient talks, tells of his past experiences and present impressions, complains, confesses to his wishes and his emotional impulses. The doctor listens, tries to direct the patient's processes of thought, exhorts, forces his attention in certain directions, gives him explanations and observes the reactions of understanding or rejection which he in this way provokes in him. The uninstructed relatives of our patients, who are only impressed by visible and tangible things - preferably by actions of the sort that are to be witnessed at the cinema - never fail to express their doubts whether "anything can be done about the illness by mere talking." That, of course, is both a short-sighted and an inconsistent line of thought. These are the same people who are so certain that patients are "simply imagining" their symptoms. Words were originally magic and to this day words have retained much of their ancient magical power. By words one person can make another blissfully happy or drive him to despair, by words the teacher conveys his knowledge to his pupils, by words the orator carries his audience with him and determines their judgements and decisions. Words provoke affects and are in general the means of mutual influence among men. Thus we shall not depreciate the use of words in psychotherapy and we shall be pleased if we can listen to the words that pass between the analyst and his patient . . . .

> The information required by analysis will be given by him only on condition of his having a special emotional attachment to the doctor; he would become silent as soon as he observed a single witness to whom he felt indifferent. For this information concerns what is most intimate in his mental life, everything that, as a socially dependent person, he must conceal from other people, and, beyond that, everything that, as a homogeneous personality, he will not admit to himself.
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> Thus you cannot be present as an audience at a psycho-analytic treatment. You can only be told about it; and, in the strictest sense of the word, it is only by hearsay that you will get to know psycho-analysis. (Freud 1916/17, pp. 17-18)

Twenty years later Freud (1926e, p. 187), responding to the question of a fictive "impartial person" as to what psychoanalysis does to the patient, gave a very similar answer: "Nothing takes place between them except that they talk to each other. The analyst makes use of no instruments - not even for examining the patient - nor does he prescribe any medicines . . . . The analyst agrees upon a fixed regular hour with the patient, gets him to talk, listens to him, talks to him in his turn and gets him to listen." Freud even interpreted the impartial person's presumed skeptical attitude, saying "It is as though he were thinking: `Nothing more than that? Words, words, words, as Prince Hamlet says.'" Such reactions can still be frequently heard in discussions about psychoanalysis, and can also be expected from patients until they have convinced themselves of the power of their thoughts and the effects of their words.

Although Freud swore by the power of words and referred to both emotional impulses and affects, the sentence that *nothing else happens but a verbal exchange* in psychoanalytic treatment has unnecessarily restricted the therapeutic range and the diagnostic understanding of psychoanalysis. For Freud, in fact, "words" were not the beginning, and in his theory of development the ego had its origin in the body ego. It was the *physical* symptoms of hysterical patients that were accessible to the "talking cure." The ideas these patients had about the origin and significance of their physical symptoms did not fit into the sensory motor disturbances that neurologists were familiar with. By paying attention to body language and to what the physical symptoms had to say and by letting himself be guided by what is today referred to as the patient's personal theory of his illness, Freud transformed himself from a neurologist into the first psychoanalyst. We mention this origin in order to weaken the assertion that nothing else happens in analytic treatment but an exchange of words.

Many things that take place in the relationship between patient and analyst at the unconscious level of feelings and affects cannot be completely referred to by name, distinguished, and consolidated in experiencing (see Bucci 1985). Intentions that are prelinguistic and that consciousness cannot recognize can only be imprecisely verbalized. Thus in fact much more happens between the patient and analyst than just an exchange of words. Freud's "nothing else" must be understood as a challenge for the patient to reveal his thoughts and feelings as thoroughly as possible. The analyst is called upon to intervene in the dialogue by making interpretations, i. e., with linguistic means. Of course, it makes a big difference if the analyst conducts a dialogue, which always refers to a two-sided relationship, or if he makes interpretations that expose the latent meanings in a patient's quasimonological free associations. Spitz (1976) has also referred to the nonverbal interaction that precedes language acquisition as a dialogue (see Vol.1, Sect. 7.4.3). The child learns to communicate through actions before it begins speaking. At a surprisingly early moment it enters into complex social interactions with its mother (see Vol.1, Sect. 1.8). A wealth of forms of preverbal communication are present in the body ego and in the preconscious and unconscious dimensions of the psychoanalytic dialogue; their relationship to the experiencing ego is very obscure, yet they do codertermine the quality of the patient-therapist relationship. In Chap. 5 and in Sect. 9.10 we discuss the importance of the analyst taking both the patient's ideas about his body image and medical knowledge seriously in psychoanalytic treatment and of not diluting the difference between them.

Research on the dialogue between mother and child has provided a wealth of new results about the role that affectivity plays in the child's acquisition of language (see Klann 1979). These results will have far-reaching consequences on analytic technique. The studies by Stern (1977, 1985) were, among others, important in providing a foundation in developmental psychology for Buber's philosophical ideas about the *dialogical principle* and the interhuman. Buber's ideas can be used to better understand the psychoanalytic dialogue, as demonstrated by Ticho's pioneering study:

If the [therapeutic] relationship is seen exlusively in terms of transference and countertransference and its dynamic understanding, then there is a danger that the analytic situation will become a monologue. If a dialogue is maintained, a careful observation of transference and countertransference manifestations enables us to reconstruct the environmental past. The multiplicity of infantile environmental factors may make this very difficult sometimes. But analysts at times want to avoid the painful involvement with a patient that interferes with their need to stay "independent" of their patients. In such a situation, the analyst is carrying on a monologue, and the dependence-independence conflict will likely be repeated in the analytic situation. (1974, p. 252)

Ticho's original comparison of Winnicott's and Buber's theories can be profitably applied to therapeutic technique in many ways. In the psychoanalytic exchange, the dialogical principle approaches the Socratic form of dialogue if the latter is understood as a dialogue in which the discussants are led by insight to submit to reason.

Most analysts have some image of an ideal type of dialogue. Yet since the rules that psychoanalysts apply in analysis have to prove themselves anew in every case, it is alarming for any kind of rules to impose a rigid style on an interview. In the present stage of development of the psychoanalytic technique it is more important to compile precise protocols and conduct empirical studies, including interdisciplinary ones, about how and what analysts discuss with patients than to establish the pure form in which the psychoanalytic discourse is supposed to be led. Although it has become customary to emphasize the difference between the therapeutic interview and everyday conversation (Leavy 1980), we feel compelled to warn against an overly naive differentiation since everyday dialogues often are:

characterized by only apparent understanding, by only apparent cooperation, by apparent symmetry in the dialogue and in the strategies pursued in the conversation, and that in reality intersubjectivity often remains an assertion that does not necessarily lead to significant changes, to dramatic conflicts, or to a consciousness of a "pseudo-understanding" . . . . In everyday dialogues something is acted out and silently negotiated that in therapeutic dialogues is verbalized in a systematic manner. (Klann 1979, p. 128)

It is impossible to establish an overall relationship between similarity and difference in the patient-analyst dialogue. It is disadvantageous from a therapeutic perspective to proceed from the differences and view the dialogue as an extremely asymmetric structure. Empirical studies confirm what seems obvious to common sense, namely that a helping alliance is especially likely to form when a correspondence develops between the views of the analyst and those of the patient that both parties acknowledge. The correspondence may be in apparently very banal items that the patient does not have to be consciously aware of. A workable relationship is more likely to develop if similar views exist on some things and if the patient can somehow sense them. Although the proverb "birds of a feather flock together" has its counterpart in the idea that opposites attract each other, that which is different or completely foreign is more likely to be sinister for most people, and this is especially true for anxious patients. It is therefore reasonable to proceed from the familiar to the unfamiliar in structuring therapeutic interviews. While common sense can be deceiving, it is still advisable not to simply disregard the judgements that result from it.

The analyst and patient live, after all, in the same sociocultural reality even though they may have different attitudes toward it, a fact the patient cannot help noticing. Most importantly, each is subject to the same biological laws governing the life cycle from birth to death. Every patient senses from the very beginning that his analyst is not above the rhythms of nature and that he is thus familiar with the vital needs which provide the patient pleasure or cause him pain. These features that they have in common are given, and the fact that these features are commonplace has deeper implications because the manner in which the patient learns that the analyst is not spared the consequences of aging or illness itself has significant consequences.

The analyst's role in developing a helping alliance is always in part mediated by something general in nature, i. e., that goes beyond his specific professional role as prescribed by his therapeutic tasks. The resulting relationship is characterized by numerous forms of interdependence and by an abundance of discordance; the manner in which it is structured determines in large measure the success or failure of the therapy. Although it may seem

banal, the fact that the interdependent nature of the relationship between role and person and between intervention and relationship has been verifed by empirical research into psychotherapy, such as that summarized by Garfield and Bergin (1986) in the third edition of their handbook, is not unimportant. This leads us, to go beyond our discussion in Vol.1 (Chap. 2), to the question of whether the psychoanalytic therapeutic alliance, which is related to a specific definition of roles, also contains those items that in Luborsky's opinion constitute a helping alliance, i. e., a therapeutically effective relationship. Even the therapeutic relationship is based in large measure on the formation of a "community of feeling" and the emotional ties created "by means of identification," two phenomena Freud (1933b, p. 212) identified in his correspondence with Einstein as being at the basis of human society.

Dialogues demonstrate that significant processes take place in the medium of conversation. This understanding is threatened by one-sidedness if we assume that it is sufficient to describe psychoanalysis as conversation (Flader et al. 1982). Speaking and remaining silent are dialectical elements of conversation that link acts - silence as the act of not speaking and an independent factor - with the verbal acts that, as a rule, negate other acts. This alteration of positions is the means by which the exchange process that is decisive for both parties takes place.

In Vol.1 (see Sect. 8.5), we have already described several features that characterize the occasionally extreme polarizations of the style of interview specific to psychoanalysis. The following example features the significance of speaking and of remaining silent in the analytic process, events that are frequently observed and clinically very familiar.

Example

Arthur Y told me that he felt very well and that he was on the right path. He added that he was not sure where he should start, and mentioned business problems and conflicts with competitors. The patient was unusually silent in this session. Most of all he would have liked to fall asleep.

A: You used to feel the pressure from thinking about the fact that being silent was a waste of money - so and so much per minute.

Arthur Y was pleased by his increased calmness.

P: Yes, I have much better control of myself today; the basis has become much wider. Still, I don't have as many debts as I used to.

A: You used to always overlook the credit side when you thought about financial matters.

P: Yes, the calmness I have today that the world is not going to collapse when I let myself go a little, well I'm very pleased about it. That I can do it without immediately becoming anxious that everything will get confused, as implied by the questions "What's going to happen to me if I blow the hour here?" and "Does my financial existence depend on it?"

Commentary. In our opinion this is an example of productive silence because the patient was able to allow himself the experience of being calm and thus of displaying some passivity without experiencing feelings of guilt. He displayed increased self-security, and he passed his test. In other words, he managed to deal with his time in a generous way and to overcome his anxieties associated with impoverization and the reaction formation of miserliness.

7.2 Free Association

At the beginning of treatment it is important for the analyst to familiarize the patient with the fundamental rule. He must decide in each individual case which information he should provide about the multiple functions of the rules (see Vol.1, Sect. 7.2). Since elements of

psychoanalytic theory and technique have become part of general knowledge, although frequently in caricatured form, numerous patients now come to psychoanalysis with more or less accurate expectations.

First Example

Franziska X told me in the first session about the information she had received from her health insurance company. She also asked me about the report I was supposed to write. After I explained what this was, she asked how long the therapy would last and expressed her concern. Her brother, who claimed to know something about it, had told her that she would need at least a year. After reflecting briefly, I said that it was impossible to make any precise predictions and that it depended on what kind of progress we made.

I then informed Franziska X about the formalities of treatment, saying it was advantageous for her to lie on the couch and that I would sit behind her. She was supposed to try to tell me everything she happened to think about. After I had inquired whether she had any more questions, to which she said no, I suggested that we begin immediately.

P: Can I now tell you what I'm thinking about?
A: Hum.
P: I have to think right now of the lullaby about the seven angels around me [laughed in embarrassment], because you are sitting behind me, at the head of the couch. Last night I even dreamed about it; I wanted to come here, but I couldn't find you or the right room. I'm bound to tell you about a lot of dreams. I dream almost every night. When I wake up, I can usually still remember them. Yesterday I got terribly angry. I spent the weekend in the town of X, where I attended the university. I liked it so awfully much, and I always get mad when I have to come back to Ulm. Everything is so ugly in Ulm, no pretty girls.
A: Are they important to you?
P: I'm just not interested in men. In Ulm it's as if the clouds always have it covered up.

Commentary. It is not difficult to see that this is a well behaved patient who promptly followed the analyst's instructions. Her first association about the situation - she on the couch, the analyst behind her - was about a childhood scene in which she calls angels for help, to protect her during the night. This precipitated an anxiety that the patient related to being left alone in childhood, which was ameliorated by her embarrassed laughter. The next (second) association continued the subject of insecurity. In a dream Franziska X looked for the analyst's office, but found neither it nor the analyst. Her third association loosened the tension; she assured the analyst that she was ready to cooperate and added that he might even find her dreams interesting. Her fourth thought was indirectly related to a substantial anxiety symptom, which began when she started working in Ulm. She longed to return to her student days.

The patient expressed further associations about her student days and about visits to bars in the evenings, where she would sit around with friends until late. This had made her husband mad, even before their marriage; he would get tired and go home alone.

The patient then accused herself on not being able to say no, and changed the subject. She asked about the results of the psychological test. She said she was definitely inadequate in intellectual matters, yet she still wanted to get her Ph.D., as

she had realized in the last few days. The brother she had asked for advice about treatment had just finished his dissertation.

After a moment of silence Franziska X wondered whether everything would not just get worse if she thought about it too much. She said her parents would not have wasted a thought on it, and that it would be completely pointless to talk with them about it. There was another pause in which I did not say anything. She continued that she was afraid of making debts; she always needed a cushion at the bank, and this was her sole concern in analysis.

In the pause that then followed I noticed that the patient was examining the room and her eyes had stopped on the old-fashioned oven.

P: Psychotherapy is in bad shape in Ulm [laughing].
A: Because of the old oven?
P: Not just that; the other house, too, the one I had my first interview in with Dr. A is almost falling down. When I visited him I was afraid that he would turn me down because my stories were so trivial.
A: Just like you couldn't find the room in your dream.
P: But my stories are trivial. This is bound to be an adventure. I'm curious to see what comes of it.

Commentary. The patient's associations have to be viewed as statements she made to the analyst. They do not create a simple story in which the plot is easy to follow, but a collage whose individual pieces are part of a more general motif that is often difficult to recognize.

The thought that "everything is ugly" was also directed at the office and the analyst, who related the comment about there not being any pretty girls here to the patient's negative self-feeling, yet without assuming that this allusion referred to an intention that had already become conscious.

The remarks the analyst makes while the patient is learning to freely associate have a significant function because they give the patient to understand that there is a counterpiece to how he is supposed to act, namely an answer to the jumps in his thoughts. Interventions inevitably direct the further course of events because they interrupt the process that tends to destabilize the patient. On the other hand, silence is frequently a comment after all, especially since the patient not yet familiar with the analytic situation will expect the interview to follow the rules of everyday communication (see Vol.1, Sect. 7.2).

Second Example

Linguistic studies on cases recorded in the Ulm Textbank document that in one sense patients enjoy a privilege at the beginning of therapy. According to them, patients can start by more or less holding monologues and in this way follow the fundamental rule. The analyst's role as a listener is then judged quite positively. This is demonstrated by the following short example from an initial session of a patient named Amalie X.

P: I feel something positive, that there really is a person to whom I can tell everything or who has to listen for better or worse and who can't complain when I say something stupid.

At the same time the patient developed her own ideas about the (listening) analyst, who usually participated in the conversation in a manner that did not meet the patient's expectations.

P: I have gradually realized that you more or less don't give answers; at the most you make something more precise. And I wonder why you act this way. Because

this won't really become a conversation. I simply want to know what the reasons are. I really wonder about it, and it's an entirely different kind of conversation than I'm used to. [From the second session]

In the eleventh session the patient repeated her observation about the different nature of the situation and complained in more detail that there was too little response.

P: Well, I think it's an entirely different kind of conversation than what I'm used to. What bothers me the most at the moment are the gaps between what is said, because I don't know whether you're waiting for me to say something, or I'm waiting for you to speak. Always the pauses between what I say and what you say. It's pretty uncomfortable. And when I say something, then maybe it reaches you via some pneumatic dispatch. But then I'm not here anymore and I can't know and can't experience what you think the moment I tell you something. I don't even get an answer to my dispatch.

This excerpt demonstrates the stress that the fundamental rule can cause. The problems of technique that are encountered at the beginning are centered around the question of how we can facilitate the patient's transition to the specific kind of discourse that characterizes psychoanalysis without being able to eliminate every burden, but also without causing any unnecessary iatrongenic damage that we would have to expend great effort to overcome bit by bit. In this chapter in Vol.1, we argue in favor of flexibility on behalf of the analyst, in order to create the proper conditions in accordance with the patient's own circumstances.

At the end of the analysis the patient referred once again to her initial difficulties:

P: Moreover, in hindsight it sometimes seems strange to me that . . . well, I'll just say it in one short sentence. I sometimes thought, "Why didn't he say right away what he wants [laughed a little], and give me a set of instructions." I can remeber it precisely. I asked in horror, "Do I have to lie on the couch?" and I thought it was terrible. Then I said, "What do I have to do now?" and you said something like, "Tend more to say what you happen to think of." It was words like these. It may have been formulated differently, but the word "more" was there in any case.

A: More than in sitting.

P: Yes, you said it, and that was everything. That was the entire rule, the instructions, whatever it's called, and then I thought, "Boy, he's overestimated you; why doesn't he say any more, and then I wouldn't have to struggle so much myself." I often had that thought. He's looking at an entirely different person. He doesn't know me. He's just trying out how it works. He's starting from preconditions that are not very applicable to me, that are his own, and that only gradually became my own. It took me a good half year to get used to the couch. Even if it's theoretically clear, it doesn't help for a long time; everything you read about it doesn't help at all. Yet I wouldn't have dared to take a good look at you if I had been sitting. I don't think I would ever have managed to have that pleasure.

Commentary. Some years had elapsed since the beginning of this analysis. From our present perspective, we recommend that analysts provide more explanatory and interpreting answers in the initial phase, for example, in order to diminish the traumatic effect of pauses and enable the patient to use and master them more productively. The establishment of a helping alliance should be at the focus, and flexibility adapted to the requirements of the individual patient is necessary to achieve it. We have given several examples of the beginning of treatment that are of more recent origin in Sects. 2.1.1 and 2.1.2.

Amalie X made a significant contribution to the revision of our technique by drawing our attention to the significance of letting the patient be a party to the background and the context of the analyst's thoughts and actions (see also Sect. 2.4.2). We are convinced that this participation is neglected by many analysts, the consequences of which might be antitherapeutic. It is important for the analyst to structure the interaction in a dialogical manner and to reduce the asymmetry, especially in the initial phase.

Third Example

In the initial phase of therapy patients often pose the question as to what they should do if they cannot think of anything to say. The following example from the treament of Christian Y demonstrates one possible way of handling this difficult question; this procedure promotes the working alliance and is an indication of the first steps of interpretation.

P: What should I do in case I can't think of anything to say, if there's nothing of any significance on my mind.
A: Well, at first there was something on your mind. You said "nothing of any significance."
P: Yes.
A: Then just say what is on your mind, even if it doesn't seem siginificant to you.
P: You mean even a statement like "You have a lot of English literature here"?
A: Yes, precisely, that's a thought after all.
P: Or the noise from outside? I don't see that there's any connection to the treatment.
A: Well, we don't know. At any rate, it crossed your mind.
P: Yes?
A: Hum.
P: Am I making a mistake about what's important?
A: Right now, yes, inasfar as you assume and say that it doesn't belong here, for example the English literature you see here, that you've noticed, and that belongs here, and the saws outside that you can hear, and you notice it and it belongs here too.
P: I would have thought it was a digression.
A: Well, perhaps you went from the English literature to the saws because you might have thought that the idea with the literature was too personal, and therefore you quickly switched to the saws. That would be a wandering of your thoughts from the books in this room, which belong to me, to the outside, i. e., away from here. Insofar it could be a digression.
P: I just wonder, "Why?"
A: Maybe because a red light - to speak figuratively - lit up that told you not to think about the room or English literature any more.
P: Hum, yes. [Pause]
A: Do you have any other thoughts?
P: No, I've just thought a little about how good you are at remembering so many things, like a couple of words or a particular subject. Your concentration, how do you manage it. [Pause]
A: Yes, and then there is - the English literature, the masses of books - the question of knowledge. What does he know, does he know a lot, is his concentration good, and does he have a good memory, and maybe you feel envy?

P: Hum, not just envy, but interest too because I would like to know how you manage it. I'm not your only patient. You can't just concentrate on me because there are others you have to help in the same way, don't you?

Commentary. Digressions, which of course constitute an important part of association, can be used to clearly demonstrate a momentary resistance to association. In this case the analyst used the image of a red light to refer to it. The patient's digression seems to have started when he tried to find out whether and how the analyst maintained his concentration. Also involved was the acquisition of knowledge and the related comparisons, in which the patient did not fare well because his capacity to work and concentrate was severely disturbed. Every patient is interested in knowing how analysts manage to store so many data about a large number of people and their life histories in their memories and usually have it functional. By using suitable comparisons, an analyst can let patients participate in aspects of this mental achievement. The deidealization associated with it can also help the patient establish an access to his own cognitive processes.

It would certainly be wrong to belittle the analyst's trained ability to recall even apparently secondary details and dates. They are remembered by their thematic correspondence to categories or contexts and can be easily evoked by situative precipitants. Kohut, in particular, recognized the degree to which idealizations contribute to the maintenance of life. Of course, the more a patient falls behind his ideal and the more the latter becomes unattainable, the greater is the patient's envy, together with all of its destructive consequences.

It was wrong for the analyst to interpret the envy instead of continuing to focus on the interest the patient showed for the analyst and his collection of English literature. The patient's envious impulses toward the analyst's possessions, his knowledge, his abilities, his potency etc., which were disguised by the idealization, had a destructive effect on his imagination and paralyzed his thinking and acting. Many therapeutic steps are necessary to reduce the self-destructive consequence of such envy, and the first is for the unconscious envy to be thematized. Although this patient did not reject the interpretation, in the initial phase it was too early to mention envy. It would have been better to extend the theme of identificatory interest - How does he do it, and how can I do it - in order to establish a helping alliance.

7.3 Evenly Suspended Attention

Freud's recommendation that the analyst surrender himself in his evenly suspended attention to "his own unconscious mental acts" describes in more precise terms the nature of the participative observation that facilitates the perception of unconscious processes of emotional and cognitive exchange. The variety of the associations the analyst can have in the state of evenly suspended attention was clearly demonstrated by a thorough study of retrospective comments about analytic sessions that we conducted together with Meyer (1981). The analyst's associations can be classified according to their source and goal (Meyer 1988). They occur at various layers, some of which presumably became clear to the analyst during the session, while others appear to be independent continuations of affective and cognitive processes and were only recognized in hindsight.

Thinking Out Loud

The therapy of Ignaz Y was recorded as part of a research project on the origin and goal of interventions. As part of this project, the analyst dictated his afterthoughts immediately after the session, partly in response to predetermined questions (Kächele 1985).

P: That's really a funny microphone; it's got three parts. [Pause] This morning I'm so tired because I drank two big glasses of wine last night. [Long pause]
A: Any other ideas about the funny microphone?
P: I'm a little startled; I thought of a bug.

The patient concerned himself with where the tape recordings go; for a long time he had thought that I was not really recording "his shit," and now he was concerned about what might happen to his career if it got into the wrong hands.

P: It's gradually getting eerie, I mean everything I say here . . . . Maybe it's my need to run away from my own trash . . . . I don't think I've ever mentioned my dumb slogans; I've always felt so terribly ashamed about them . . . . Maybe you'll understand . . . . A thought just came to me, but I'm afflicted with new words just coming to me and that I completely ruin names and terms.

The patient described how he twists names around, even the names of his children and his friends, and that these words were filled with a special meaning for him, representing a kind of secret language. In puberty he had invented entire sequences of syllables and amused himself with the idea that he was the king of this empire. He noticed that he only twisted the names of people to whom he felt a positive tie.

A: It might be that this junk is only junk for others but that it is something valuable for you personally.
P: Yes, that's true, even though it's awfully childish, but I have the time of my life with these sounds, as if they were toys . . . . I turn the others into my toys a little . . . . That's how I reduce my fear, even with my children, when I'm sometimes afraid that they'll devour me.

In the further course of this session it became clear that the first name he had twisted was that of the most important role model in his childhood, namely that of a half-sister who was 7 years older than he was and whom he gave the name Laila. With this endearing nickname he was able to find consolation and to fill his empty early years. After he admitted how he distorted my own name toward the end of the session, he was also able to express his concern that he experienced the analysis as a threatening vacuum cleaner that sucked his inner world out of him and captured it.

The analyst's summary of the session, which was dictated immediately afterwards, contained the following unstructured report, which we have only slightly edited:

A terrific session; I'm really surprised at what came out. Even before the session began I had hoped that he would continue to talk about the tape recordings because this was the only way I felt that I could reexamine if I could still abide by the agreement we made about the recordings; it would make me feel less disturbed and worried. What was good was that the idea of shit was developed further, that the patient spoke about his relationships, that anxieties developed, that he was punished for them, and also that he constructed a world of transitional objects, which he had not mentioned before.

I had already had the feeling that the thematization of shit also expressed the magical animistic stage. It was only in response to his question whether the analysis was supervised [it was not] at the beginning of the session that I had not known what to say; I thought that he had to have the idea that I was also supervised and that it might be connected with the mastery of anxiety, since he was very anxious about an indiscretion occurring . . . . Of further importance from the session is that the theme "Laila," the important person from his childhood, has now reappeared after it had been dominant for the entire year . . . . I even felt his comment that he used these playful neologisms to be a great present; I recalled a patient with a skin disease who

had just recently told me about such games, very private things that are both much more intimite and shameful than all possible object-related acts, this jabber, this stammering, the onomatopeia, and therefore the idea suddenly seemed very sound and fitting that in the small boy's perception his mother only consisted of a Laila, a dear Laila, and that this neologism had remained so vivid. And I never understood where the name Laila came, nor do I really know now who Laila actually is; is she a stepsister, is she another illegitimate child of his mother? I don't know anything about it; she is simply both hidden and present, the one who replaced his mother. That was actually the image, that Laila was actually only a figment of the patient's imagination, and yet a unimaginably important figment. I have always compared the Laila with a film from Agnes Varda about happiness [the reference is to the film "Le Bonheur"], the bright colors, the overpainted and apparently completely unaffected world of happiness. The magical creation of the name led me, via thoughts about Carlos Casteneda and Schreber's protolanguage, to the idea that he had created a world of his own that offered him autonomy.

I also liked his reference to a "private sound shift," and I had the idea that he was able to avoid depressive moods. He had obviously felt understood when he had read A.Miller's book on depressive constellations. He had been able to get over his depressive moods by inventing a children's zoo with the help of a fairy.

I have the impression that he departed rather quickly; his sorrow is genuine.

My interpretation that the neologisms represented creative achievements took a great burden off him, and also calmed him by removing his constantly returning anxiety of being schizophrenic. At the end he will probably have told me several specific distortions of my name and of that of his second boss in his home dialect. I hardly expected it any more; he transformed it into his own Swiss dialect.

The subject of his return to Switzerland and his comments about this idea stimulated a number of thoughts. Was he looking for the language of his father and mother? Why did he distort my name? He distorts names when the relationship is dear and tender. He did not have to distort the name of his stupid administrative boss because such disappointments did not go so deep; the frustration of tender, merging impulses, in contrast, apparently made him feel the need to make the fairy come alive. I believe the patient took a large step forward here because he was able to view his clowning and silly behavior from this perspective without my having to do much about it; I even have the feeling that my reports about the sessions are not yet very freely associated, but maybe it is also a matter of time before one can let oneself have more space.

Commentary. The task of associating about a just ended session cannot simply be conceived as an uninterrupted continuation of the analyst's "unconscious mental activity" during the session. One important result of this study was the impact the separation from the patient had on the analyst's hindsight. The transition from the therapeutic situation, in which a dyadic and a monologic (partly verbalized, partly nonverbalized) level exist in parallel and which both promote and inhibit each other, into an externally monologic position, in which the analyst's task is to associate by reflecting on the dyadic situation that is only present in his memory, led to a rapid reorganization of the analyst's psychic situation. The retrospective report demonstrates this.

The analyst expressed his pleasure very directly, even grasping the comments that had disturbed him as presents. The analyst's style of language makes one sense an identification with the patient's game, and enabled him to reconstruct what advances the patient had made. The unmentioned idea the analyst had about the film by A. Varda was from the realm of his own personal experience, in which he felt the hypomanic defensive character of the patient's self-invented happiness was convincingly demonstrated. The reference to the motive of the

proto-language emphasized the character of this language game, which was not only based on a childhood world but that expressed a defensive formation in the patient's present. In the further course of his fantasies, the analyst again achieved some distance and reflected on the outcome of the session. He then said goodbye to his imaginary listener (who stands for a real person who does research) with an act of distancing that was less justified by the factual content of his comments than by the emotional content of the session. Such an assumption seems logical since the analyst immediately thought of this session - which had taken place many years before - in response to a question as to the choice of a suitable example of evenly suspended attention.

7.4 Questions and Answers

We have discussed this subject in detail in the context of the *counterquestion rule* in Vol.1 (Sect. 7.4). Today most analysts reject the method of directing questions back to the patient in a stereotypic manner - such as with the phrases "What are you thinking of in connection with your question?" or "What thoughts enter your mind when you think about why you wanted to ask me this question?" - because it frequently has antitherapeutic consequences, and not just in severely ill patients.

Example

Arthur Y, my patient, and several of his relatives were involved in a conflict over an inheritance. Apparently uncertain about what to do, Arthur Y asked me: "Now I'm asking you for your private opinion, not your analytic one." The patient emphasized the urgency of the matter by referring to his increasing uneasiness and a worsening of his symptoms. My thoughts about the difference between private and professional opinions was initially linked with an embarassed feeling of insecurity.

A: Since my private opinion is probably the common sense one, our opinions on this issue are probably pretty similar, but it is my professional task to help you solve the matter in your own best interest. I'm asking myself why you want me to reinforce you in something you already know.

Consideration. Although doubts about common sense are sometimes quite justified, an issue we discussed later, I made the remark about probably having similar views after considering the matter carefully and not out of embarassment. It was clear that the way the patient behaved would either aggravate or moderate the conflict between the members of the family entitled to an inheritance. Such simple reactions are a part of common sense. Yet the patient was uncertain as to which direction he should go and wanted to have my advice, which I was unable to give him. Yet I did reinforce his anticipatory knowledge of the consequences that this or that act would presumably have.

P: It's a very normal human trait for your opinion to be important to me.

A: Certainly.

P: With my earlier analysts I always had the feeling "Don't get too close to me." Especially Dr. X gave me the impression that by asking such questions I was transgressing a limit, as if to develop a relationship among pals. Maybe that's the reason I formulate everything so awkwardly or in such an involved manner.

We spoke about the fact that is satisfying to reach agreement and share an opinion, i. e., to become pals. Then one aspect of being pals became clear that had bothered the patient in a previous therapy. We spoke about the various possibilities to defuse or resolve the family conflict. It became clear to the patient that the consequence of one particular action - correcting something and thus acting correctly - had to be to

continue the war in the family. By acting in this way he would really draw people's attention to the feud in the family.

P: I've just thought of a phrase from Schiller, that I can mold to fit you: From a safe refuge it's easy to give advice.
A: Yes.
P: Yet if I want to have my peace and quiet, I cannot continue to shoot. But I can't let myself get shot either.
A: But you haven't been shot and killed.
P: My feelings have been hurt, I've been insulted.
A: You've been gravely insulted because you experience yourself to be so powerless.
P: Yes, sure. My brother-in-law took it differently. He didn't get excited at all. My self-esteem sinks to zero. Then I don't have any ground to stand on any more. There's no limit to how far I could fall.
A: And that's why it was so important to you that I reinforce your common sense, because otherwise you wouldn't have thought about asking for my private opinion, which you somehow already know.
P: Yes, I do know it already.
A: Well, you cannot always assume that the other person has common sense.

Apparently encouraged by my comment, the patient then mentioned sectarian thinking in psychoanalysis, but immediately became anxious that this might have offended me: "I hope that I haven't attacked anyone here who means so much to me or made him my enemy."

Consideration. In this session there was a turn toward an intensification of transference, which my comment had made easier for the patient. All too often in his life he had submitted to others and appeared to adopt their opinions, but inside he had retained his doubts, which increased with time. By asking for my private opinion, the patient was seeking a means of access to his own unvarnished needs, which gained in strength during the conflict over the inheritance and which he was afraid of.

The Request for a Book

Erna X was interested in books on psychoanalysis. A friend of hers had drawn her attention to the book *Les mots pour le dire* by Marie Cardinal (1975). She had been surprised and astonished when her friend asked her whether she would dare ask her analyst for the book. The closer the session came, the uneasier she became. Erna X immediately raised the question, which contained two aspects. I could take her question about whether I possess the book, which according to her friend was out of print, and would lend it to her to be presumptuous. After examining the intensity of the potential presumptuousness in detail, I answered her question realistically, also emphasizing that in view of all the books in the room, which however did not include the one she desired, I thought it was logical for her to ask and that I did not take it to be presumputous at all. Then the patient turned to the second aspect. Would I lend her a book, and would I expect her to read it thoroughly? Erna X feared that in this case she would be put to a test and queried about what she had learned.

P: I expect to be checked.
A: So you would have to read it so thoroughly that you would be ready for every possible question.
P: Yes, I don't know whether I really want to read it that thoroughly.

I emphasized to her that I did not have this expectation and that it was up to her to read what she wanted.

Commentary. The patient's thoughts show which inhibiting responsibilities would have resulted if the analyst had actually been able to lend her the book. Of course, these consequences could have been worked through by interpretations. The consequences that rejection and cooperation have on the relationship and on how they are to be interpreted differ from case to case.

There are various means to meet a patient's interest in obtaining publications on psychoanalysis. We consider it to be wrong to discourage or forbid patients from gaining information about psychoanalysis from books. As impressive as it is, for therapeutic and scientific reasons, for an analyst to encounter a completely naive person who retains his naivete in treatment, it would be just as antitherapeutic to stifle this emerging interest. The problems of rationalization and intellectualism that are occasionally associated with it certainly do cause problems, but these cannot be compared with the consequences of forbidding a patient to read. Initially Freud seems to have discouraged patients from reading publications about psychoanalysis; later, however, he expected patients, at least analysts in training and educated patients, to inform themselves by reading (Doolittle 1956).

Erna X described the typical feature of her story:

P: It was clear to me that I would ask you until I sat down in the waiting room. Then I had one doubt after another. It's the same way with other things. I get the doubt that this or that might get disagreeable. It's the same way, too, with my career. Then I let everything go.

A: It's the subject of being presumptuous again, about your taking something for yourself when you want to advance, when you intrude into my library, or when you want to learn something about my thoughts during the analysis.

P: So deep inside I knew that you aren't mad at me for asking for the book. Where does my anxiety about being presumptuous come from?

A: Probably a lot of curiosity has accumulated because of the restrictions you experienced when you were small. Your interest is so intense that you fear your desires might be excessive. The desire for a book then becomes an example of a presumptuous and illicit desire.

P: Yes, that's right. My desire for the book might be considered too personal. I wouldn't have had any inhibitions about asking a friend to lend me a book. But you're the doctor, somebody special, somebody I look up to. I can't let myself do this or that.

A: That would create something you have in common. You would take part in what belongs to me.

P: By no means do I want to be obtrusive. You would have to look for it; it might be bothersome. But there isn't any way out if you think like this. If I hadn't asked, I would have left feeling very dissatisfied.

Erna X then spoke about the things that currently were a burden on her, in particular about her mother's illness.

P: I have more responsibilities. I need more time to take care of my family. I need someone more often for my children. My husband suggested that I cut back on therapy, and I had a dream about it. I was at home, and you drove over to visit me. You excused yourself, saying you had to interrupt the treatment because you were overworked. I felt honored that you visited me and accepted your suggestion. I accompanied you to your car and saw two young and attractive students sitting inside. It puzzles me that in my dream I accepted my husband's suggestion and that *you* interrupted the treatment.

A: It's a reversal. To return to the subject, it is probably an expression of your concern about being presumptuous when you want more and I reject your desires. Your dream indicates that other things are more important to me than you are. Maybe it's the two pretty students who are more important?
P: Yes, presumably that's true. At the end I was in a ridiculous situation, rejected, alone, sad. I'm thinking about something else. The rejection. You were friendly, by no means cold and rejecting, not brusque like my husband - "Just leave me alone" - but just like you always are. You explained something to me. I understood it and accepted it although I didn't like it.
A: But you didn't object. You felt I had paid attention to you by driving extra to see you and to turn you down.
P: Dreams are really often surprisingly amazing. It's unbelievable, everything that took place in this dream. You forget a lot. Did I really want to go with you? You left so abruptly.
A: You wanted to come along, and in a particular sense you did come along, only indirectly, in the form of the students. The fact that you lost out and were turned down was terrible for you, but indirectly you were there. The rejection probably had something to do with the pretty girls who take part in what happens here at the university. That's the reason you were so astonished. It would be presumptuous for you to want to have a book.
P: Yes, that's what I thought. I asked myself if it would be presumpuous if I studied psychology and went to hear your lectures. I'm sad that I've missed my chance. I get angry when I think back about how I chose the simple and safe way.
A: Yes, you've missed some chances, but there are others, for example in your profession.

Commentary. It should be emphasized that the analyst referred to the positive opportunities at the end of the session, stimulating hopes that also have a transference component. It was realistic for the analyst to help the patient perceive her future opportunities in the profession she had learned.

7.5 Metaphors

7.5.1 Psychoanalytic Aspects

In Vol.1 we considered the meaning of metaphors in connection with the controversy about Strachey's translation of Freud's works and discussed the role that metaphors play in the language of theory (Sect. 1.4). In accordance with Arlow's (1979) reference to the fact that metaphoric thought predominates in transference, we have assigned the clarification of similarities and dissimilarities a prime role during transference interpretations (Sect. 8.4).

Similes, metaphors, and allegories play an important part in Freud's style, as can also be seen from the size of the corresponding section in the index to the *Standard Edition* . It contains a list of the shorter quotations or peculiar uses of language that are directly related to psychoanalytic concepts. As this special index demonstrates, Freud frequently used similes to illustrate psychoanalytic theory.

Metaphors are a figure of speech that originated in rhetoric and that have finally become the object of an independent *metaphorology* (Blumenberg 1960). Original metaphors make a special contribution to helping new ideas acquire vivid substance (Lewin 1971). Metaphors have played an oustanding role in all the sciences, especially with regard to discoveries, because they link that which is known and familiar with that which is still strange and unfamiliar. They are well suited for achieving the balance that is implicit in Kant's (1965

[1781], p.A51) aphorism that "Thoughts without content are empty, intuitions without concepts are blind."

The problem posed by metaphors has attracted many researchers since Richard's (1936) pioneering study. Various linguistic and multidisciplinary studies and symposia, such as those documented by Ortony (1979), Miall (1982), Sacks (1979), and Weinrich (1968, 1976), demonstrate that metaphors are obviously an object of great interest in many disciplines in the humanities. In the psychoanalytic literature, however, there is still an insufficient number of publications dealing explicitly with the significance of metaphors in the language used in theory and in practice, a fact which Rubinstein complained about in 1972. Psychoanalytic papers are almost completely lacking in multidisciplinary studies. In 1978, Rogers published the results of an interdisciplinary study group on psychoanalytic aspects of metaphors, but it attracted much criticism (Teller 1981) because it followed the tension-discharge model of cognitive processes. Göbel (1980, 1986) discussed the relationship between metaphor and symbol with reference to the distinction that Jones made, and took newer publications in philosophy and linguistics into consideration.

In order to gain a better understanding of the meaning of metaphors in the psychoanalytic dialogue, we should look at the origin of the term, which makes it logical that a psychoanalyst thinks of the process of displacement. The term, taken from the Greek, originally referred to a specific act, namely the carrying over of an object from one location to another. Aristotle referred to the metaphor as "the right carrying over" (*eu metapherein*), as the ability to recognize similarities. It was not until later that the word came to refer to a figure of speech. Such carrying over becomes a metaphor when it is taken *figuratively* , not *literally* . Metaphors represent an intermediate stage to the complete use of symbols. They are rooted in the anthropomorphic world of images and in man's bodily experience.

Characteristic for metaphors is their mixture. The concepts "image," "simile," "allegory," and "metaphor" are frequently used synonymously in works on literature (see Köller 1986). The distinction between these concepts is not complete even within linguistics. "Image" often serves as a generic concept for metaphor, simile, and allegory. A simile is a construction referring to an image that contains the words "as" or "like."

The tension between similarity and dissimilarity in the transference from the original object, or referent, to the new object is central for understanding metaphors. In contrast to simile and allegory, in which image and object can coexist, in all metaphors the image takes the place of the object. It is therefore logical to assume that a statement such as "I feel *like* a wilted primula" expresses a weaker identification in a dialogue than do the sentences "I *am* a wilted primula," "I *am* a jellyfish drying up on the sand," "I *am* a desert," "I *am* a porcupine," or "I *am* a heap of shit."

The fact that metaphors play an outstanding role in the psychoanalytic dialogue is due to this intermediate position; the clarification of similarities and dissimilarities is a constant issue in the dialogue (Carveth 1984). This was the reason that Richards, writing 50 years ago from a linguistic and philosophical perspective, classified the phenomena of transference as examples of metaphorology, a field his concepts greatly enriched. Black (1962) summarized these concepts in his "interaction theory of metaphor."

Considering that the carrying over was originally taken literally, it is also logical that many metaphors originated in analogy to the human body and lead back to it. From a therapeutic point of view it is therefore essential to rediscover the unconscious physical starting point in figurative language and to refer to it by name. Of course, we cannot expect it to be possible to trace all metaphors back to particular bodily experiences. Such a general reduction, which Sharpe (1940) defended and explained with reference to case histories, is not appropriate for the diversity of metaphoric language. We share Wurmser's (1977, p. 472) view that the metaphor is "a guide to unconscious meaning - not unlike dreams, parapraxes, or symptoms."

Since the analytic dialogues cited in this volume contain numerous metaphors and allegories and the following section contains a thorough linguistic study, we will only mention three examples here. The world of images exerts a great fascination. Metaphors are well suited to be used as flattering descriptions of concrete bodily needs and the feeling of

shame associated with them, since theories and concepts are not the only instances in which rationalizations can serve resistance. This is also true for metaphors. After unfolding a figurative language related to emotions, it is therefore advisable to locate and call by name the bodily and sensual source of perceptions expressed in metaphors. The concern that this might destroy meaningful images or even the creative foundation of fantasizing is unfounded; our experience is just the contrary, namely that the world of images becomes even more vivid and original when it is linked to the starting point of the analogy. It is, of course, no coincidence that the intermediate position of metaphors makes them well suited for elaborating the struggle between iconophiles and iconoclasts. Grassi (1979) demonstrated that this involves recognizing the power of fantasy, which is the reason that analysts are always on the side of the iconophiles, i. e., those that revere images, and not on that of the iconoclasts, who destroy them. The function of metaphors in psychic life should be examined from psychoanalytic points of view. For example, negative metaphoric self-representations are frequently encountered in therapy, and the allegories invented by patients are therefore useful as indicators of altered self-esteem.

The Analyst as Irrigationist

At the beginning of his therapy, Gustav Y had described his world as a desert in which only meager and resistant plants could survive, and afterwards he compared the consequences of his therapy with the effects that an irrigation system has on barren desert soil, making it possible for rich vegetation to develop. Metaphors related to plants are especially well suited to represent the inconspicuous aspect of the development of psychic processes (Kächele 1982). Yet it is impossible to be satisfied with the fact that the desert lives, as pleasant as the changes are that produced the new metaphor. For this patient it was just as surprising as it was important that the analyst asked him why he structured his world in the form of a desert. In doing so the analyst assumed, contrary to the given facts, that this was not necessarily the case - an assumption that is always justified with neurotic patients because of the functional character of their inhibitions. It was also important that the analyst asked him why he had made him into an irrigationist. This attribution served the anxious defense of the patient's own pleasureable oedipal and preoedipal fantasies of fruition. As was shown in the further course of the therapy, the specific forms that his symptom and character took were a consequence of the repression of desires that stemmed from a variety of sources - a metaphor that Freud (1905d) used to represent his libido theory.

Commentary. Although specific urophilic and uropolemic memories themselves were not mentioned in the analysis, it would have been helpful in this case for the analyst to have been aware of Christoffel's (1944) theories. As with everything that is human, even the bodily experience linked with urination has been portrayed poetically. The figurative language of poetry has been used to express the unconscious fantasies, to use psychoanalytic terms, that Freud described with his theory of *psychosexuality* . The step from the poetic description to the scientific discovery introduces connections into human nature that are reminiscent of the laws of nature. For instance, in his famous novel Rabelais described the omnipotent and uropolemic fantasies of Gargantua, the main figure of his novel who was able to flood all of Paris by urinating. Christoffel integrated such urophilic fantasies into the theory of psychosexuality. For a patient to experience himself and his environment as being a dried up desert goes back in part to the repression of his impulses, which he then tries to find as an irrigationist in the person of the analyst.

The Source

Erna X used to withdraw quietly when she was disappointed and felt tense, to be alone and simply to cry out of desperation. She was now able to express her conflicts more openly, but she was still helpless as to what is to come next.

She finally came to speak of her reserves. I picked up this train of thought by comparing her reserves with a source she could tap. She turned it into a flowing fountain. The bubbling water became an allegory. Erna X laughed. "Now that's a picture," she said, "that makes it possible to have lots of ideas, in contrast to the picture of a pool of standing water. I think of myself more as the standing pool than a bubbling fountain. Bubbling is impossible for me - it was turned off." The session ended with the patient expressing her satisfaction that she was returning to the source, and that with analytic help she would make fewer mistakes in raising her children.

I was all the more surprised when Erna X began the following session by stating that she had not wanted to come. She felt she were in a void. She answered my question about whether the last session had been unproductive with a clear no, saying the business with the bubbling water had just carried her along. Such figurative comparisons exerted a strong appeal on her. While in the waiting room she had still thought about the bubbling. She described the vitality of her daughter, who really bubbled with high spirits. She said her daughter took great joy in life, her eyes sparkled with pleasure, she exuded a feeling of satisfaction, and she could also go wild. Bubbling was, according to the patient, a normal manifestation in childhood. Erna X reflected on her own childhood and the limitations that had been imposed on her.

I expressed the assumption that this was the reason that she-had not wanted to come or that she had wanted to stay away for good because she had been raised to have the idea that she had to come with a clear programmatic purpose and only if she were sure that she had something to offer. Her uneasiness increased when we discussed spontaneous statements. I reminded her that her wish to touch my hand had previously filled her with anxiety. To give her relief I mentioned that all ideas and fantasies are directed to the outside.

Commentary. We would like to draw particular attention to the analyst's helpful comment that gave a general meaning to the patient's transference. Such actions thin the transference, which can have negative consequences if the patient experiences the generalization as a rejection. In this case the result of the generalization was rather that this patient became much less shy about including her analyst in her fantasy world.

P: I may have started to bubble here but the big flood can still come, the full-fledged bubbling. It's like with a water tap that was turned off so firmly that it's extremely difficult to open it bit by bit. I couldn't think of anything else, although I've had the opposite experience.

I then gave the interpretation that her thoughts about stopping might be motivated by her concern that she might think of too *much* , not too *little* .

P: The tap was closed. It's just as simple as it is extremely difficult, because in opening it I'm also trying to turn it back bit by bit. I try to tell myself, "Be satisfied with what you have and get along with it." I don't see any alternative.

After a long pause Erna X posed a surprising question.

P: Have you ever sent a patient away and told the person that there wasn't any point in coming any more?

In the pause that followed I could sense that the patient was urgently waiting for an answer.

A: I'm thinking about it.

P: What prompted me to ask? I can tell you that. An acquaintance was in therapy that her analyst ended with the justification that there wasn't any point in continuing. Subliminally I'm probably also afraid that there isn't any point.

A: You're anxious that too much might bubble out of you, and fear being sent away, not because you have too little to offer, but rather too much.
P: If I don't bubble enough, then you send me away, and if I bubble too much at home, then my husband sends me away. I'm more spontaneous that I used to be, and rasher. I feel as if I were left in between.

I agreed with her that this was a genuine difficulty that would be gone if she did not come any more. The session then continued along the ususal lines. I explained that it was natural for both the patient and the analyst to occasionally raise the question about the sense of continuing.

P: If you're asking me whether I want to make more progress or not, I couldn't answer spontaneously with a clear yes or a no.

She described her ambivalence by referring to the example of her desire for children, on the one hand, and the rejection of a further pregnancy on the other.

P: If I made more progress, what then? It's awfully difficult.
A: What bubbling are you afraid of? What minor bubbling could turn into a full-fledged one?
P: That I can't continue to live under the momentary circumstances . . . . I made a mistake that I have to fix. At the same time, it's impossible to change it.
A: Do you think you have so little influence on your husband, or that he has so little scope for acting? Have you already tested the various possibilities you have for influencing your husband?

The patient answered in the negative.

A: You still haven't discussed a lot of things, and your husband doesn't give you any encouragement. A lot is still overcontrolled, so that what in reality is there somewhere - your desires and your fantasies, presumably of both of you - has disappeared.
P: I am reluctant to do everything myself. I would much prefer having a husband who is active.
A: It's a natural expectation to want more stimulation, but there is probably another side, namely that it is not proper for you to mention some things, e. g., sex.
P: Yes, sex is something that men are supposed to control. It's like a cliff - do I jump into the water or not? That's what I'm struggling with right now. I'm looking for a way out, to leave it alone. If I had had a little more time, then I would have read something. Then I would have come here better prepared. But even then I wouldn't have the session under complete control and somewhere the bubbling would start. If I'm the one to start, then I might reveal too much of myself. Waiting makes it possible for me to feel my way. My wishes and needs must have been completely strangled. And not just wishes and needs, abilities too. I would never dare to say that I'm capable of doing something. [Long pause] I can't get over that figurative comparison. I'm thinking about a pond, on a fountain that is flowing and bubbling. That's not how I want to be. I don't want to stand there and be seen, standing out there alone and in the open. I would stay down there in the water and cautiously look up, but prefer to stay down there, surrounded by warm water. That's more my style.
A: It's probably connected with the fact that in the figurative language of similes, talking about bubbling, showing, and flowing out expresses a strong relationship to an entire individual and to his body. This is the reason water streams out of the mouths of statues at fountains, and nymphs are there, and so is urination. A person is the source of a stream in urination. That's why there is that famous little statue in Brussels, the Mannikin piss, where the water comes out of his penis. That is what is suggested by these images.

P: [Laughed] I know it. Years ago, I might have been 10 or 12, my father was in Brussels and brought back some pictures, including one of the Mannikin piss. I looked at it without saying a word. I thought it wasn't important, but even then I probably had questions that were simply brushed aside.

Commentary. The analyst's idea might seem farfetched if the anthropomorphism contained in all metaphors were ignored. Metaphors and allegories start from bodily experiences, which are always present at an unconscious level. This is not the least important reason for the fascination that metaphors exert. Nonetheless the analyst made a considerable jump here. Was the jump very risky? No, because water and urination are closely associated in unconscious anthropomorphic thought.

The Metaphors "Porcupines" and "Barbed Flowers"

Clara X returned from a vacation in the mountains, which was hoped to have a positive effect on her daughter's chronic illness, in high spirits. While we greeted each other, she beamed at me, which led me to respond in a particularly friendly manner. At the beginning of the session Clara X uttered a sound that I took to be a grunt of satisfaction and involuntarily responded by making a similar grunt. This echo died away without having any effect.

After some silence I spoke about the two sounds. Her friendly greeting at the beginning and the onomatopoeia of the sounds created an intimite atmosphere in which closeness and warmth could be felt - or so I thought. I referred to Schopenhauer's allegory about the porcupines in order to discuss the subject of how distance is regulated. Clara X had frequently used, in various forms, the porcupine as a metaphor for herself.

An abbridged form of the allegory, which reappeared in in the patient's self-representation without her knowing its source, is:

> A group of porcupines gathered very close together on a cold winter day so that the warmth they emitted as a group would keep them from freezing. Yet they soon began to feel each other's barbs, which caused them to move apart again. Now when they felt the need for warmth and moved closer together, that second evil repeated itself, so that they were torn back and forth between the two sources of their suffering until they had found a moderate distance from one another, at which they were best able to stay . . . . Social needs drive . . . men together in the same way, but the numerous repulsive qualities und unbearable mistakes they have repel them from another . . . . Yet whoever has much inner warmth of his own prefers to avoid society, in order neither to give cause for complaints nor to receive any. (Schopenhauer 1974, p. 765)

Believing that Clara X had moved closer to me, I mentioned my assumption that the grunts symbolized the steps from a hedgehog to a pig. Clara X, however, had taken the grunts to be more the cry of a sow who was warning her piglets. She did not feel that the sound she had emitted expressed satisfaction, even though she did feel at ease. She said she was once again faced with the questions of whether to continue and which goals might still be achieved in therapy. She could not really imagine getting much further. For a long time she felt she had been running in place, not getting anywhere. While she did feel at harmony with herself, both she herself and her relations to others were still full of contradictions and rough edges. She felt she would just have to accept it as a fact, and asked me if I believed that she would manage to be able to change her behavior in any way.

At first I told the patient that I shared her doubts, emphasizing the difficulties that stood in the way of change. Once again she employed the image of a wild rose, which she had mentioned in an earlier session, asking what kept it from flowering. Long ago she had described how she had rejected a boy who had approached her - as in the German folk song "Sah ein Knab' ein Röslein stehn," based on a poem by Goethe - in a fantasy in which a seagull released a stream of excrements on the boy.

Commentary. Coming closer apparently precipitated significant defense processes. The seagull served to illustrate anal aggression.

Being more satisfied with herself as a woman and having an appearance that others find more appealing was linked for this patient with a mortal threat, which was expressed in her associations. She referred to a frank statement I had made emphasizing that I liked her more when she felt more comfortable as a woman and that this good feeling, stemming from inside, made itself felt in a change in her figure, i. e., in her appearance. I had thus also expressed the conviction that she would also like herself more and could then achieve greater harmony in her interpersonal relations. Referring to the autobiographical stories of anorectics, she expressed her doubt as to whether truely fundamental changes inside would ever really effect changes in external things and vice versa, so that an anorectic girl might be reconciled with her condition and even become a happy woman. She had simply, yet with disbelief, accepted the positive reports I had given earlier about anorectic patients. She said she would not overcome her doubts until she herself had met one of these cured individuals and might use her as a role model. Knowing that it would not be easy to fulfill such a wish, she would continue her search for a role model but without any prospects of success.

Clara X admitted that she occasionally had a feeling of complete happiness, but only for a few brief seconds. I responded that the issue was then to determine how the length, intensity, and frequency of these moments might be increased. She used exclusively oral topics to describe these moments, speaking about nursing a child.

The patient explained that she might like to have the feelings of confidence and security. It then came out that for the patient the word "please" (or "like") was linked with a mortal danger, i. e., with the word "fall," the two words having the same root in German. This was the reason that she was so irritated when I used this word. Clara X referred to a story to illustrate the danger she might get into; at first she referred to it as a joke: A man had attempted to convince a woman that she could jump off the tenth floor of a building without injuring herself. He had said he would catch her. In response to her disbelieving questions, he had assured the woman that he had just recently caught a woman who had dared to jump off the twentieth floor. Now the woman started having even more objections, asking about the injuries that the man must have suffered while catching her. He had only said that nothing had happened to him because he had let the woman bounce first.

The terrible end of the story was made ridiculous by her allusion to a bouncing ball, and the patient's ironic tone of voice was perfectly attuned to the story.

Each of us immediately realized the dangers that Clara X would be exposed to if she relied on me. Her story had expressed what could happen if she surrendered herself to her spontaneous needs, including that of wanting to please people.

Commentary. To turn to someone in confidence implies intimacy, and just the thought of it was repulsive to this patient. In such moments she might have the satisfying feeling of nursing, i. e., the fulfillment that posed such a danger to her. It was impossible for her to experience this satisfaction as happiness because every satiation was a withdrawal, and to avoid this feeling of withdrawal she had put herself into a state of autarchy, i. e., into a position of almost complete independence. That in the process her longing had become immense could be seen in the destructive force she attributed to her hunger in the widest and deepest sense of the word. If, namely, she did not restrain her lusting for life and her craving, the object - the world - would be destroyed. The patient's radical abstinence was her attempt to preserve the object and - as paradoxical as it might sound - herself as well. Fusion and union can be experienced unconsciously as destructive self-dissolution if aggressive instincts

predominate. A fasting that is undertaken for primarily other reasons, which may frequently be superficial, e. g., a person's figure, can subsequently turn into a vicious circle. The frustration of the nurturing impulse, which requires great effort, leads not only to a loss of differentiation in orality if the impulses break through, but also to a continous stimulation of aggression. In every kind of surrendering, the patient experienced anxiety about the destruction of the object or herself instead of experiencing a pleasurable "oceanic feeling" and an unlimited union with the world. It is thus no wonder that Clara X and her analyst found it very difficult to modify the form of self-preservation she had established in her illness.

Some time later Clara X starting using the *echinoderms* , e. g., a starfish, as her symbol.

P: I have to maintain an external skeleton, because when the external skeleton is removed from an echinoderm then it flows apart, like a mollusc. Then there's nothing left. Everything dissolves.
A: Then it's logical that you've put on such a skeleton.
P: Yes, it's so dangerous if you don't have one that you can't . . . nothing . . . .
A: . . . then the fear that . . .
P: . . . that if the external skeleton is removed, that they sill simply collapse. Molluscs.

The analyst referred back to the hedgehog.

A: Oh, the *hedgehogs* have an internal skeleton.
P: But then I don't have one at all.

Commentary. We would like to draw attention to the smooth transition from one sentence to the next. The patient completed the analyst's thought and vice versa. The analyst took up the new metaphor, the *echinoderms* , for the old one, the *hedgehogs.*

The analyst continued by asking a question.

A: Where does the idea come from that you could dissolve if you stopped showing your external skeleton?
P: From real experience. I can start crying and, independent of the reason, get into a state of utter helplessness. Then it's impossible for me to say why I have lost control. Perhaps it's the wish to be understood and for my weaknesses to be accepted, and not have to be big and brave. It's my wish to let myself fall down and to say, "I can't do any more, you do it now." Besides, I don't want to be able to do any more. But then from others all that I encounter is displeasure, embarrassed concern, and awkward situations - "My God, what's wrong now?" It's terrible. It's bad enough in itself, but it's made even worse by the others. So I naturally think, "See, now you're being left alone, to punish you because you've been so childish." It was a feeling I often had when I was a child.
A: Then you have the feeling of dissolving, of being carried away by the immense stream from inside you.
P: Yes, precisely, that's how it is, dissolving into tears. Dissolving in tears. That's where it comes from. It's a part of oneself. Or losing the ground under one's feet. There is only one kind of reaction that makes it all bearable, namely if other people let me cry, and if something has been accepted, then I don't need it any more. Then I only cry as much as I need, and then it's over. But most people react differently - fussing, becoming disconcerted, being startled, and so forth, and then exactly what I don't want sets in. I cramp. Recently I even cried in front of my husband, and neither of us was moved. It was impossible for him to misunderstand it, which made it possible for me to cry in front of him without triggering his usual reactions. Sometimes I start crying in a way that I just can't

stop. Right now I imagine that you can't understand me, partly because you're a man and crying is something that stopped when you were a 4-year-old boy.

A: Well I did contribute the expression "dissolving into tears."

P: Oh well, but that came through your head. My father also always stood outside the matter, or at any rate, yes, somehow above it.

A: But it isn't entirely negative for someone to be above the matter in such moments.

P: But I don't have the feeling I've been understood. In this point, not at all, not at home.

Consideration. Since I had been very involved with this patient, her criticism hit me very hard. Of course, it was also a kind of transferred disappointment, as shown by her reference to her father. I had a consoling thought, namely that it seems inevitable for there to be a certain distance between someone who is crying and the others around them. The tears of another person, even those of a significant other are not one's own tears; they are the tears of someone else. Empathy seems to approach a state in which two people feel as if they are one, yet without them forming *one* identity.

7.5.2 Linguistic Interpretations

In the current phase of the development of psychoanalytic technique it is important for precise protocols of analyses to be compiled and for empirical studies, including interdisciplinary ones, to be conducted about how analysts talk to patients and what they say. As early as 1941 Bernfeld entitled one section of an article that has remained relatively unknown "Conversation, the model of psychoanalytic technics" (p. 290). In a subsequent stage of development the dialogic orientation receded in importance. The Study Group for Linguistics at the New York Psychoanalytic Institute, under the leadership of Rosen (1969), concerned itself with language, especially from the perspective of ego functions. The study of dialogues entered another new stage when the step was taken to record and transcribe therapeutic interviews.

It is important particularly with regard to interdisciplinary cooperation that the participants remember what they have been trained to do; otherwise there is the danger that, for example, linguists who have some knowledge of psychoanalysis will not do a proper linguistic examination but will ask what psychoanalytic interviews would presumably be like if analysts followed the basic rule. It is a fact "that the character of psychoanalytic therapy as a special kind of verbal exchange (in the sense of a regulated performance of discursive activity) has hardly been discovered in the psychoanalytic literature as an object of specialized study, let alone researched in detail" (Flader 1982, p. 19). Mahony and Singh (1975, 1979) reached a similar conclusion in a critical discussion of Edelson's (1972, 1975) efforts to make Chomskian linguistics applicable for a revision of dream theory.

In linguistics there are various theoretical perspectives. There are theories that view metaphors as a unit of "langue," following the Swiss linguist F. de Saussure - who viewed language as a sign system - and others that see metaphors as the unit of the "parole," i. e., the actual, "spoken" structure of language. The starting point of langue theories is that metaphors are a feature of expressions or sentences within an abstract system of language. They follow Aristotle's definition of metaphor as a simile without the word "like" or "as."

Parole theories accept as given that metaphors originate in their actual use. One school of thought is interaction theory, which assumes that there is no actual expression for a metaphoric one. Weinrich assumed that the significance of a metaphor results from the interaction between the specific metaphor and its context. According to Kurz (1982, p. 18), "The metaphoric meaning is thus more an act than a result, i. e., the constructive creation of meaning that somehow takes place via a dominant meaning, a movement from . . . to . . . . "

Keller-Bauer distinguished between two fundamental manners of understanding metaphors: "The metaphoric use of X, which can only be understood on the basis of the literal use of X," and the "metaphoric use of X, which can also be understood on the basis of previous metaphoric uses of X, via precedent cases" (1984, p. 90). These forms of understanding have a common basis. Although literal communication is dependent on conventional knowledge, nonliteral communication is based on nonconventional knowledge. Precisely the nonconventional thoughts are relevant in metaphoric understanding, and awareness of such "thoughts" is necessary to understand them. "We understand a metaphor via such associated implications" (Keller-Bauer 1984, p. 90).

These "associated implications" play a significant role in the mutual interpretation of the meaning of metaphors in the dialgoue between the analyst and the patient, and they can be seen in the symptoms that are formed.

Kurz (1982) saw only a difference of degree between a metaphor and a symbol. In his opinion, attention is directed at words in metaphors, i. e., at the semantic tolerance and intolerance. Linguistic awareness is stimulated. In symbols, in contrast, the literal meaning is retained, and the referent, the consciousness of the object, is stimulated. The question is how we proceed when we understand a text element symbolically. To clarify this process of symbolic understanding Kurz distinguished between pragmatic and symbolic understanding, considering pragmatic understanding the elementary form of understanding. In everyday language we ask, for example, what the reasons and motives are, i. e., what the relationship between the means and ends is and, thus, what the empirical facts are. In symbolic understanding the issue is to understand the meaning "beyond the given," i. e., to understand that a knife can also be a symbol of aggression. What is symbolized is not a pragmatic empirical element but always a "psychic and moral object of meaning in our own environment" (Kurz 1982, p. 75).

An allegory is a constructed simile. To refer to a dictionary definition, "While the simple simile links two individual thoughts to one another, the allegory extends the comparison to an independent connection, as is often characteristic of epic allegories, especially Homer's. In contrast to the metaphor, the simile does not put the image in the place of the object, but presents each as linked together by an explicit conjunction" (Brockhaus 1954, p. 699).

The Interpretation of Metaphors: Relating Different Images and Referentsin the Psychoanalytic Dialogue

In this section we present a linguistic study of a psychoanalytic dialogue that demonstrates which linguistic acts can be determinative in the dialogue between the analyst and the patient. Our purpose is to describe linguistic acts; we will not make any conjectures about how, according to the rules, the psychoanalytic dialogue is supposed to take place or be interpreted. The text following the introduction by the analyst who provided the treatment is from the perspective of a linguist.

Introduction. This linguistic study made much clearer to me what actually took place in the dialogue. The spatial and temporal connections that were identified and that utilize metaphors based in an individual's subjective experiencing contain important curative factors of general importance. A patient acquires a new attitude to the present as a result of viewing himself from different perspectives and at different points in his biography.

Linguistic Study

Arthur Y spoke about the tension between confirmation and devaluation. In describing a problem, he first stated what it was, viz. the doubts that plagued him when he received confirmation.

P: When someone confirms something that is positive for me and that, although I also know it to be a fact, still somehow cannot believe, that in some corner of my inner self I feel is impossible . . . .

Then the patient described his self-doubts.

P: Somewhere there is still a lot left in me that tells me the entire time: Regardless of how you act and whatever you do, it doesn't matter. It won't change anything in the fact that ultimately for the others, your surroundings, for everyone who sees you, you are just a pile of shit, just lying there and stinking and smoking and for all I know steaming. You will never manage to hide this reality, this shit, this pile of shit, from others for long. You won't even manage by resorting to some tricks or by hiding behind some kind of endearing way of acting or behind professional success. In other words, you can do what you want.

The patient even let this "something" comment in direct speech. Furthermore, he spoke at first as though the identity with the pile of shit only existed for the other one, not for himself. Yet then the patient said that he was not only speaking from the perspective of the other one, but also from his own: "Sooner or later everyone who has any dealings with me will find out that I'm nothing but a pile of shit." Then he referred to the image of the jellyfish and that "it looks quite attractive in water, but if you take it out and throw it on the sand, then it just lies there like a pile of slime." With that the patient concluded his description of the problem and made a longer pause. He then got ready to start his next statement.

In everyday language it is normal for an individual to expect another person to raise some questions or make some comments after listening to such a description of a problem - such as "That's terrible!" or "That doesn't bother you, does it?" The analyst, instead, responded in an unusual manner by mentioning the following thoughts: "Yes, and this image makes me think of the following idea that your image refers to . . . . " Here the analyst used the concept "image" as a synonym for metaphor. As we mentioned above, the terms "image," "simile," "metaphor," and "allegory" are frequently used synonymously in literary studies. Firm distinctions are not even made in linguistics. Weinrich, for example, used the word "metaphor" to refer to all forms of linguistic images. And "image" is often used as a generic term referring to metaphor, simile, and allegory.

The analyst referred explicitly to the patient's *image* , to his jellyfish metaphor. He referred to the experiencing of the jellyfish and thus also to that of the patient, who identified himself with the jellyfish.

A: . . . how the condition was as long as you were still swimming on a feeling of well-being, you had a feeling of well-being, namely in the feeling of well-being on the throne. And I can imagine that you still experience this much humiliation because you do *not* compare this state with what you are today and what you . . . .
P: That's the problem, yes.
A: . . . have achieved, but with the state of admiration, with the jellyfish state, with the state of sitting on the throne.

The analyst emphasized the patient's feeling of well-being as long as he (as a jellyfish) was in water or sat on the throne. i. e., before he became a pile of shit. So while the patient only emphasized the aspect of external attractiveness, the analyst referred to the patient's inner experiencing. He thus expanded on the patient's use of the metaphor (an extension of the meaning and the frame of reference), and in the process changed the focus (a change in the focus of attention). At the same time he established a relationship to the patient's earlier experiences.

In making this interpretation the analyst performed several linguistic acts simultaniously. We would like to examine one of these acts in more detail, namely the act of using language to indicate something, which opened new realms for the patient's thoughts.

On the basis of studies by Bühler (1934) and Ehlich (1979), Flader and Grodzicki viewed the use of deictic (showing) expressions "in connection with certain spheres of reference, which a speaker opens each time in order to demonstrate something specific to the listener" (1982, p. 174). They distinguished three spheres of reference: the spheres of *perception and time spoken* , often referred to with deictic means such as "I," "you," "that there," and "now"; the sphere of *speech* , which is opened by something being shown within the temporal or local organization of the development of a speech or a text, with means such as "Before I explain how . . . " or " "Later I will develop . . . "; and finally the sphere of *imagination* (or Bühler's term "fantasma"), referred to with expressions such as "then," "afterwards," "there" (at an imagined location) (Flader and Grodzicki 1982, p. 174).

In the recorded session being considered here the analyst opened the sphere of perception and time spoken, using the personal pronouns "me" and "you" and the expressions "By means of this image" and "in this image." He referred to the sphere of speech by means of the expression "have the following ideas." He opened several spheres of imagination at the same time in order to link the experiencing of today with that of prior times.

Three spheres of imagination can be distinguished in this analytic dialogue: first, previously (before his sister was born); second, then (after his sister's birth); and third, today. The analyst established a connection between these three spheres of imagination and demonstrated the degree to which the patient's present experiencing is determined by "previously" and "then." This act of showing is performed in terms of language in part by the deictic expressions "as long as," "still," and "today."

In the framework of his interpretation the analyst returned to the meaphor of "throne," which had already played a role. For the analyst the jellyfish's feeling of well-being in water corresponded to the patient's sense of well-being as long as the latter was on the throne, i. e., as long as he gets the admiration of being the first born (renewed reference to the past world of experience; the first imagined world - the experiences of the first born, the time of admiration).

Afterward, i. e., after the birth of his sister and after the patient had lost his throne, he was only a pile of shit. Afterward came the disparagement following the embarrassing acts of shitting in his pants every day in kindergarten. The temporal deictic word "afterward" referred to another, a new imagined world (2). By referring to the meaning of the metaphor "pile of shit," the analyst emphasized one feature, i. e., the patient's experiencing of disparagement (change in focus).

The analyst created a reference to the patient's world of experience at the time of the therapy (third imagined world) in the statement: "And I can imagine that you still experience this much humiliation because you do not compare this state with what you are today and what you . . . . " This emphasized the experiencing of humiliation. Here, too, the analyst incorporated the level of experiencing into his interpretation of the metaphor "pile of shit."

The analyst pointed out to the patient that he was still experiencing the same humiliation as previously (linking the second and third worlds of imagination) because he compared current confirmation ("earned" admiration) with the admiration of the previous period (admiration paid to the first born, admiration for free), thus disparaging the confirmation that he was now given.

The therapist was able to speak in such a differentiated manner here about the patient's disparagement and humiliation because of his knowledge of the events. The patient had frequently talked about the conflicts in him that the birth of his sister had precipitated, as reflected in the symptom that he began to shit in his pants, to which his mother and grandmother reacted by scorning, disparaging, and humiliating him.

In summary, in the interpretation analyzed here, in which the interpretation of the metaphor was one act in the behavior pattern "interpretation," the following points should be emphasized. By referring to the patient's experiencing, the analyst carried out a change in focus in each of his interpretations of the metaphor. At the same time, he also established a

connection between the different experiences "then" and "today." The analyst indicated the continuity between "at first," "earlier," and "today," which the patient experienced, and then interrupted the continuity by pointing to the difference between then and now. This passage also indicates the amount of work done by the therapist in putting all these images into a coherent relationship.

Clarifying Symbolic and Vivid Meanings in the Analyst-Patient Interaction

Arthur Y described his feeling from the day before, which he characterized as "stable, surprisingly so." This was just the opposite of his experiencing in the evening, when he noticed the pocket knives his son and daughter had. The patient described the unease and anxiety that the knives has precipitated in him that night.

P: And then yesterday evening I discovered this knife, and then it started all over again, the fear that I might go after someone in my own family - this fear is always strongest regarding my children.

His attempts to defend himself against this threat - to get it under control - became clear in the very orderly manner he described the situation and his behavior (then, at that time) and mentioned his subjective experiences (fear, frightened). He attempted to determine what significance the knife held for him, considering it at the pragmatic level of symbolic understanding.

It was conspicuous that the patient emphasized the normalcy of the situation and used a series of techniques indicating that he attempted to master his feelings. Both of these probably enabled the patient to maintain distance to his experiencing to keep him from getting lost in it (an indication of a borderline situation).

This distancing was strengthened by the allegory about the hamster, which Arthur Y explicitly referred to as such.

P: And then I remembered our hamster. When I, when we set him on the chair and put something in front of him, a spoon or something, then he would take it with his snout and mouth and throw it on the floor. It's funny to watch [sniffled]. Apparently it bothers him. This knife in there bothered me in the same way.

This night the patient's distancing was a success, as might be indicated by the fact that he subsequently only referred to "the thing," saying that he actually did not need to fear it at all.

In the following passage Arthur Y established a connection to a knot that had already been a topic in therapy. The knot probably really existed in some staircase. For the patient, it had something to do with his aggressions, which the analyst often referred to by name.

P: That I would have such difficulty realizing that I too have aggressions.

He said when he reached this point, then his feelings of both anxiety and real opportunities became all entangled. The patient then developed this metaphor of a tangle, which led to the association with "disentangle," into an allegory or a simile.

P: I can't find a better comparison, and if I had the beginning of the string or the other end, then I could try to disentangle the mess, but somewhere I would have to, I mean, of course I have the beginning, I would have to try with the help of the beginning to get somewhere.

The patient not only explicitly described this allegory about the tangled mess, which clearly indicates the patient's inner confusion, as a comparison, but also described its quality - "I can't

find a better comparison." This kind of explicit description of a comparison or allegory might, in turn, be an indication of the distance between the patient and his inner experiencing.

That the patient experienced his feelings of anxiety and being threatened as coming from outside himself might be indicated by his impersonal statements: "And then it started all over again, and the reason that this thing made me feel so anxious receded into the background once again."

After having discussed another topic, Arthur Y returned to the knife. He said that he had actually wanted to examine this problem in the session under study. He expressed doubt as to whether he had benefited from the session, expressed criticism, and retracted the criticism immediately. He did not say explicitly, "The session was a waste of time." but expressed himself in the following manner: "And now, although I don't have the feeling - when I think about it - that the session was a waste of time, really I don't, although I almost said just as much, and now nothing has come of it."

The patient used various techniques to retract his criticism: (a) the conjunction "although," (b) the negated feeling "don't have the feeling," (c) the reiteration "really I don't," and (d) a fictive double backdating, expressing an incompleted act, "although I almost said just as much."

A ten second pause followed, before the analyst picked up the topic the patient had started on, not by thematizing his criticism but by directly referring to the topics of "pet" and "knife." He referred to the allegorical meaning of the story about the hamster who used his snout to push everything that bothered him onto the floor.

A: You thought about the hamster, so, whatever bothers him, well, push it out of the way . . . .
P: Yes.
A: . . . push it out of the way . . . .
P: Yes.
A: . . . whatever bothers it.
P: It looks so funny.
A: Hmm.

The patient applied the story about the hamster directly to his own personal situation, until it became complete nonsense. His interpretation of the hamster's symbolic meaning was entirely at the level of pragmatic understanding.

P: Well, yes, I could take the knife and destroy it, but that's silly. That's no solution. In reality it's not the knife at all, I think, and if I throw it away, then there are more in the kitchen, then I could throw them away, too. [laughing] And when my wife starts looking for them and says, "Damn it, where are all the knives?" then I can say that I've thrown them out, and she would reply, "Your're crazy." All I could say then is simply, "Yes."

In the following passage the analyst was concerned with the symbolic meaning of the hamster.

A: Yes, yes, the hamster gets hit and is killed . . . .
P: Yes.

The hamster and especially the butchering of domesticated animals, e. g., pigs and rabbits, had already been mentioned several times in therapy. These animals represented for the patient enslaved and powerless beings that get hit and are killed. Thus the analyst established a relationship from this session to earlier descriptions (linking different spheres of imagination). The patient agreed with the analyst, but relativized the analyst's reference to the association about the hamster, saying it was a coincidence.

By saying "It's a coincidence," Arthur Y rejected the connection that the analyst had established. At first the analyst agreed that the association was coincidental, but then relativized his agreement by saying "perhaps" and then reiterated that the hamster had a symbolic meaning and that the association had probably not been a coincidence, saying "but I'll classify it as such."

A: That's a coincidence, yes, yes, perhaps a coincidence. Yes, definitely, but I'll classify it as one.

Here it is clear that from the analyst's perspective the patient had not entirely understood something he himself had said. By referring to the fact that the hamster had frequently played a role, the therapist left the interaction at their common level to move to the "analytic" level, in order to make something that was incomprehensible (nonintegrated) to the patient comprehensible (to integrate it). By means of his rejection, the patient attempted to reestablish the cooperation at the first level, which the analyst did not accept, insisting instead on his perspective.

The patient's rejection of the analyst's interpretation led the analyst to begin a discussion of a series of further aspects of the symbolic meaning of the hamster, the rabbit, and the knife, which the patient accepted in the course of their interaction, i. e., the patient accepted the analytic level of interpretation.

A: Namely, inasmuch as knives disturb you because they pose a threat, and the hitting, then a person can't do enough to avoid getting hit if he's, so to speak, a guinea pig . . . .
P: Yes.
A: . . . a hamster that's equated with these objects . . . .
P: Oh, yes.
A: Let me anthropomorphize this for now.
P: Yes.
A: . . . Gets hit and stretches out, then he can't do enough to get out of the way. But if the issue is different, if he's not the hamster, but the one who has power and therefore, in order to defend himself, needs . . .
P: Hum.
A: . . . a knife, then he naturally doesn't want to get rid of them, but . . .
P: Then he can't have enough of them.
A: Yes, then he can't have enough of them.

Here the analyst interpreted the hamster as a symbol in a general manner and without making an explicit reference to the patient, using the indefinite third person. The hamster symbolized the patient's powerlessness, yet according to the analyst the powerless patient had also maintained unconscious fantasies in which he was the one who had power, namely the knives to protect himself. The patient was thus not only the one threatened by the knives but also the one who needed the knives to defend himself. The analyst attempted to make it clear to the patient that the knives both symbolize the external threat and represent the patient's own possibility to defend himself, i. e., repesent his own aggression (which can injure others).

By making the short comment, "Then he can't have enough of them," which the analyst picked up and repeated, saying it almost simultaneously, the patient confirmed the analyst's interpretation. The patient recalled that he had thought that he was not afraid, telling himself "You know that you would never hurt a fly. So why are so afraid of this thing?"

The analyst picked up this line of thought and related it to the patient's son. He then relativized the patient's statement to the effect that it was not the patient's intention to hurt anyone but that it was an "inevitable side effect."

A: Somewhere you know that you didn't want to hurt anyone, but hurting someone was a kind of inevitable side effect, but . . .
P: How do you mean that?
A: I mean that you are not the one who is enslaved; I mean that you, when you tell X to go to hell . . . .
P: Yes.

The analyst thus made it clear that the patient's current identification with the hamster was not logical, because in current reality he was not the one who was enslaved, but the one who told X to go to hell and who then thought about "rationalizing away" the job of his less successful colleague.

In the following interpretation the therapist attempted to convey to the patient that he was the one who has power and who has the ability and desire to hurt others:

A: The point is that you are no longer the one who is oppressed and beaten, but that you have power and thus can turn the tables. Then the other person gets hurt, not you. In turning the tables, you also want to hurt the other person.
P: Yes, that's precisely it, now we've reached the knot.
A: Hum.
P: Hurt someone, yes, hurt someone, take revenge.
A: Yes, yes, hum.
P: It would be nice if . . . .
A: But precisely the moment you take revenge, hurting someone is part of it, and then you immediately feel . . . [the patient sniffled] . . . the tables are turned around again. In other words, you know how it hurts to stand there and have your pants full.

In this interpretation the analyst established a relationship between the patient's experiencing in which he was the one who was enslaved (then) and (current) reality in which the patient was the one who was powerful and who can/will turn the tables (sphere of imagination 4). Yet precisely the moment the patient realized this, the tables were turned again (today) because he knew what it was like to stand there and have your pants full (then). In other words, he knew what it was like for someone to be despised and hurt. The analyst had thus put all the symbols and metaphors the patient had mentioned into a coherent whole.

After a long pause the patient returned to the knot (here as a block to thinking), which the analyst used in the following allegory:

A: Yes, where would you go further - maybe you don't have the confidence in yourself to go any further, now that you have reached some end.

This challenge was followed by a longer pause, following which the patient only concerned himself briefly with his own aggression. Until the end of this session the patient talked about the humiliation and aggression he had suffered and about his helplessness. The powerless hamster was again in the forefront.

The patient thus introduced certain empirical facts into the conversation (here: knife, hamster, knot) and attempted to understand the meaning they had for him (pragmatic level of understanding). The analyst referred to the other kinds of meanings that these empirical facts could also have for the patient. He interpreted their symbolic relations and extended them allegorically. At the same time, he indicated the limits of such symbolic meaning.

Summary

The linguistic analysis crystalized the following facts out of this text. This was a patient who frequently used images, allegories, and symbols in therapy. In contrast to everyday communication, the therapist and patient were not restricted to the manifest meaning of the images, but attempted to find their latent meanings. In other words, the therapist worked with the patient to discover the biographical significance of words - metaphors and images - that the patient was only familiar with at the level of their manifest meaning.

The therapist helped the patient understand his own comments, to put them into context, to go beyond their incidental nature, and created the biographical continuity between "earlier," "then," "today," and "tomorrow." He achieved this by means of linguistic acts such as extending the meaning and the connotation, changing the focus, opening spheres of reference and imagination, and linking different spheres of imagination.

This linguistic study demonstrated that in this dialogue the analyst examined all the patient's comments systematically for their latent meaning and that he created biographical continuity by linking various comments the patient made. This study is also a demonstration of how productive interdisciplinary cooperation can be.

7.6 Value Freedom and Neutrality

Values play an important role in psychoanalytic therapy, which is inevitable considering the fact that a large number of normative questions are at stake for patients. These questions concern, for example, the most favorable resolution of conflicts, the issue of happiness, and the justification of certain desires. This, however, does not in itself imply that a analyst introduces his own norms into his discourse with the patient.

Freud related the value free nature of psychoanalysis to scientific research, not to the therapeutic sphere:

> Moreover, it is quite unscientific to judge analysis by whether it is calculated to undermine religion, authority and morals; for, like all sciences, it is entirely non-tendentious and has only a single aim - namely to arrive at a consistent view of one portion of reality. (Freud 1923a, p. 252)

Freud's goal in this passage was to uphold the scientific nature of psychoanalysis, against critics both outside and inside psychoanalysis. Freud felt that the greatest threat to its scientific nature was posed by countertransference (see Vol.1, Sect. 3.1). In his warnings against countertransference reactions he used in 1914 for the first time the German word *Indifferenz* , which Strachey translated as "neutrality." In doing so, Freud adhered to an understanding of science that was characteristic of nineteenth century empiricism. He adhered to a "positivistic philosophy" (Cheshire and Thomä 1991). According to this view, the acquisition of knowledge must be kept free of subjective factors, to ensure that statements correspond with "external reality." One purpose of this neutrality (or *Indifferenz*) was thus to guarantee the objectivity of analysis. Yet it is just as impossible to uphold this claim as it is the demand that the analyst pursue the goal of objectivity by remaining neutral (*indifferent).* Kaplan (1982) has shown that Freud himself did not follow this ideal, frequently making normative statements.

Despite the fact that values are implicit in psychoanalytic therapy, the utopia of a value free science is commonly mentioned in the literature, especially when the issue is analytic neutrality. This is the result of deep-rooted conceptions about the nature of objectivity. Making value judgments is frequently identified with being subjective, which makes it impossible for them to be grounded rationally. Since there are no intersubjective rules for applying values that can be grounded, an individual's freedom to make his own value judgments is thus opposed to the open or manipulative coercion of the individual to adopt particular life styles. Yet if one aspect of psychoanalytic therapy is that values are implied somehow in "neutral" interpretations, is it then not true that psychoanalysis violates the idea that each individual should be happy according to his own wishes? Or can we justify our

actions by claiming that psychoanalytic therapy does not impose any values, only helping people to achieve self-awareness? The argument is frequently raised that psychoanalysis does not promote norms, only the self-determination of individuals, and that it therefore, for example, regards symptoms only as posing a limitation on self-determination that can be overcome by means of self-knowledge. According to this conception, the ideal analyst limits himself to understanding the patient and communicating what he has understood.

In our opinion both alternative views of psychoanalysis as either a clandestine normative manipulation or as value free enlightenment are themselves incorrect. The therapeutic and explanatory functions of psychoanalysis can only be fulfilled if the *relativity* of values is acknowledged. We would therefore like to contrast the two opposite interpretations of psychoanalytic neutrality, i. e., of its alleged value freedom and its manipulative character.

According to the first thesis, therapy can only be grasped as a process of enlightenment. The most important therapeutic means are, consequently, interpretations, which are statements about unconscious determinants of behavior. Although these interpretations frequently refer to values, a distinction must be made between the description of the patient's judgments and the stance the analyst takes to these decisions. Incidentally, it was precisely this difference between empirical facts and an independent judgment of facts that interested Max Weber (1949 [1904]). According to the thesis of value freedom, analysts are not to make recommendations as to how conflicts should be solved, but should make patients aware of the implications and causes of their conflicts.

The opposite thesis maintains that the idea that therapy is a value free undertaking is a contradiction in itself, the reason being that therapy implies an initial constellation that is negatively valued, for example one characterized by symptoms. Moreover, therapy also has goals that are positive in nature, just as it has means of realizing these goals. According to this thesis, it is impossible to assert that psychoanalysis is value free and at the same time put forward the maxim that what is unconscious should be made conscious. This demand itself is said to contain the judgment that unconscious strategies of conflict resolution must be considered to be less favorable than conscious ones, for example because of the consequences in terms of symptoms. Equally justified is the reference to the fact that the autonomy of the individual is also a value that contradicts the ideal of value neutrality in psychoanalysis.

Even a proponent of the value free position would acknowledge that the attempt to assist a patient reach self-awareness is based on a value judgement. This position asserts that this is a precondition for therapy, whose justification lies in the unprejudiced conviction that symptoms are caused by unconscious processes. Furthermore, it claims that there is a categorical difference between the identification of specific goals and the formal matter of whether an individual is in a position to make a decision regarding goals. In this sense, autonomy is not a value like hedonism or asceticism because it concerns the manner in which individuals are able to determine their desires. For example, symptomatic behavior is not defined as mentally ill on the basis of the nature of the goals but on the basis of the fact that individuals do not have the choice to decide against the symptom. Tugendhat (1984) asserted that symptom-dependent behavior impairs the practical nature of wanting. Meissner (1983) has formulated a series of values that he believes belong to the essence of psychoanalysis: self-understanding, the authenticity of the self, truthfulness, and the willingness to remain committed to specific values. He referred to the fact that these values are located at a higher level of abstraction than concrete value-related decisions in daily life. The call for an unbiased attitude therefore has to be restricted to concrete decisions and must take into consideration the normative nature of values that are located at a higher level.

The ideal of overcoming normative prejudices is strained especially when the issue is the role that understanding and empathy play in psychoanalysis. Precisely with regard to this issue we believe, however, that it is impossible for the analyst to attain either unbiased behavior or unbiased understanding if a more inclusive notion of values is used. We do not have the option of behaving in a nonnormative manner in interpersonal relations. Even a decision to take the status of a pure observer with regard to another person would be the result of a value judgement to which there may be better or worse alternatives. To ask such an observer whether it is correct in a concrete situation to behave as a passive observer could

well be a meaningful question. A relationship without value judgements would only be conceivable if the analyst could simply escape from a relationship to a patient; otherwise he cannot evade the question of whether his behavior was appropriate to the situation or not.

Consequently, the call for the analyst to remain neutral cannot be grounded in the ideal of value freedom, just as strict neutrality in psychoanalysis is no guarantee for value freedom. The insistence on neutrality must, on the contrary, be considered as the expression of a particular normative attitude toward therapeutic work, one which corresponds, for example, to the view that indoctrination of a patient is impossible. This normative attitude, probably just like other such attitudes, is specific to particular situations as well as to particular personalities. In psychoanalysis it is linked to the fact that the understanding of the unconscious conflict is given precedence to other interests. If the analyst and patient agree to assign preference to the pursuit of these tasks and the values attached to them, then other values and differences lose in significance. Naturally, this does not result in value freedom in a philosophical sense, but it does create something that can be referred to as an open space, which is characterized by a pluralism of concrete values. The establishment of such a space free of any pejorative connotations is of eminent significance for a relationship of trust between analyst and patient. It provides the patient the security to confront impulses and thoughts that he is ashamed of or for which he feels guilty.

If it is possible to make the patient's system of values and his criteria for making judgements just as much an object of analysis as his view of reality, then who provides the criteria on which values and reality can be measured? The purpose of the recourse to analytic neutrality is to refute the argument that analysis indoctrinates patients by declaring the analyst's criteria to be final. On the other hand, neutrality is supposed to prevent the analyst from adopting in an unreflected manner criteria that are dictated by the patient's environment or that soley represent id or superego aspects. Here A. Freud's recommendation that the analyst maintain an equal distance literally imposes itself:

> It is the task of the analyst to bring into consciousness that which is unconscious, no matter to which psychic institution it belongs. He directs his attention equally and objectively to the unconscious elements in all three institutions. To put it in another way, when he sets about the work of enlightenment he takes his stand at a point equidistant from the id, the ego and the super-ego. (1937, p. 30)

The analyst's objectivity is supposed to contribute to avoiding partiality in the choice of perspective, and insofar it makes sense to speak of technical neutrality.

There is a similar problem with regard to the understanding of transference. If the relationship between the analyst and the patient itself is examined from the perspective of two-person psychology and transference refers to more than the biographically explicable distortion of patterns of relationships, then there is no secure perspective from which the relationship can be considered because both of the parties involved in the interaction influence the "reality" of the relationship to varying degrees. Freud and later Hartmann still opted for the relatively simple route of uncritically adopting common sense reality as the criterion for what is normal and distorted. Since psychoanalysis has become aware of the relativity of our reality (Gould 1970; Wallerstein 1973), it has become impossible for reality to be considered independent of the particular social norms and conventions. In this context, analytic neutrality also became an important concept, which was supposed to prevent the analyst from taking his own theoretical and personal presuppositions as the basis for evaluating transference and from letting himself be taken captive in his efforts to acquire an empathic understanding of the patient's presuppositions (see Shapiro 1984).

Yet this is where the immunizing and consequently ideological function sets in that the concept of analytic neutrality has increasingly taken on. The reason is that the dilemma resulting from the fact that it is possible to evaluate psychic topics from different perspectives and thus to arrive at very different interpretations continues to exist. Although it is definitely commendable for the analyst, as A. Freud demanded, not to become blindly subservient to the demands of the id or thesuperego, it is still impossible to assert that maintaining an equidistance to all the instances itself guarantees that the perspective is correct and appropriate. In the case of conflicts, "truth" is not always in the middle, but can take on

different appearances, according to the specific situation. For better or for worse, we have to acknowledge that the moment we adopt a specific perspective we no longer see other psychic mechanisms, including their unconscious implications, and that attempting to resolve the problem by avoiding taking a position leads us to even overlook quite decisive mechanisms. One-sidedness is an inevitable aspect of our work with the unconscious. Yet nonetheless many publications surprisingly create the impression that all forms of one-sidedness could be avoided if analysts would only demonstrate *even* more neutrality and would be *even* better analyzed. Such an unrestricted idealization of the psychoanalytic method corresponds to the hesitation to make judgments that currently characterizes clinical work. The underlying ideological tendency of this apologetic approach is evident even in the use of language. You only have to pay attention to how often sentences occur in psychoanalytic publications that specify what "the analyst" has to do or what psychoanalysis is, the result being that whoever rejects the alleged features (e. g., being neutral) is not really an analyst or that he is acting in a nonanalytic manner. In this way, the psychoanalytic method is kept free of any doubt. It is such definitions of psychoanalysis that obstruct the dialogue between psychoanalysts and representatives of other disciplines and that have given psychoanalysis the reputation of being an orthodox school of know-it-alls. They have also prevented the subjective influence that the analyst exerts on the therapeutic process, including his influence as a human being, from being sufficiently observed and empirically studied.

The process of finding an adequate position from which to make judgments in psychoanalysis or for an examination of reality can thus be slightly facilitated if the analyst takes a neutral attitude, but neither neutrality nor objectivity provide a definitive answer to the problem. Reality is determined for the specific situation by means of a consensus of those participating. Thus analyst and patient must be willing, despite resistance and all of the problems associated with countertransference, to let themselves be convinced by the other; this is a precondition for the creation of a consensus (see Vol.1, Sect. 8.4). The social contact of each of the participants, i. e., the confrontation of the patient with his environment and of the analyst with the opinions of his colleagues, provides the guarantee that this consensus does not develop into a folie à deux. The consensus that the participants in the process reach has to prove itself in this social environment even if it does not prove capable of changing possibly divergent opinions. If the patient in analysis retreats from social life or is no longer interested in a consensus with his social surroundings, there is an increased danger of a restricted view of reality. The same is true if the analyst stops facing the judgments of his colleagues or if the professional group he belongs to withdraws from the scientific discussion. In the latter case, a folie à deux is only replaced by an unjustified one-sidedness in which many participate. The great significance that case reports have had since the beginnings of psychoanalysis is based, in our opinion, on the necessity of overcoming a folie à deux by means of reaching an intersubjective consensus.

The fact that this problem has been mixed together with the rule of abstinence has had unfavorable consequences on therapeutic technique. The abstinence rule is based, as we explained in Vol.1 (Sect. 7.1), on the libido theory. It is supposed to prevent gratification via transference. As explained above, the purpose of the neutrality rule is to promote a properly understood autonomy on the part of the patient and to create a space free of value judgments. The word "neutrality" does not describe this attitude any better than Freud's original term, "indifference." We therefore suggest that the term "neutrality" be replaced by the concept of an "unbiased and balanced" attitude.

The unbiased quality is threatened in therapy from several sides. It cannot develop if the patient insists on being offensive and argumentative in asserting particular values against the analyst. This can be the case, for example, with religious patients or patients who are firmly bound in an ideology. In this case the patient must always experience any attempt to achieve an unbiased situation as a "no" to his own hierarchy of values. It is not unusual for a longer period of an exchange of ideas to be necessary before a common basis is created; in some cases therapy even founders on the lack of agreement. This is particularly the case if the analyst attempts to impose his own idiosyncratic values on the patient.

The limits of impartiality also become visible if the patient acts, either within or outside the therapeutic situation, in a manner that makes it impossible for the analyst to focus his concentration on the psychic conflicts. Neutrality can no longer be responsibly upheld if the patient becomes brutal or is grossly inconsiderate to himself or people in his social surroundings. It is then necessary for the therapist to set limits, until the patient himself is in a position to recognize that his system of values is distorted and to correct it. On this point Heigl and Heigl-Evers (1984) emphasized the importance of testing values in the analytic process and pointed to the limitations of neutrality.

If a correctly understood sense of impartiality is to be retained as an ideal of therapeutic technique, then it is necessary to specify the issues and the concrete goals under which the analyst can remain neutral or impartial. Exaggerated abstinence is just as incompatible with such an ideal of therapy as is insufficient distance to the patient's conflicts. As is frequently the case with ideals, there are no criteria that are simple to identify; neutrality refers to a particular position in a specific situation that is characterized by the integration of opposites. These poles can be described in more detail in several different dimensions.

1. Openness - Neither Prejudiced nor Uninformed

The analyst takes the first step away from the ideal of objectivity when he begins to create his own image of the patient. He inevitably classifies some information as important and discounts other information as being unimportant, and activates preconceived patterns of anticipation and experience. These patterns, first, stem from the analyst's practical experience in life, and second, correspond to psychoanalytic working models of a patient (see Vol.1, Sect. 9.3). If this model gains too much influence on the further processing of information, it can disturb the process and lead to prejudice, as Peterfreund (1983) has shown. It is thus quite sound for an analyst to leave his image of a patient incomplete and not to believe he already knows everything that the patient will say and experience at some later point.

If the goal of being unprejudiced becomes an ideology, the analyst ceases assorbing important information and does not draw important conclusions, in an effort not to be prejudiced. A spectacular example of this is the practice common in many places of strictly avoiding every kind of advance information before the initial interview. The reason given for this is to avoid any contamination. What is achieved is that the patient meets an analyst who in the patient's eyes is obviously uninformed regarding important information such as letters from referring practitioners. This creates distortions in communication and the patient takes such a refusal to provide information as disinterestedness on the part of the analyst. It also obstructs the analyst from obtaining a comprehensive image of the patient. Even if one follows Hoffer (1985) in acknowledging the priority of working through intrapsychic processes, there is a big difference between whether this priority is within the context of knowledge about the patient's social reality or whether it is simply linked to an ignorance of the patient's social frame of reference. A properly understood sense of neutrality is thus a balance between prejudice and being uninformed.

2. Cautiousness: Avoiding Domination and Aloofness

Caution toward feelings coincides to a large extent with the problem of handling countertransference (see Chap. 3). Here we will only explain the problem of drawing a line. The analyst is advised to display reservation in paying attention to or acknowledging countertransference because there is the danger that the analyst might seduce the patient or vice versa. On the other hand, an extremely souvereign and objective treatment of countertransference leads the patient to have the impression that the analyst can never be reached, injured, or offended. This experience might ultimately so discourage the patient that he gives up his efforts to please the analyst - out of resignation, not out of insight.

For the patient to achieve structural change it is necessary for the analyst to admit that he has human reactions and yet to retain his professional role and thus to resist being seduced or destroyed. In this regard it is also necessary for a balance to be recreated in each and every session in the therapeutic process.

3. Openness in Values - Neither Partial Nor Faceless

Freud's warnings apply to the danger that the analyst might impose values on the patient. This danger seems minimal if the analyst and patient share the same sociocultural values. We know, however, that the chances of success sink the greater the discrepency between the systems of values. The distance can only be overcome if the therapist is able, at least temporarily, to identify with the patient's system of values; othewise he sacrifices the opportunity of adequately understanding the patient and of helping him make progress within the framework of his understanding of the world. Depending on how flexible the analyst is, at some point a limit is reached at which this identification is no longer possible, which makes it necessary for the analyst to depart from his ideal of neutrality (Gedo 1983). The large scale on which some analysts reject patients because they "simply can't" work with them reflects, on the one hand, wise foresight; on the other hand, the spectrum of patients that are not excluded very clearly demonstrates how rigid or flexible the analyst is toward his own system of values.

An analyst's neutrality toward his own set of values quickly reaches its limits in the daily work of analysis. He inevitably provides at least some indication of his own attitude when he confronts the patient's values. The patient interprets every "hum" at an appropriate spot as a confirmation of his view of things, and comes to demand it as something he is entitled to. In contrast, the patient may interpret any omission of a "hum" where one might be expected on the basis of the style of the presentation to be a sign of skepticism and disguised rejection. Although the analyst can mention his doubts about such interpretations, it is very difficult to convince a patient that such a perception was wrong, especially since patients' perceptions are frequently intuitively correct. The more alive and natural the analyst is in dealing with his patient, the more indirect expressions of opinion are contained in the concrete interaction.

Greenson (1967) has described a vignette exemplifying how the analyst's political opinion can be made visible in paraverbal expressions, which can make the patient feel that he is under pressure. Lichtenberg (1983 b) has also described a case in which the analyst's actions expressed specific values that were visible to the patient and that obviously exerted an influence on him.

An apparent way out of this dilemma is for the analyst as a matter of principle to restrict himself to a minimum in providing confirmation, making it more difficult for the patient to perceive where the analyst secretly approves and where he has doubt or is being critical. Although this enables the analyst to gain better control of the danger of indirectly expressing an opinion, it also makes him appear impersonal to the patient, making it impossible for him to fulfill his function as an object of identification (see Sect. 2.4). The amount of involvement that is necessary in an undisturbed course of therapy depends on the personalities of the analyst and the patient. Decisive is probably less the degree of the disturbance than the nature of the primary socialization of each participant.

4. Being Open to the Direction of Change

Especially complicated is the relationship between analytic neutrality and the analyst's goals in therapy. Therapeutic goals are necessarily linked with values, and it is with reference to such goals that it is easiest for the analyst to assert his values. That Freud had concrete goals of change in mind can be seen in the fact that he actually assigned the analyst the task of improving and educating the patient (1940a, p. 175). Yet in the same breath he warned analysts against misusing this function to create the patient in his own image. Clinical

experience demonstrates that an analyst succumbs to this danger most easily when he knows that he is close to the patient and feels bound to him by strong sympathy. The situation in which the analyst indirectly influences the decision-making processes usually coincides with the patient's willingness to please the analyst; such behavior can therefore take on very sublime forms.

A questionable solution is for the analyst to forego the determination and pursuit of therapeutic goals or to phrase them so loosely that they become meaningless. It is in this guise that "nontendentious psychoanalysis" celebrates its revival: the only goal that remains is "to discover the traces and dents that growing up in our civilization leaves behind" (Parin and Parin-Matthèy 1983), if one then does not want to pursue the general goal of transforming terminable analysis into an interminable one, and in the process making the psychoanalytic process into a goal of its own (Blarer and Brogle 1983). Here, too, idealization and immunization are at play; in very few cases is it sensible to have only the patient's self-analysis in mind and leave its consequences entirely up to the patient - and even in these few cases, this can only be done in an especially satisfactory phase of analysis. Self-analysis is no sacrosanct value that is never misused and whose independence from the social context is guaranteed. We tacitly link the ideal of self-analysis with the idea that it proves to be worthwhile in each individual situation. The specific meaning of "proves to be worthwhile" depends on the criteria that both the analyst and the patient apply to their situations in life. As a rule, it is the patient's neurotic problems that cast doubt on the worthwhileness of the psychoanalytic process, and an analyst demonstrates a substantial amount of disinterestedness if he remains indifferent to the consequences of the analytic process, even if they violate the patient's own best interests.

Even Hoffer, whom we referred to above, succumbs to the danger of denying this empathy toward a fellow human being when he compares neutrality with a "compass [that] does not tell which way *to* go, but helps us to see which way we *are* going and where we *went* " (1985, p. 791). In this metaphor, neutrality denies the interest and influence the analyst has in and on the patient. The compass metaphor also recalls the metaphor of the analyst as a mountain guide, which Freud regarded highly. A substantial amount of knowledge is in fact required for the analyst to correctly estimate the dangers posed by different routes and the patient's capacity for solving problems, in order to avoid serious complications. The therapeutic ideal of impartiality cannot amount to providing rules of behavior that save the patient from making the experience of testing himself or to treating him like a child. Neutrality, however, cannot consist in leaving the patient alone with his self-analysis when it is proving to be a failure.

5. Cautiousness About Exerting Power

The influence that power exerts on the psychoanalytic process is rarely made an object of reflection, a fact that has often been the object of polemics by critics of psychoanalysis. These polemics correspond to a tendency of analysts to use a reference to the analytic technique as a means to avoid the real issues. Yet to argue that the analyst does not exert any power because he limits himself to making interpretations and to abstinent behavior is not an adequate response to these problems. Some elements of the analyst's behavior can play a role in struggles between the analyst and patient precisely because of the meaning the patient unconsciously attributes to them. It is well known that an analyst can employ interpretations to get the patient to accept certain conditions of the setting. The discrepency between the patient's power and the analyst's is further increased when the analyst makes deep interpretations utilizing privileged knowledge about unconscious truths.

The analyst can employ his silence as an instrument of power, just as the patient can experience it as being one. In a favorable case the patient can feel satisfied in a state of regression. The analyst should not ignore the fact that a lack of feedback during a long period of silence can have numerous consequences - the more silent an analyst is, the more powerful he becomes for the patient and the stronger is the reactivation of infantile patterns of

experiencing (see Vol.1, Sect. 8.5). It may be a pleasant self-deception for silent analysts to believe that they behave particularly neutral because they never make statements of judgment. Yet in the process they deny the fact that a patient who has longed for some form of emotional response might gratefully accept the slightest statement or impulse. Even the fact that the analyst simply opens his mouth at certain places will direct the patient onto the analyst's unstated intentions. The analyst can in this way, of course, manipulate the patient's resistance, but not resolve it in an analytic sense. The analyst's inscrutability is a fiction concealing the misuse of power. Truly inscrutable for the patient would only be an unempathic analyst whose reactions are incalculable and inconsistent.

The misuse of power in deliberate silence or forced interpretations has been especially criticized by analytic self-psychology (see Wolf 1983). On the other hand, referring to the concept of empathy does not provide a guarantee against the misuse of power; even an empathic analyst has power and can misuse it. Therefore if neutrality is supposed to be realized as an ideal for therapeutic technique, then it cannot consist in abstinence, being silent, or making forced interpretations. The ideal position is in the middle, with the patient codetermining to an important degree the course of things yet without him having complete control of them. The danger of a misuse of power is substantially limited if the analyst makes his technical steps comprehensible to the patient and reflects together with the patient on the power contained in them. Reaching agreement on the delegation of power creates space in which the analytic situation can unfold.

Example

We would like to illustrate the different dimensions of neutrality by referring to an example taken from the analysis of a 30-year-old man. He sought help for anxieties related to his body, which were connected with problems in his relations to his partners.

At the beginning of approximately the 200th session Norbert Y expressed his concern at recent acts of terrorism. On the one hand, he was anxious about being affected by a terrorist act, yet he also thought wrathfully that it served people right for the terrorists to defend themselves. He said that inconsiderateness had become so widespread that life had become difficult to take. The limits of what people could be expected to tolerate had been long transgressed in the area of environmental pollution. In this phase I primarily listened to the patient, only asking questions or making comments to clarify what he said.

Next the patient described how he recalled a situation with an inconsiderate driver, who did not pay any attention to pedestrians. He had sometimes really enjoyed, when he had been out with a pushcart, pushing the cart so that he blocked traffic, making the drivers in back of him proceed at a slow pace. During this story I again mainly listened to the patient. He then described a fight he had had with his girlfriend, in which he tried energetically to resist her attempts to tell him what to do. The patient described a relatively harmless situation and his intense reaction to it. He had made a massive attack on her, calling her unattractive and an egocentric dragon and saying she did not have a trace of tact. It was possible to sense emotionally the patient's feeling of triumph at having so successfuly defended himself.

I was so moved by his report that I remained silent at this point although the patient was obviously waiting for me to make some approving comment. The patient then complained that I obviously did not support him in this point, but took his girlfriend's side. Becoming increasingly enraged, he then complained that I took his girlfriend's side more frequently than his although he had read that analysts are supposed to support their patient if they really want to provide help. He felt, however, that I had abandoned him in this matter, adding that maybe I was not an analyst who

had the patient's interest at heart and I only gave therapy by following the instructions in some book.

I told the patient that he had apparently noticed that his report about his argument had irritated me, and that the fact that I had offered him so little support apparently hurt his feelings. I added that in that moment I was apparently interchangeable with his girlfriend, whom he had also picked to pieces. I had also become interchangeable with inconsiderate polluters and drivers.

Here the patient hesitated, saying after a pause, "First I thought that you were going to throw me out, and then I suddenly became afraid that you were really going to give me a grilling."

This comment in which grilling was the object of his anxieties attracted my attention, and I asked him about it. He had ideas such as that I first wanted to sound him out, only to then show him how confused, dumb, and clumsy his thoughts were. It was possible to relate these thoughts, which the patient himself experienced as being nonsensical and also embarrassing, to a part of his relationship to his mother. According to his recollection, she had spoiled him, but had also intentionally made him feel like a dumb and awkward boy, especially in the presence of relatives and friends. That he was so enraged in such situations that he began to cry just made the whole affair worse. I had already been aware of these individual items from his biography before the session, but it was only now that I was able to understand how immense his feelings of shame and helplessness had been, and how much greater was his need to act wildly, as it were, to liberate himself from his helplessness. His argument with his girlfriend had apparently reactivated this tendency to react uncontrollably as a preventive measure. When we had grasped this mechanism, the patient was able to reestablish a normal distance to me and to his girlfriend, whose opinionated manner continued to upset him but ceased to be a source of anger.

This example demonstrates that the analyst did not have to comment on the patient's political opinions and that this did not disturb him during his later critcal comments about me. In analysis, psychic problems take priority and political values become secondary. In the inital phase of this session the analyst was especially interested in the patient's affect, and it was not difficult to discover aggression in his comments, whose origin at this point was unclear.

The patient's story about the inconsiderate driver and how he had taken revenge on such people differed from his comments in the previous episode in that the patient in this case made his own behavior the object of discussion. His behavior contradicted the ideal of self-responsibility, since the patient interpreted the situation of a victim as justifying his own inconsiderate actions.

The patient's comments about his argument with his girlfriend was a kind of intensification of the previous episodes. The issue was once again a complaint about inconsiderate behavior and aggression, which led the patient to express massive criticism of his girlfriend. Here too the patient had obviously experienced himself primarily as a victim and expected the analyst to agree with him. The discrepency to the ideal of self-responsiblity was so large here that the analyst was moved and obviously was no longer able to follow the patient emotionally and denied him the sign of understanding that he expected, even if only in the form of a "hum." In doing so the analyst transgressed the limits of the kind of behavior that the patient expected. It is possible to argue that the analyst only refused to make an explicit value judgment or to take the side of either the patient or his girlfriend. For the patient, however, the analyst's explicit refusal to take sides was not an example of neutrality, particularly since the analyst had previously been understanding. Therefore the patient had to conclude that the analyst had secretly taken a critical stance toward his actions. It was therefore logical for the analyst to confirm the plausibility of his perceptions (Gill 1982).

This change in behavior made the analyst into an inconsiderate object for the patient, which he promptly attacked and whose value he denied. It was important at this point for the

analyst to bear this criticism without being insulted or injured, but also without accepting a position of aloofness.

The purpose of the analyst's interventions at this point was to signal his interest in the patient's emotional reactions. The fact that the analyst's comments were *even* harmful remained secondary. Fortunately the patient responded to the offer; he did not rapidly retract all of his statements or intensify them defensively, but reported about a new emotion, namely his fear of the analyst. It was only at this level that the mutual interest in understanding each other took priority over the condemnation of actions and it became possible to understand the patient's anxiety and his overreaction as a kind of exaggerated preventive response that corresponded to his earlier traumatic experiences.

7.7 Anonymity and Naturalness

We contrast the behavior of an anonymous and impersonal analyst with his natural behavior because the latter definitely expresses a personal touch. We hope that the latter approach will help us resolve difficulties that arise within a relationship between two parties who have different interests. These differences do in fact exist, and even the legitimate criticism of the exaggerated stereotypical descriptions of these roles does not justify ignoring them. In the office the analyst's role is different than outside it, and the same is true of the patient. This topic therefore poses a challenge for us to locate the sensitive points at which they intersect. Meetings outside the office, which we will pay special attention to, must be considered in light of the analytic situation - and vice versa, i. e., the definitions of the different roles are interrelated. The problems that patients and analysts have when they meet outside the office add another perspective to the subject of naturalness in the office.

"If in doubt, act naturally" - this recommendation is only easy to make in a state of sociological naivete because the issue of being natural originates in man's *second* nature, i. e., from his socialization. For example, experience shows that it is difficult for analysts and patients to talk in an unconstrained manner when they happen to meet outside of the office. This is presumably related to the differences that exist between the psychoanalyst's office and other social situations. It would be inappropriate for the patient to let himself freely associate in public, and the analyst would behave conspicuously if he refused to talk about the weather or vacation plans and instead remained silent or interpreted the conversation. The contrast that each experiences is intensified by their inequality. The patient is insecure because he is anxious that the analyst will use what he knows from treatment; he feels embarressed. On the other hand, the analyst's spontaneity is restricted because he thinks of the consequences it might have on the analysis.

The intensity of the contrast between the therapeutic situation and outside it can be expressed in numerous forms, as can the topics, and numerous factors are involved in determining which forms are taken. This makes it impossible to provide a comprehensive description by compiling a list of examples. Acknowledging this situation is the decisive precondition for reaching an adequate solution to the problem it poses. By admitting that he is also affected by this contrast, the analyst makes it easier for the patient to find a suitable role and to be independent in it, which in turn makes it possible to fulfill the goals and tasks of the treatment. The analyst's functions in the therapeutic situation can be described in terms of role theory and then compared to other roles that the analyst has in other capacities, for instance as the head of a discussion group or as a politically active citizen.

The acknowledgment of this diversity of roles implies contrasts, and the patient and analyst classify the latter on the basis of comparisons with the experiences that they have had with each other in therapy. To take an example concerning naturalness, it was not until the end of her professional career that Heimann (1989 [1978]) discovered that it is necessary for the analyst to act naturally toward his patient. We refer to this as a discovery without a trace of irony because Heimann, who intuitively never had difficulties being natural as an analyst, was unable to admit until this late publication that acting naturally is therapeutically necessary and therefore justified despite her acceptance of neutrality and anonymity. It was

hardly a coincidence that this publication had the involved title "On the Necessity for the Anaylst to Be Natural with His Patient." This text is relatively unknown, and has just recently (1989) been published in English.

Rules that exclude spontaneity and stipulate that the analyst must first reflect before reacting demand the impossible. If the analyst believes that spontaneity is incompatible with his professional role, he will feel particularly unfree when he is together with a patient in social situations. The patient, in turn, will be eager to make his analyst finally act or say something spontaneously in the analysis itself or to meet him on a person to person basis outside of analysis.

There are many factors that justify the assumption that the rule "if in doubt, act naturally" is easier to accept than to follow, whether in the analytic situation or outside it. We would like to mention several instructive examples. Many analysts avoid their patients if it is at all compatible with social norms. Candidates in training, who themselves avoid meeting their training analysts, are particularly affected. If a meeting does take place, any conversation that results is more likely to be inhibited than free. The unnaturalness is greatest in training analyses, which candidates assume to be a model of pure and untendentious analysis. The unfavorable consequences of a teacher-student relationship in which the master avoids even professional encounters, e. g., in seminars on technique, have been known for a long time. Fortunately there have always been some opportunities to make corrections. Each contrapuntal experience with a training analyst has a deidealizing function and is easily remembered. Although the question of whether all the stories that are later told can be believed is another matter, we must ask ourselves why a spontaneous comment by the analyst, which a third party might find completely banal, might retain a place of honor in a candidate's memory, and why many profound interpretations sink into oblivion. Everything exceptional occupies a special place in our memory. For example, the *one* and only direct confirmation that an analysand receives in analysis becomes something unique.

According to Klauber (1987), the analyst's spontaneity is necessary to enable the patient to moderate or balance the *traumas* originating in transference. Yet if the analyst's naturalness, which we equate with his spontaneity, has a compensatory function, then the strength of the traumas is something that depends in part on the analyst and his understanding of the rules. The problems that arise during encounters outside the office become greater to the degree that both participants avoid acting in a natural manner within therapy.

Acknowledging the diversity of roles that the patient and analyst play in public and private life can increase the tolerance for differences. It is therefore essential that in their training candidates develop an uncomplicated relationship to the various roles they will play in and outside their professional lives. The degree of natural behavior by their analysts that candidates experience both in and ouside psychoanalysis is an instructive measure for such tolerance toward the diversity of roles. We have investigated the changes in the system of psychoanalytic training from this point of view and reached a disturbing conclusion. Even into the 1940s it was frequently the case that analyst and analysand alternated roles and played different roles. The story of Freud's best known patient, the Wolf Man, was full of complications and entanglements that Freud and many of his students were involved in, as Mahoney (1984) described in his comprehensive report. The mingling of roles that M. Klein practiced was no less varied, as can be learned from Grosskurth's (1986) biography. This diversity of roles seems to have played a large role into the 1940s, particularly in the formation of different schools. Many of the analysts in training at that time were embedded in a frightful entanglement of personal, professional, and institutional interests. In hindsight it is easy to understand that reaction formations occurred, which after the experience of such "human, all too human" behavior swung to the opposite extreme. We gave too little consideration to this side of the development of the psychoanalytic technique in the relevant passages of Vol.1 (Chap. 7 and Sects. 1.6, 8.9.2). The painful experiences of many analysts have contributed to the sudden change from a diversity of roles to stereotype ones. Once schools have begun to form, then the adherents are always less tolerant of deviance than the master. By reactively adhering to written prescriptions, it is extremely easy for such idealizations to be combined with the interests of each group in professional politics.

Naturalness was lost in the stereotype role of the impersonal analyst. Although this apporach made it possible for much confusion to be avoided, the idea of finally being able to arrive at an analysis of a pure transference free of all outside influences proved utopian. *Traumas* resulting from *stereotype roles* took the place of the burdens resulting from a *mingling* of roles.

This dichotomy cries for a third option, which we have described at many places in Vol.1, in particular in discussing the extension of the theory of transference. Viewed from the perspective of role theory, the analyst's tasks imply certain definitions of his role that have practical consequences in therapy and with which the patient becomes familiar. The patient unveils his own world in the analyst's office, including the roles he plays and the ones that come naturally to him, where he is genuine and where he is phony, and how he can find his way to his true self. The fascination exerted by self-realization and even more by the search for one's true self is connected with the fact that precisely the latter lies in the sphere of unlimited opportunities or seems to lie in the still unconscious preliminary forms of one's own prospects in life. The dreamer's script contains foreign, supplementary, and desired self-representations. It is precisely the still unborn and the unconscious anticipations that are brought to life in the analyst's office. The patient knows from his own experience that the analyst also feels at home in many roles and is in a position to respond to certain roles that the patient offers and to react emotionally to them. The patient may pull all stops to test the analyst's capacity for empathy. If there were no natural reactions, transferences would be nipped in the bud and die off. This unique stage permits the analysand to perform trial actions free of all danger, the precondition being that the analyst provides confirmation and offers him roles that correspond to the patient's unconscious offers (see Sandler 1976). The professional restrictions on the relationship between patient and analyst become a symbol of *borders* that as such also provide *security* . The limited space in the analyst's office becomes a simile for protected naturalness.

The rediscovery of spontaneity and naturalness means that the patient may learn more from and about his analyst that he already knows about the latter's feelings and thoughts from the interpretations. It is precisely via interpretations that the patient gets to know himself from the analyst's point of view, and for this reason we believe it is extremely important for the patient to become aware of the larger context in which the analyst's comments, statements, and interpretations are part. *It is therapeutically essential for the analyst to let the patient share in the context and to reveal and ground the background of interpretations.* This must be distinguished from letting the patient share in the analyst's countertransference. The less the patient knows about the context, the more curious he will be to learn more about the analyst as an individual. It was unfortunately quite late when patients made us aware of these very neglected and yet easily resolvable problems of psychoanalytic technique (see also Sect. 2.4). From this position there is a rather simple answer to the question as to what the patient may learn in the office about the analyst as an individual, namely everything that promotes his knowledge about himself and does not obstruct it. Via the analyst's naturalness, the patient learns corresponding facts about himself. Even a deficit can be the starting point for discoveries because it would be a contradiction in itself to fulfill some conventional expectations or to equate them with natural reactions. Obviously, the analyst's spontaneous and natural behavior can stay within the code of socially accepted behavior or transgress it. The latter seems to be the case particularly when a specific countertransference is precipitated. The recommendation "if in doubt, behave naturally" is oriented on the rules of accepted social behavior, which meet in common sense.

Thus the analyst will behave naturally in his office and at coincidental encounters outside it if he structures the expectations associated with his various roles in a personal manner. This still leaves much room for spontaneity in connection with a patient's particular circumstances. A rich source of psychoanalytic knowledge would dry up if analysts adopted an anonymous stereotype role.

We would like to explain our comments by referring to two examples. First we describe how a female patient gave a bouquet of flowers to her analyst. Although we by no means categorically reject the rule of never accepting presents, on the basis of our experience we are

convinced that rejecting presents often prevents analysts from recognizing their true meaning. Rejections and condemnations can have consequences that are very difficult to correct (see Van Dam 1987; Hohage 1986). Accepting flowers naturally has consequences on the analytic process, but more important is the question as to which form of behavior has the more favorable consequences in a particular situation and which criteria the analyst should use to make a decision.

In the second example we describe an encounter in the office building but outside the analyst's office. It would be easy to mention many more examples. In large cities many analysands belong to the same social strata and professional groups as the analyst, and encounters between the patient and analyst at cultural events can therefore be frequent even in large cities. In our opinion it is only natural for a feeling of insecurity to arise during such encounters.

First Example: Flowers

Amalie X held a bouquet of flowers in her hand as she greeted me.

P: It may not be very original, but it was my idea!

I accepted the flowers, noted that they needed water, and put them in a vase. Of course, there was the rustling of paper, action, brief comments, the sort of thing that happens until the paper has been removed and a suitable vase has been found.

P: They're bound to fit; I bound them extra tight.

A: The flowers are lovely.

The patient explained that she had had the idea the night before, and that just before the session she had received flowers herself, which made her think of it again.

P: I asked myself if it would be better for me to have them sent to you at home.

Yet then she added that this thought had probably been just an excuse.

A: There were other, more important reasons.

P: I thought that I wouldn't have to run amok as much here. [She laughed and corrected herself.] No, how do say, run the gauntlet [laughed again], yes, not amok or run the gauntlet if I have them sent to you at home, it would simply be more discreet and, uh, I don't know, maybe I didn't want to be that discreet . . . .

She herself discovered that the flowers "are simply a combination of things that happened on the weekend, so I don't know quite rightly what they mean either." She talked about the connections to the flowers she herself had received just prior to the session. And she mentioned the visit of an acquaintance who was a student and knew me.

P: And he talked about you from the perspective of a student, and somehow it bothered me terribly, because I suddenly knew things about you, not much but still . . . despite my great curiosity I have never heard much about you. You've never left your place, and somehow the flowers may be something like, well, I can't really say . . . .

Consideration. Amalie X forgot what she had wanted to say, and I could tell that the tension was gone. I assumed that she had encountered resistance, presumably because something critical had been said about me.

I pointed out to her that she had only given a very brief summary of what the student had said. It turned out that the young man had asked if she got along with me; he had said he did not because my manners were not direct enough, too involved.

P: And then I had the feeling, today with the flowers, it's a kind of compensation, but the word bothers me because it's not compensation. When my acquaintance said it, it didn't bother me, because I've often had the same feeling. Sometimes

your sentences just never end. Just two sessions ago we talked about it, but I've sometimes asked myself, "Why does he intentionally want to teach me I can't think," and in a way this was just a compensation for these years . . . . For a long time I thought that you were trying to prove to me how complexly and multifacitedly you can think and leave it up to me to follow you or not. And the moment the student said that he looked at it the same way and when he even dared to call it "involved," it was naturally a relief for me, hum, and at the same time I thought that somebody should stop the nasty boy from talking that way [laughed while talking].

The patient then spoke about her experiences with difference acquaintances she had made via newspaper ads, and how confused it all made her.

P: Okay, somehow everything I do seems to work, and probably to keep it all and to guarantee it by linking it to you, I bought the flowers [laughed briefly]. Somehow that seems to come into it. Yes, I believe in such a superstitious talisman. You see everything you're good for, even right now.

A: As you said a moment ago, the flowers are supposed to end the confusion.

The patient then told me about another episode that confused her, in which she was supposed to give another man flowers.

P: I naturally wanted to give S. the flowers, but there was too much distance, in every sense, and then you had to stand in. It's not very nice. [Brief pause] Are you hurt? [Brief pause] Oh, yes, of course I won't get an answer.

A: And how could it hurt me if the distance is too large or that I have to be a stand-in?

P: The latter might hurt *you* . *I* am hurt that S. isn't close enough. [longer pause]

A: And the flowers here reduce the distance to me.

P: You sometimes have a way of taking things right out of my mouth and neutralizing them at the same time. Oh, it triggers different things, actually always two kinds of feelings. On the one hand I hold it against you, but it also fascinates me.

A: Yes, because you've used the flowers to neutralize it yourself. [Short pause]

P: Who or what?

A: Amok. [Patient laughs]

Commentary. This comment triggered a surprising turn in the conversation. The patient was in a state of inner tension before she gave the analyst the flowers, which caused her to make a slip of the tongue. Her anxiety about being criticized was expressed in her thoughts about running a gauntlet, but she fought against this subjugation and ended up with amok. There was thus a lot bound up with the flowers, even long before this session. If the analyst had not accepted them in a friendly manner, then this instructive dialogue would never have taken place.

P: I have to laugh because I believe I've hardly ever made a slip of the tongue. I believe that I've rarely done you the favor, don't even need two hands to count the number of times, but that's not much over a period of 4 years . . . . That it's not very easy with the flowers is probably clear, but it's okay. In the waiting room I said to myself that I would give them to the secretary. I had the feeling that you are mad, which was the reason I had to say that the idea was not very original, to excuse me as it were . . . . I had the feeling I would have been indiscreet, uh, showed something, I should have had them brought to your house, with a card and glove. [Laughed and sighed at the same time]

A: Why did you think that it isn't original?

P: Well, I have to say something. Most of all I would have liked to have simply beamed at you [laughed]. Now I've at least said it.
A: With your flowers, to show me your shining directness, namely that you've made the decision to answer the ads in the paper.
P: Yes, it stands for that, because the things I have experienced, especially in the last few days, but also in the last few years, the things I was terribly afraid of doing, that if I did do them then it has always helped me get a step further . . . . and without being here I really wouldn't have done a lot of things.
A: Yes, I'm very happy for you and thank you that you have mentioned it and that I was able to help you a little to do the things that you want to do.

Commentary. At the end of the session the analyst thanked the patient, in a context that offered encouragement and confirmation. This was the preliminary end of this interpretative work.

Second Example: Encounter Outside the Office

When patient and analyst meet outside the office it is not easy for either one to behave in a natural manner that is fitting to the situation or to talk in an unforced manner. The dialogue in the office is too intensive and too different in nature for them to be able to easily find their way into different social roles. We recommend that these difficulties be acknowledged, and in our experience this can have a liberating effect on both the patient and the analyst.

Erna X was walking past me into the building; I was standing together with a group of men. At first she thought it was the janitor, because my suit was blue. This thought startled her, and her insecurity about how she might get passed this group of men became unbearable. The following is a summary of her most important associations.

She said that Mr. Z, the janitor, is friendly, in contrast to many of the people she encounters in the building. It is unusual for anyone to say hello. Maybe the staff believes they're not permitted to look at the patients. The ladies and gentlemen whose rooms are up here would walk past you and would be unfriendly, dreamy, absent-minded, carrying books. The janitor's friendly manner was in clear contrast to their behavior. "Maybe that's I why I associate you with the janitor, because he's the only friendly person in the building."

The next theme was her double role as woman and as patient and being greeted as such. As a patient she should greet the doctor, but as a woman she should be greeted. My interpretation referred to her insecurity in these roles. "Are you the patient who greets humbly, or the woman who expects to be greeted and is pleased when people pay attention to her? Attention expressed in everyday life by the fact that women are greeted by men." The patient recalled memories of her childhood, and that as a child she had had to greet people. "It was very important to my grandmother that people thought I was a friendly child." I interpeted her anger at her having been so obsequious, which in turn increased her insecurity. I also mentioned the possibility that she might greet so rapidly in order to avoid situations in which she was greeted first. Thus she did not give male doctors the chance to pay attention to her and to fulfill her wish. She admitted that she avoided such embarassing situations; she put her coat on by herself and did not let anyone help her to avoid becoming embarassed.

She then recalled memories of her puberty. She was embarassed when her father or uncle helped her into her coat. "You feel you're being watched. He holds the coat, and I don't get in. If you held the coat for me, I would be excited and surely

make a mess of everything. It's a form of attention that is irritating." She preferred to leave her coat in the car, to avoid the problem of putting it on and taking it off again. And on this day she would have gone a different way if she had known that she would have to walk past me. I related the previous role conflict with the momentary one in the following interpretation.

A: It wasn't right for people to view you as a growing young woman. Then you would have had wishes, wishes that in a broad sense have to do with getting dressed and undressing, with being seen and paid attention, with being admired.

P: I still feel like a small girl.

The subject of dressing and undressing had already been a topic the previous week. The patient recalled that she had thought for several nights about the following scene during the period we talked about someone helping her into her coat. Her aunt and uncle had often come to visit, and she went to bed early. Twice it happened that her uncle entered her room without knocking. She had been undressed, almost naked. To relieve the patient I first referred to her uncle's role.

A: Perhaps he was curious. It wasn't a pure coincidence, was it?

P: It was terribly nasty of him. He had had something to drink. It was all very disturbing. And I couldn't say anything because I was the little girl who wasn't supposed to be bothered by such things.

A: If you had complained, then you would have made it known that you no longer experienced yourself as a little girl, but as a young woman who was aware of her erotic attraction. You would have made this plain if you had complained.

P: He would have said, "What do you want?" And my parents would have said, "What are you thinking of? What dirty ideas do you have?" This uncle was always telling jokes, and I wasn't supposed to laugh. If I laughed, then I was asked "Why are you laughing? You don't understand any of it." I stopped wanting to laugh. I still haven't got over these two experiences.

She had come up with all sorts of tricks to prevent her uncle from entering her room.

Prior to a later session there was a comparable scene outside my office. I had seen the patient coming through the main door and was ahead of her on the stairs. To avoid having to walk up several flights of stairs together, I went into the office of a colleague, with whom I had wanted to discuss something anyway. My reaction was both reflexlike and intentional, and I had the preconscious intention of avoiding the complications that frequently occur from walking together. I had forgotten the earlier scene.

The patient thought that I had quickly gone into my colleague's room for her sake and to save her an embarassing situation. At some point I mentioned that I did not have any recollection of the janitor scene, which was long ago. I told her I had in fact had something to discuss with a colleague, yet added that it was not easy for me either to handle the problems that occur during encounters outside the office. I said I also felt a little embarassed and the situation would be awkward because making small talk would be very different from the analytic dialogue, but not to say anything would also be very unusual.

This comment made the patient feel very relieved. It was objectively, as she expressed it, not easy - even for me, the analyst - to solve this problem. Walking along silently would contradict accepted social behavior. It was, instead, rather customary to exchange a few words after greeting. I added, "That's also how I feel about it, but there is no reason we have to act that way. Why shouldn't we just walk together without saying anything."

7.8 Audio Tape Recordings

Instead of constructing an ideal of the psychoanalytic process, such as Eissler (1953) did, only to have theoretical arguments about which compromises are more or less acceptable, we believe it is more meaningful to investigate the influence exerted by various factors. One of these conditions that we have examined in detail is the subject of audio tape recordings (Ruberg 1981; Kächele et al. 1988). Our results indicate that the specific impact of this variable can be recognized and worked through in a therapeutically productive manner. Some problems are even encountered more rapidly, showing that projection onto the tape recording can be a starting point for a productive dialogue.

In our experience both parties become accustomed to the idea that third parties might listen to their dialogue. The tape recording then becomes a part of the silent background that, like all the external factors in the psychoanalytic situation, can have a dynamic effect at any point. The simple presence of both the silent recorder and the inconspicuously placed microphone remind the participants that they are not alone in the world. The procedures used to make the analysand anonymous and to code the tape can also become a topic for joint thought, even though confidentiality and the removal of names are two preconditions for the introduction of this aid. Of course, this protection only applies to the patient. The removal of the name of the analyst in question does not prevent colleagues from finding out who the treating analyst was. They can easily recognize in the published dialogues the analyst's manner of speaking and the way in which he thinks and acts analytically.

In our opinion there are many reasons it can be useful for analysts to inform patients about the purpose of the recordings of therapy. The most important is that the analyst is willing to consult his colleagues. However, the style of discussion that still predominates among analysts makes it comprehensible that the majority of analysts still hesitate to use this tool, although it is better suited than any other means to improve therapeutic skills by stimulating critical reflection of the transcribed dialogue.

The analyst has, of course, not only a right to personal privacy but also to organizing his professional sphere according to his own best convenience within the profession's system of values. A specific mixture of various character features, which have to be paired with scientific curiosity and a belief in progress, probably make it easier to commit such an act of largely unprotected self-exposure to the profession. At any rate, we have tried to make a virtue of necessity and ascribe a curative function to the introduction of audio tape recordings in several regards: for the individual analyst, whose narcissism is put to a hard test; to the profession, which no longer has to rely solely on recollection in scientific discussions, but can refer to authentic dialogues; and to the patient, who can indirectly profit from it. It is a sign of the times that some patients even bring their own tape recorders. It is advisable to reckon with such surprises. Since it can certainly be useful for a patient to reconsider dialogues, the analyst should take this interest seriously, even if such an action should be motivated by the unconscious intention of being well prepared for a malpractice suit. Shocking was a dialgoue that Sartre (1969) commented upon, to which a patient had coerced his analyst and which he had recorded. In that interview it had come to an reversal of roles; the patient tormented his analyst with precisely the castration interpretations that the analyst had allegedly given him for years.

For the psychoanalytic profession it can at any rate hardly be harmful if original recordings or transcripts are used to enable researchers to examine closely what psychoanalysts say and do in therapy and to identify which theories they follow. It might have a positive effect on the narcissism of individual analysts for them to be confronted with their own therapeutic behavior. To allude to a well-known expression of Nietzsche's, in the struggle between pride, deeds, and memory, the voices on the tape recording revive memories that make it difficult for pride to remain relentless and triumph over memory.

7.8.1 Examples

The community of psychoanalysts is apparently more disturbed by the introduction of audio tape recordings than are the patients. In attempting to locate the common denominator of their concerns we encounter once again Eissler's (1953) basic model technique and the "parameters" that belong to it, which we have discussed in detail in Vol.1 (Sect. 8.3.3). This model has created more problems than it has solved.

We have not yet experienced the situation that the resistances precipitated or reinforced by the presence of a tape recorder have not been accessible to interpretation. In the following we illustrate this with reference to our experience in using tape recordings, placing special emphasis on the interpretative response to the patient's reactions.

A Supercensor

Amalie X talked in the 38th session of her therapy about her experience with a therapy while she was at college. Her therapist at that time had not returned her diary to her, which had made her feel disheartened. I suggested that the fact that the analyst kept her diary corresponded to the tape recorder keeping her thoughts. The patient said that she knew nothing about the use of the recordings, adding "I also have to say that I'm not very concerned about it." In the following hour the talk also focused on *giving and taking ,* and I again mentioned the idea that the tape recorder took her thoughts.

P: That probably bothers me less; it's such a distant medium.

This answer made it clear that this patient managed in the initial phase of the therapy, after working through a disturbing experience from an earlier therapy, to arrive at a clear statement of how she viewed the situation.

Specific desires for discretion sometimes lead to the request that the tape recorder be temporarily turned off. This patient, for example, talked about a colleague who was also in therapy; she did not want to mention the name of the latter's therapist until the tape recorder had been turned off (85th session). The analyst can accept such a wish or can emphasize the aspect of resistance or explore ideas such as whether the patient believes the colleague might be negatively affected. The phenomenon that the analysand wishes to protect others by being discreet and therefore suspend the basic rule regarding a specific item of information also occurs, incidentally, in every analysis, including those without tape recordings.

Analysts can repeatedly observe the fact that thinking about the tape recorder can stimulate a thought to suddenly come to the fore in the patient's free flow of associations, as shown in the following example.

In the 101th session Amalie X spoke with great decisiveness about her sexual difficulties and managed to disclose a relatively substantial amount of information; in the middle of the session she became increasingly horrified by the intensity of her longing. I interpreted her anxiety "that she views herself and her fantasies as an addiction or as being perverse after all, and somehow I do too, and I only act as if I wouldn't find it perverse or addicting." The patient herself arrived at a differentiated opinion; "When I think about it, I know that this is not what you think." Yet she herself saw herself in such terms and was afraid that others would say something like, "Yes, the old X." In this moment she asked herself, "Is the tape recorder still running?" The thought was linked with the idea that an older secretary might type the transcripts, and other associations led to the father confessor etc.

In her 202nd session Amalie X took a statement I had made to be an explanation of my therapeutic technique. She found it "unusually positive" and mentioned the inaccurate assumption that the tape recorder had been turned off and that I was thus able to act more freely and was less inhibited. The patient imagined

that the presence of the tape recorder had the same inhibiting effect, as a supercensor, on me that the presence of her supervisor at work had on her. "If I don't see the black wire here some time, then you will feel freer and for once can say what you're thinking."

In the 242nd session the patient noted that the microphone wire was not on the wall. She speculated that the presumed disappearance of the tape recorder (or microphone) signalled the end of her therapy. She said she was afraid of the separation, and that her earlier idea that my colleagues would listen to the recordings and laugh at them had disappeared.

By the way, for this patient we can report that, based on the empirical research we mentioned at the beginning of this section, examination of a sample of one-fifth of all the sessions (113 sessions) of Amalie X's therapy showed that the tape recorder was a topic in 2.7% of them (Ruberg 1981).

A Fake

Franziska X had a positive attitude toward tape recording from the very beginning because her brother, who was a sociologist, had recommended that she use a tape recorder as a means of self help. The patient quickly developed transference love and exhibited the corresponding difficulties (see Sect. 2.2). In the third session she stated that most of all she would like to bracket out all the expectations, fantasies, and desires, simply everything that constituted the emotional involvement with the therapist.

P: Yes, if that would be possible, then it would probably be much easier for me to be uninhibited in describing things, if you weren't buzzing in my head, if I could turn you off completely, if I would just be lying alone in the room and talking to the tape recorder.

Here the tape recorder serves as an artificial psychoanalyst, not precipitating any anxiety about a loss of distance.

In the following session Franziska X asked if the tape recorder was turned on or not, since the cover was closed. She then told me that she had drunk a lot (several glasses) of wine the night before. I linked the two statements by asking whether she felt the desire for the recorder to be off. The patient responded in the negative, emphasizing, "No, I don't think so, it's never bothered me . . . [almost a little ironically] Perhaps I'm worried that my valuable comments won't be recorded . . . and perhaps it's running after all." Her ironic tone reflected her anxiety about her worthlessness, as was shown in the further course of the therapy.

The patient's reactions to the tape recorder changed in accordance with dynamic changes that occurred. In the 87th session she reflected on the pleasure and unpleasure she had in the therapy.

P: Sometimes I think about what we have already achieved in the analysis, and then I'm always overcome by the feeling that I would like to take all the tapes and throw them into the fire and start all over. I've talked the tapes full with bla bla. I imagine that in an session there might be one good sentence, and for this one sentence you have to sit and listen 50 minutes, hoping that one comes. Sometimes there aren't any. And that's why I believe that you then become dissatisfied and mad at me again.

A: That I use so much, use so many of the tapes, and get so little in exchange.

P: Yes, I feel as if I'm taking private lessons. I would like to be a good pupil, so that you might be happy with me.

In the following session Franziska X at first did not have many associations, but then explained that when she had the feeling she liked somebody, then she would "talk a lot, sometimes even too much . . . but if I have merely the feeling that they're cold, then it just doesn't work right." I related this to her associations about the tape recorder; "In the last session you had the feeling that you only reveal invaluable stuff; at least a good worm has to be in it for me." Franziska X confirmed again that she had the feeling that she always had to offer something special to gain confirmation.

Auditorium

Kurt Y, a scientist, was in analysis because of impotence and an incapacity to work. In the fourth session he glanced at the microphone as he entered the office, laid down, and after a short pause began to speak. He referred back to his experiences as a child, which had also been a topic in the preceding session. In general he had been a quiet, good boy; it had only been in his soccer club that he had been able to let out his pent up energy. He added, however, that he had always played poorly when spectators had been present.

A: As if you were afraid of the attention.
P: Yes, everything was over as soon as I felt the expectation that I would have to demonstrate my skills.
A: While you were coming in, you glanced at the microphone. Is there perhaps an expectation associated with it?
P: No, today I don't have to think about it much, but yesterday I noticed it. I had the strong feeling I had to fill the tape, that there couldn't be any gaps, that something had to go onto it.
A: These expectations, the ones you identify with the tape recorder, represent in your opinion the expectations I place on you.

Kurt Y began the 54th session with a comment about the tape recorder. He had the feeling he had to hold a speech, as if he were in an auditorium, and this was linked with the idea that what he had to say was not really finished and needed further elaboration. It was like in his workbook, where he recorded his notes about his experiments; he would not make it accessible to anyone prematurely. Kurt X talked for a long time about the tape recorder, leading me after a while to assume there was a resistance, and I told him that it seemed to be easier for him today to speak about the tape recorder than about other things. He then began to speak, albeit with many qualifications, about the sexual experiences he had had the past weekend with his fiancee.

At the beginning of the following session Kurt Y again referred to the tape recorder. He said it was much friendlier today, as if it were a third person in the room, someone he could imagine to be a young physician. He could bear it after all for someone to listen, adding that the recordings were presumably used for teaching.

The threatening, fascinating idea of the large auditorium had become milder, more realistic, and also easier to bear. This was accompanied by his resumption of his description of his sexual intercourse with his fiancee, which he told with visible enthusiasm. For some time intercourse had not been possible because of an illness she had had, and this had given him the feeling that the wall he had to scale was not so high after all. Yet as the weekend with his fiancee had approached he had registered how his anxious anticipation had constantly increased. And he had promptly been unable to do "it" that evening; in his helplessness he had not achieved an erection.

I offered the interpretation that he presumably had been unable to let himself fall, just like he here was unable to let go. I added that I assumed that he felt he was being watched and that he compared himself with other men, a fact he had not included in his description but I added.

He said that he had then slept "black," without dreaming, and tried to explain the color "black" from his dream, which seemed unusual to me. In the morning he had had a slight erection, and he had taken advantage of the situation to scale the wall.

I thought to myself that this had probably been a major barrier for him, just as talking about his sexual life was a major barrier that he scaled in this session. I told him so, and he was very surprised. Yet he agreed that it was true that he had never talked about it here although he had often felt the need to.

It was clear to me that the work on the meaning of the tape recorder, and especially the interpretations of transference that were associated with it, had reached him, and that he had therefore been able to scale the wall of intimacy in therapy.

In the 57th session I told Kurt Y about my vacation plans, including about a long absence that was partly for professional reasons. While thinking about the professional reasons that might lead me to make this trip, he had the idea that it might be to hold lectures. In this connection he mentioned the tape recorder again. This time it was an indication of scientific work, laboratory experiments, and that he himself was a guinea pig, all expressions of the therapist's coldness. The patient's mood changed, though, in the further course of talking about these feelings.

P: The tape recorder does have something positive to it. At the very least the tapes will stay here and thus something of our relationship will stay here as a kind of pledge.

I interpreted the connections between vacation, distance, and his reactions to them as a kind of fundamental question about what he was worth to me and how regularly I would be there for him.

Controls

In the case of Heinrich Y, my efforts to motivate him to undertake therapy were quite difficult, which let me envisage the problems that his general mistrust toward analysts would also mobilize against tape recording.

In the 16th session the patient surprised me by bringing a cassette recorder along, which he prepared for recording while he asked me whether he could use it. I pointed out the simultaneous timing of the two actions - the request for my approval and his actions as if I had already given my approval - and added that the recording of our talk had to be very important to him. Since I had previously obtained his informed consent for recording the sessions, I said it was only appropriate that I permit him to do the same. The patient laughed at this, obviously relieved. At this point I did not ask any more questions about the purpose of his actions.

Heinrich Y then began to complain intensely that, as is frequently the case at such an early stage of therapy, nothing was happening, that the therapy had shown little sign of success, and that his depressive states had begun to preoccupy him more again. On the previous weekend, he said, he had been at a conference on Zen Bhuddism, where he hoped to be able to obtain additional advice for helping him cope with his life.

A: Additional advice? That also means that our sessions don't provide enough.

P: Precisely, the sessions are over so quickly, and afterwards I can never remember exactly what happened.
A: But then tape recordings must be a desirable means to listen to everything in peace and quiet.
P: Yes, I hope to be able to work through everything in detail, to get more out of the sessions. I play them to my girlfriend Rita - who has had some experience with psychotherapy - and she can tell me whether everything is alright here.
A: Yes, in this initial period it seems natural to ask somebody for advice, especially since you were very reluctant in agreeing to undergo therapy. Your severe depression was precipitated, after all, by Rita believing herself to be pregnant. Might it be possible that the tape recorder permits you to exert some control on what you are able to speak about with me?
P: Rita should just find out how bad off I am and what part she's played in it.
A: So that this is an indirect means of telling Rita something that you cannot or don't want to tell her directly.
P: Well, things I say here, I can point out that it's part of the therapy.
A: That I'm responsible for it and you can't be held accountable for it.

At this point the patient laughed mischievously and emphasized that I traced his most secret thoughts. He added that it might be better after all for him to turn off his recorder and tell Rita that it simply had not worked correctly.

A: At any rate the space we share here would be protected from somebody's censorship. This would also provide some freedom.

This form of working through, however, did not deal with the other aspect of the conservation of sessions that the patient sought. I therefore emphasized once again that this observation was very important and that we together had to look for the ways and means as to how he could organize his review of the sessions productively.

Turning Off the Recorder

In one session Arthur Y requested that I turn off the tape recorder before talking about the subject he did not want to be taped. The subject was a conflict precipitated by the unanswered question as to which profession his daughter should choose. She had had doubts about whether she should continue her education at a vocational college or switch to a regular university. She wanted to first have a trial period at the university before making a final decision to leave the college, but universities required applicants to confirm that they are not enrolled at other schools before permitting registration. Arthur Y was afraid that the schools would check on this information. I interpreted his exaggerated concern in the context of his old anxieties about inflicting harm, similar to the way in which harm had been inflicted on him. In other words, the topic was once more the relationship between subject and object and confusing sadomasochistic identifications. By having the tape recorder turned off, the patient not only wanted to avert the practically nonexistent danger that something might become public; the real issue was once again apotropaic magic, namely the reversal of a potential harm by means of the magical power of his thoughts. The rest of the session was dedicated to this topic, and the tape recorder was not turned on again.

This was the first time that the patient had mentioned the tape recorder in a long time. Before turning it off, I had reminded him that in one session long before he had even requested that the recording of one session be kept at all cost. He said he

always wanted to have a means of gaining access to his idea that he himself had felt like a brutal SS officer for a moment. This was linked for him with his insight into his punishment anxieties and the reversion from delusions of grandeur to delusions of nothingness and from sadism to masochism. The patient had also once had the desire to read the transcript of one session; we agreed that he could read one in the waiting room prior to his next session. He had made the arrangements to have the time, but the text had not told him anything new. The only important result had been that he had been satisfied with the coding.

A Disgrace

Following a clear improvement in his severe symptoms and a substantial increase in the pleasure he found in life, Rudolf Y wondered at the beginning of one session when he might be able to discontinue the therapy. He talked enthusiastically about his friendships and his growing capacity to make contacts. The dialogue then moved to the topic of the relative contributions each of us had made to the therapeutic progress.

P: Yes, that's it, that I don't let you have the pleasure of gaining knowledge at my expense, don't give you confirmation of how good you are and of how much you know about me.
A: So it isn't a pleasure related to you that you in turn might profit from.
P: Yes, I'm a means to an end. [Very long pause] The tape, it's in vain; there's nothing on it. [laughed]
A: So I, the one who would like to demonstrate something, to show myself, how good I am, can't demonstrate anything.
P: Yes, that's it.
A: I could show the collected moments of silence. [Both roared with laughter] It documents my powerlessness.
P: Yes, the silence.
A: So a balance has been created. Today's long silence on the tape is the compensation for the submissiveness with which you agreed that I may know so much about you. Today I'm the one who's been disgraced, shown to be powerless, and made the butt of laughter. You were pleased by the idea that my colleagues would laugh at me.
P: Yes, I still switch between these extremes of either complete submission to superiors or of thinking they're sons of bitches.

Commentary. The tape recording is a factor in the patient's alternation between these extremes and in the polarization into power and impotence. The laughter accompanied an insight into this distribution, which the patient's attribution had the effect of increasing and maintaining. Tape recordings provide a good occasion for considering the topic of transference, an example of which is given in the following section. Rudolf Y obviously realized that his silence might be a disgrace for his analyst. Old scores are settled in transference as well as in catharsis.

7.8.2 Counterarguments

We take counterarguments very seriously precisely because we place a high value on the use of complete original texts in clinical discussions and scientific studies. Frick (1985), for example, tried to support the assertion that tape recordings distort the therapeutic process. She reported that the associations of one patient, despite his having given his approval for the

recordings, indicated that he felt latently exploited and seduced. It was only after the therapist had taken the initiative to give up the tape recording that the patient showed positive changes in several areas of his life.

Frick took this to be a confirmation of her opinion that Langs' idea of an ideal therapeutic framework had to be retained in order to protect the "sanctity" of the therapeutic relationship. Allegedly no interpretation was able to "detoxify" the negative and destructive consequences of the tape recording.

If this assertion were accurate for a larger group of patients, and not just in an individual case, then it would be necessary once again to submit the advantages and disadvantages of this tool to a thorough comparison. In fact, however, something seems to have gone wrong in this *one* case, which Frick blamed on the tape recording. The patient was treated in an outpatient clinic by two residents in supervision. The first therapist withdrew after four weeks, entering private practice, while the second therapy was limited to nine months, meeting twice a week. In the last quarter of the initial interview the therapist informed the patient about the basic rule and asked for his approval for tape recording all the sessions. The fact that the resident was being supervised was implicit, but was not discussed with the patient.

We assume that Frick functioned as the supervisor; at any rate, she has provided instructive commentaries to passages from the transcript. Completely open is, however, whether any interpretations were given, and if so which ones, in order to help clarify and solve any problems that the tape recording might have posed to the patient. If a larger numer of interpretations are not reproduced in context, it is impossible to clarify the influence the tape recording exerted or to assert that the process was distorted. In *one* interpretation an analogy was made between a situation with a girlfriend and the transference, specifically with regard to giving and taking, being exploited and being used, etc. In our opinion the most that such analogies can achieve is to direct the patient's attention to a possible connection without in itself providing a clarification. Without a deeper explanation, such allusions have rather a toxic effect than a "detoxifying" one; they even increase the paranoid meaning attributed to the tape recording.

This example in no way supports the author's negative conclusions and is at most suited to demonstrate once more that verbatim protocols can put the clinical discussion on a solid footing (see Gill 1985).

At the present state of our knowledge evaluation of the overall influence of tape recordings on the psychoanalytic situation is positive. Obviously, both participants are affected by the fact that third parties are involved.

What kind of a person would it take, we might ask in conclusion, who would not let himself be affected or let his spontaneity and freedom be restricted by knowing that unknown third parties studied his thoughts once they had been put into an anonymous form? This question is not far from another problem, namely at which stage of the psychoanalytic process do the analyst's thoughts about him become less unimportant to the patient? At some point the "interesting points" pale, to use the phrase Nietzsche employed in *Dawn* :

> Why do I keep having this thought . . . that we *presume* that man's well-being depends on *insight into the origin of things* . That we now, in contrast, the further we go back to the origin, are less involved as interesting points; yes, that everything we treasure and the "interesting points" that we have put into things begin to lose their sense the more we return with our knowledge and arrive at the things themselves. With our insight into the origin, the meaninglessness of the origin increases, while the nearest objects, which are around us and in us, gradually begin to show their color and beauty and puzzles and riches and meaning . . . . (Nietzsche 1973, p. 1044)