CHAPTER FOUR

Changes in dreams—From a psychoanalysis with a traumatised, chronic depressed patient

Marianne Leuzinger-Bohleber

> *"It is like a deeply engraved, though entirely irrational program: that alone and without protection, love and security I am unable to survive in this world …" (Mr. W.)*

Preliminary remarks

Established by Freud, the psychoanalytic extended case report continues to be one of the most important forms of communication in international psychoanalysis, albeit in more recent years such reports have rarely been published in international journals of psychoanalysis. Among others, the partial disappearance of this erstwhile tradition in psychoanalysis as "clinical science" may be linked to the heated controversies in which various authors have questioned the very validity for science of such case reports (cf. e.g., Thomä & Kächele, 1985). A discussion of these controversies would exceed the constraints of the present contribution (cf. also, Leuzinger-Bohleber, 2007, 2010; Leuzinger-Bohleber, Rüger, Stuhr & Beutel, 2002, 2003). I myself contend that, to date, no credible alternative to the case reports has been developed for adequately and "legibly" presenting the "narrative truths",[1] as acquired over the course of lengthy psychoanalysis, to the psychoanalytic and non-psychoanalytic

SIGNIFI.indb 49 1/31/12 1:11:09 AM

communities. Indeed, while precise reports of sessions (either verbatim, or else based on analysts' notes) may be indispensable for many clinical and conceptual discussions, they nevertheless remain insufficient for conveying the total impression of a treatment and the results thereof. By contrast—and naturally as best exemplified in Freud's own literary extended case studies—the comprehensive case report succeeds in conveying both to students and to a broad public "what psychoanalysis is", the goals it pursues, and the types of transformations it effectuates within patients etc. Hence, as empirical psychoanalytical researcher and as clinician, I do not confine my admiration exclusively to the work and legacy of Freud: it also encompasses writers and poets as a whole to the extent that the latter succeed in giving masterful articulation to their insights in complex, psychic processes of transformation of the unconscious, and in mediating the results to their readers. For these reasons, I concur with leading narrative researchers who postulate that many "truths can only be told and not be measured".

And it is precisely because of this esteem for the clinical case reports that I am an active member of the Project Group for Clinical Observation in its endeavours to improve the quality of clinical research. The drawbacks associated with this tradition are well known. These range from the arbitrary status of clinical observations for buttressing a given theoretical stance or hypothesis; the hazard of hermetically closed viewpoints; narcissistic confirmation, in lieu of the (self-) critical reflection of an observation; a gravitation towards "positively resolved" star cases, in contrast to the absence of poorly performed treatments; the danger of (unconscious) "fabrication"—especially in training cases; repetition or conformity to mainstream discussions within the psychoanalytic community and, as a consequence, the disappearance of innovative, unconventional ideas, and much else. The various methods elaborated for dealing with such drawbacks of "clinical research" also comprise the object of critical discussion. One such drawback will be presented for discussion in what follows: it is an attempt to critically approach the arbitrariness and condensation in the presentation of clinical materials, in theoretical assessment as well as in the interpretation of clinical observations with the aid of so-called *clinical expert validation* (cf. among others, Leuzinger-Bohleber, Engels & Tsiantis, 2008, p. 153 ff. Leuzinger-Bohleber, Rüger, Stuhr & Beutel, 2003). In summary: in periodic clinical conferences, this psychoanalysis was presented by way of a patient suffering from chronic depression—carried out as part of the LAC Study on Depression[2]—such that the colleagues were already

well familiar with the course of the treatment. This was documented systematically and in detail. The "truth content" of the following summary was similarly presented to colleagues for mutual deliberation. Based on the Hampstead Index, we furthermore elaborated a means for systematising the compression of complex clinical observations, without, moreover, restricting the creativity of the narration as a consequence. One of the aims of our "clinical research" is to provide a comprehensive, systematic collection of case histories on psychoanalyses and psychoanalytic long-term therapies of chronically depressed patients. The following case history is the first of such attempts I am presenting here for discussion. I hope to motivate other groups of clinicians to write such systematic, expert validated case studies on other groups of patients. The method proposed here is very close to clinical practice. Supervision and intervision groups, as well as courses with candidates or IPA members, could be systematically used to expert validate ongoing psychoanalyses and document the gained knowledge in extended case reports with different theoretical foci. In my view this would be a contribution to improved clinical observation and its public communication in contemporary psychoanalysis.

As is discussed in this volume, dreams have long since been considered the "via regia" to the unconscious. Hence considerable importance has been and continues to be attributed to them in the clinical observations in psychoanalysis. In the following case study the transformation of manifest dream content, as well as the analytical work with dreams, serves as an indicator for the unconscious reactions of the analysand to the therapeutic process.[3] In this narrative, all relevant clinical observations are compressed, summarised, and "recounted" by "validated experts" with the greatest possible precision. Here, a compromise is sought when summarising the entire treatment "narratively": to mediate, on the one hand, the above-mentioned, total impression of the psychoanalytical process as it occurs, along with the transformations in the inner object world of the analysand, while at the same time the selection of central sequences of consecutive sessions is to be reproduced verbatim, at least in part though without thereby rupturing the narrative structure of the summary.[4]

Depression and trauma: focus of the case study

In psychoanalytic literature reference is frequently made to the connection between depression and trauma (Blum, 2007; Bohleber, 2005;

Bokanowski, 1996; Bose, 1995; Bremner, 2002; Denis, 1992; Kernberg, 2000). However, we found it astonishing not to have discovered in the LAC studies on depression currently being conducted almost any among the patients suffering from chronic depression who had not experienced cumulative traumatisation. The first systematic analysis of all the patients who are in treatment in our Frankfurt group shows that 84% of chronically depressive analysands indicate an explicitly cumulative history of trauma. For this reason, one of the results of this extensive, comparative psychotherapeutic study will be to provide a detailed empirical, as well as analytical, reappraisal of this connection. As mentioned, the Frankfurt group of the LAC Depression Study is working on a publication with comprehensive case reports illustrating both the influence of early traumatisation on the emergence of chronic depression, and a range of consequences relevant to treatment of these findings. The following case study represents one of these narrative summaries of a lengthy psychoanalysis with a chronic depressed patient. The following observations will be presented for discussion here:

a. Unresolved traumatic experiences may lead to chronic depression.
b. The traumatic experiences are buried in the body as "embodied memories"[5] (Leuzinger-Bohleber & Pfeifer, 2002; Pfeifer & Leuzinger-Bohleber, 2011), and unconsciously determine present thinking, feeling and action.
c. A sustained transformation of a depressive complex of problems can only be introduced to the analyst by an understanding of the enactment of the specific trauma within the transference situation.
d. The "historic reality" of the trauma must be acknowledged. To this also belongs the fact that although the effects of traumatisation may be alleviated in the process of working through the analytical relationship, they cannot be erased. Recognition of the destruction of the basic sense of trust in good, helpful inner objects through the traumatic experience appears to be a prerequisite for recognising the enactment of the trauma, and thus for containing its effects (see Leuzinger-Bohleber, 2008).
e. The traumatic experience may also manifest itself in dreams. For this reason, psychoanalytic work with dreams may contribute to the symbolisation and mentalisation of the trauma.

SIGNIFI.indb 52 1/31/12 1:11:09 AM

In that this contribution places emphasis on the communication of clinical observation, the following theoretical deliberations must remain fragmentary.

"There is no unitary concept of depression …" Theoretical remarks on the genesis of depression, psychoanalytical and epigenetic reflections

Contemporary psychoanalysts and psychiatrists agree that only a multifactor model is capable of doing justice to the complex and always very individual causes leading into a depression. "There is no unitary concept of depression …" (McQueen, 2009, p. 225). The psychiatric model by Schulte-Körne and Allgaier (2008), for example, postulates that various factors have an influence on the genesis of depression although to different degrees and intensities. Many replication studies have investigated the influence of genetics on the neurotransmitter system. At the same time, the influence of early traumatisations by physical and sexual abuse on later depression has been shown in many studies that hint at the biographical as well as the societal factors just mentioned. The interaction between genetic and environmental factors can now be considered as a valid model of explanation in psychiatry as well as in psychoanalysis, although, as will be discussed in the following case report, the influence of early trauma on depression still seems to be underestimated.

Psychoanalysis adds another dimension to such models: we postulate that there are many different *unconscious* determinants, which finally may lead to a depressive symptomatic. All our experiences, from the very beginning, are retained by the unconscious and determine—as secret, unknown sources of our psyche—the affects, cognition, and behaviour in the present. Particularly traumatic experiences as well as other developmental conflicts and fantasies have left their specific marks and characteristics in the *dynamic unconscious* of each person (see Leuzinger-Bohleber, 2001). Hence, "normal" and "pathological" psychic and psychosocial functioning is always the product of a distinct biography.

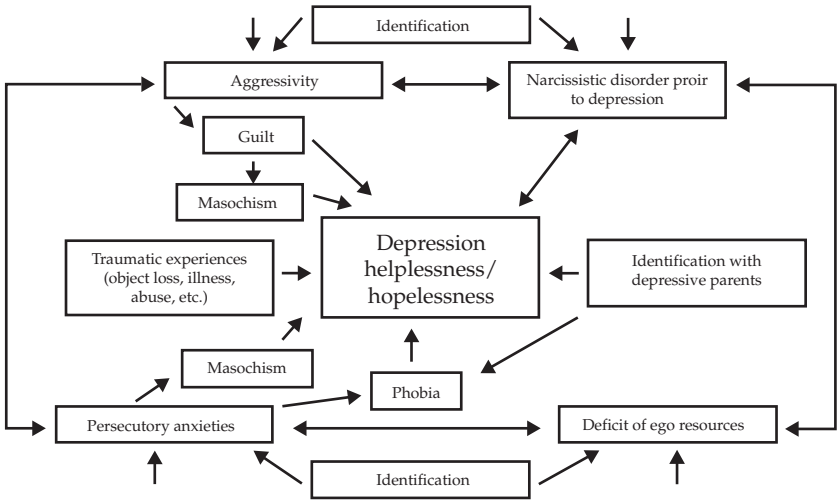
In short, psychoanalysts working with depressed *case studies* seek to discover the unique unconscious roots of his or her depressive functioning: each patient has complex individual pathways which lead to a specific form of depression:; each depression possesses its own

SIGNIFI.indb 53 1/31/12 1:11:09 AM

unique features. Depression is not a closed category, but is considered as an ongoing process.

Bleichmar (1996, 2010), a senior clinical psychoanalytic researcher on depression, has developed a model which recognises the multiple paths through which a person proceeds from one circuit, as dominated by one factor, to another when becoming depressed. Bleichmar describes these different, though not exclusive pathways, by means of the graph below.

For Bleichmar (1996, p. 77 ff.) Freud's paper *Mourning and Melancholia* continues to be the fundamental text for our psychoanalytic understanding of depression. Freud characterised depression as a reaction to the loss of a real or an imaginary object, and thus defined depression as a reaction which is not only connected to the "real loss" of an object, an idea, a self-image, etc., but depends on how the loss is codified by unconscious fantasies and conscious thoughts. In *Inhibition, Symptoms and Anxiety* (1926), Freud underscores the "insatiable cathexis of longing" of the depressed after the loss of an object: instinctual satisfactions, attachment wishes, and narcissistic wishes as well as wishes related to the object's well-being are no longer satisfied by the real or fantasised object. Corresponding to the sense of hopelessness about the fulfilment of wishes, the depressed patient experiences himself to be *powerless, helpless, and impotent*. The emotions tending towards the object of desire are deactivated: apathy, inhibition, and



passivity are some of the consequences. Many psychoanalysts have hinted at the central role of helplessness and powerlessness in depression (see, e.g., Bibring, 1953; Bohleber, 2005, 2010; Haynal, 1977, 1993; Jacobson, 1971; Joffe & Sandler, 1965; Klein, 1935, 1940; Kohut, 1971; Leuzinger-Bohleber et al., 2010; Steiner, 2005; Stone, 1986; Taylor, 2010). Rado (1928, 1951) has observed coercive rage as one attempt to recover the lost object. He also described the defensive self-reproaches meant to decrease feelings of guilt and to recover the love of the superego by self-punishment (see top right hand of the graph).

> When the pain of depression is prolonged, the restorative mechanisms prove insufficient for maintaining the illusion that the wish can be fulfilled. The psyche´s final defensive strategy may consist of mobilizing defenses against mental functioning itself, attempting to abolish wishing, thinking and feeling altogether. This might be the case with mental states described by Spitz (1946) as the final phases of hospitalism, or in the severe detachment process that takes place after an important loss not compensated by an adequate substitute object (Bowlby, 1980). Ogden (1982) describes an extreme form of defense in certain schizophrenic patients who have faced conditions of prolonged unbearable suffering, a defense which he calls the "state of nonexperience". (Bleichmar, 1996, p. 937).

Another consequence of extreme feelings of hopelessness and powerlessness are phobias and anxieties: the representations of the self as incapable, as weak and impotent establish a psychic state in which anything might appear as dangerous, and overwhelm the weak ego (dynamics on the bottom right of the graph).

It is thus possible to arrive at the sense of hopelessness for wish fulfilment which constituted the nucleus of every depressive state though multiple paths, none of which are obligatory conditions. Each one of these paths is driven by different factors or areas of pathology.

Many psychoanalysts have pronounced the central role of *aggression in depression* although there are still a number of controversial views about the nature and the function of aggressive impulses (Abraham, 1911, 1924; Blatt, 2004; Freud, 1917; Jacobson, 1971; Klein, 1935, 1940; Kohut, 1971, 1977; Steiner, 2005; Taylor, 2010).[6] Bleichmar (1996, p. 942 ff.) also stresses the connection between *depression and guilt* and mentions four conceptions of the origins of guilt.[7] Kohut (1971) and other psychoanalysts

SIGNIFI.indb 55 1/31/12 1:11:09 AM

emphasise that often in depression it is not guilt but *shame and narcissistic suffering* which is the major topic. He talked about the "tragic man" in contrast to the "guilty man". Following Kohut, Ehrenberg (1998) and others postulate that the feelings of shame are more central in contemporary depressions than feelings of guilt (e.g., due to forbidden sexual desires as Freud noted in nineteenth century Vienna). Melanie Klein (1935, 1940) suggested that *persecutory anxieties* may lead to depression because they destroy mental functioning and disturb the development of the ego, object relations, sublimation, and reality testing. Contemporary mentalisation theories explain these inner processes in a new way, such as in depressions of borderline patients (see, e.g., Fonagy, in press; Rohde-Dachser, in press). Often the reality of the loss can not be accepted but is denied (see, e.g., Steiner, 2005).

Identification with depressed parents is also a well described pathway to depression (see also Anna Freud, 1965; Hellman, 1978; Leuzinger-Bohleber, 2001; Markson, 1993; Morrison, 1983). Any condition that produces *ego deficits* (inner conflicts, traumatic reality, parent's ego deficits, etc.) diminishes the possibilities for sublimination, for establishing satisfactory relationships, etc., and may thus be another pathway to depression.

Finally, Bleichmar (1996) mentions the influence of *traumatic external realities on depression* (see also Balint, 1968; Baranger, Baranger & Mom, 1988; Brown & Harris, 1989; Winnicott, 1965) as one of several possible pathways. But as I would like to discuss by way of the following case example, the connection between trauma and depression is far more dramatic than has been postulated in classical psychoanalytical literature. In my view, the role of trauma in causing depression often remains underestimated in the literature, as some authors have also discussed in recent papers (Blum, 2007; Bohleber, 2005; Bohleber, in press; Bokanowski, 2005; Bose, 1995; Bremner, 2002; Denis, 1992; Leuzinger-Bohleber, 2010, in press; Skalew, 2006; Taylor, 2010).

Interestingly, a growing body of interdisciplinary literature has come out in favour of this position. I will mention a few such authors. Hill (2009) summarised developmental perspectives on adult depression in a general paper. Numerous studies showed the increasing probability of developing adult depression after early neglect or the loss of a parent (Bifulco, Brown & Harris, 1987; Hill, 2009, p. 200 ff. Hill et al., 2001). Fergusson and Woodward (2002) reviewed the literature as to the role of childhood sexual abuse and showed that the association with

SIGNIFI.indb 56 1/31/12 1:11:09 AM

depression in adulthood was substantial: a history of childhood sexual abuse increased the risk of depression approximately four times.[8]

Twin studies have established that unipolar depression is moderately heritable (Hill, 2009, p. 202 ff. Kendler, Gatz, Gardner & Pederson, 2006). New research in epigenetics, however, shows that even genetic vulnerability only leads into depression where the person also undergoes severe early traumatisation. Caspi et al. (2003) have been able to show that only severely negative environmental factors, such as early trauma, trigger the short allele of the 5-HHT gene which regulates relevant neurotransmitters and might afterwards cause depression. If no such trauma occurs, then no subsequent depression is observed.

These findings are of extreme importance for psychoanalysts, and support our clinical findings that early prevention and intervention programmes for depressed children, adolescents, and adults—even those from genetically burdened families—may be helpful and effective in strengthening the resiliency of those individuals at risk.

Epigenetic and neurobiological studies also give new relevance to the famous studies of René Spitz on anaclitic depression and hospitalism in the 1940s, which showed impressively how early separation trauma can determine severe depression already in infancy. Robertson and Robertson have replicated his findings in the 1970s with their impressive studies on early separation. Their observations correspond significantly with Harlow's famous experiments on monkeys. Thanks to modern research instruments, one of Harlow's successors, Steven Suomi (2010) was even able to demonstrate that early separation trauma has an enormous influence on neurobiological factors that determine the development of aggression, anxiety, and social integration, and thus to the survival of genetically vulnerable Rhesus monkeys. These findings are highly relevant for the following case study.

These influences of early trauma are transmitted to the next generation—a finding which corresponds in detail with many clinical psychoanalytical observations by many authors, including those of ours in the above-mentioned LAC depression study. Goldberg (2009) concludes his overview of more recent studies in these fields thus:

> These interactions between gene and environment, between behavior and genotype are important for the manner in which they provide explanations of how the many different features constituting the "*depressive diathesis*" arise. However, they have a much wider

> significance. They provide a possible pathway by which *changing inter-personal and cultural factors across the generations* can be both cause and effect of genotype, and through which changes in human culture might possibly operate as an accelerator of evolutionary processes.
>
> To sum up, we see that adverse environmental conditions are especially harmful to some particular genotypes, leaving the remainder of the population relatively resilient. Research in this area is expanding very fast—and we may expect many more advances in the years to come ….” (pp. 244–245)[9]

Another finding is especially relevant for us psychoanalysts. Suomi (2010) has shown that undoing the separation trauma in baby monkeys might “undo” the neurobiological and behavioural damages once again—clearly, a revolutionary finding for all forms of early prevention and for psychoanalytic treatments. As the following summary seeks to illustrate, the psychoanalysis of chronically depressive Mr. W., so the understanding of the enactment of traumatic experience in the transfer, enables the analysand to recognize the continual repetition of the trauma, and to thus counteract it with a new and different psychic reality. The horror of the original experience of helplessness and of inundation through the trauma can be countered by an adult psychic reality, an active approach to the trauma. In this sense, while the memory of the trauma is not erased—its automatic, re-traumatising effect in the present can be “undone”.

> *“… being alone without any protection, love and security, makes it impossible for me to survive in this world ….”(Mr. W.)*

Summary of a psychoanalysis

Assessment interviews[10]

When meeting him for the first interview, Mr. W. at once reminded me of Little John, a child in the famous 1970s film series by the Robertsons.[11] I puzzled over why this countertransference phantasy has at all occurred to me, since Mr. W. is in his early fifties, a well-built, handsome man, though with a somewhat severe facial expression, melancholy eyes, and heavy facial neurodermatitis. He explained that he had been

suffering from severe depression for the last twenty-five years, and that he is coming to us because after the last depressive breakdown he had submitted an application for retirement pension. The doctor who assessed his application concluded that he did not require a pension, but an "intelligent psychoanalysis", initially a response Mr. W. found highly insulting. He felt that he had not been taken seriously, especially his substantial physical symptoms: the unbearable pains covering his entire body, his acute eating disorders, as well as his acute suicidal tendencies. Furthermore, the patient suffered under acute sleep disorders. Often he is unable to sleep at all. As a rule, he wakes up after one and a half hours, or after three hours at the most. He feels physically exhausted and is barely able to concentrate his mind on anything.

Mr. W. had already undergone several unsuccessful attempts at therapy, including behavioural therapy, Gestalt therapy, "body therapy" as well as several indoor treatments in psychiatric and psychosomatic clinics. He is among that group of patients for the most part apparently unable to respond to psychotropic drugs, and whose relapses occur at ever shorter intervals and with increasing intensity. After many consultations with various psychiatrists and neurologists, he then discovered that only lyrica helped him to more or less deal with his states of physical stress and anxiety attacks.

Although four hours per week psychoanalysis is indicated, due to the distance from his place of residence Mr. W. has only been able to manage three hours per week throughout most phases of the treatment. Due to his extreme sleeping disorders, the thirty minute car journeys are often cause for concern.

Biography and trauma history[12]

The patient is an only child. One of the known details about his early history is that he was a "crybaby". Clearly, his parents most often felt helpless, and sought out a paediatrician who advised them to ignore the infant as much as possible, and to "let it cry itself out … this helps strengthen the lungs". Over the course of the first three months of psychoanalysis, the patient characterised his parents as loving, who showed him considerable care and attention. And yet over the course of time what increasingly became clear was that both parents showed a severely disturbed sense of empathy: the mother, moreover, suffered from migraines and from a pronounced compulsion

SIGNIFI.indb 59 1/31/12 1:11:10 AM

to clean. The father also complained of a series of psychosomatic symptoms. Like Mr. W. he suffered a "nervous breakdown" in a situation of professional stress. Both parents had experienced the Second World War as adolescents and still retain vivid memories of how they had suffered as children under the straightjacket of National Socialist educational ideology (the children were to be as "hard as Krupp steel" etc.). One of the grandfathers had lost an arm in the First World War. He was violent-tempered and would frequently thrash his children.

When he was four years old Mr. W.'s mother fell seriously ill. W. was admitted to a convalescent home for children, evidently founded on authoritarian, inhumane educational principles reminiscent of National Socialist ethos. Just how traumatic an experience was this stay in a home is something that became transparently clear during psychoanalysis. After a courageous aunt literally battled for and finally gained access to her nephew, she found him in a state of utter apathy, seriously ill, and in an isolated room. The official version as conveyed to the parents was that the boy was cheerful, that he played, and that he was generally doing well. The aunt sounded the alarm, and father collected Mr. W. immediately. Mr. W.'s first childhood memories revolve around the following event: he recalls how his father took him by the hand and led him out of the home. He also recalls how a girl had been forced to eat her own vomit.

When asked, the mother recounted that after his stay at the home, Mr. W. had completely changed: he had become silent; he did not wish to go to kindergarten, and was a shy, daydreaming boy who felt best in the countryside. Over the course of psychoanalysis it became clearer that through the traumatic separation from the primary objects, he lost his basic trust to his inner objects, and that he has subsequently been living in a state of dissociation for years (see, e.g., Bohleber, 2000). In many of his dreams he feels himself to be in mortal danger having been left alone and full of panic-ridden anxieties and desperation (cf. below). Mr. W. experienced two further separations from his ill mother, but these incidents had proved less traumatic since he had been taken in by relatives. The family moved house when he was eleven years old. He recalls how he had protested against this move with everything he could muster, and his parents found his panic-ridden anxiety connected with the move incomprehensible. They perceived him as being tyrannical and strange.

SIGNIFI.indb 60 1/31/12 1:11:10 AM

In spite of the dissociative states and his social isolation, Mr. W. was a good pupil, who went on to complete his first apprenticeship training and later his university studies. During adolescence, he had a psychosomatic breakdown, which the parents diagnosed as a "crisis in growing up", and sought to help him by way of a vitamin cure. At the age of fifteen years, he met his first girlfriend. His condition improved. At the age of twenty-two he separated from his first girlfriend because he fell in love with another woman. Although the separation ran in his favour, he reacted very severely to it. A few weeks later, he could barely eat and suffered intestinal complaints. After enduring horrendous diarrhoea, he then suddenly felt better. He also initiated the separation from his second girlfriend, though suffered for weeks due to the separation. After entering another relationship he was dramatically overcome by a nervous breakdown during a party held by his new girlfriend: he had to be taken to hospital due to hyperventilation (panic attacks). "I have been unable to trust my body ever since that experience. I experience repeated panic attacks and a sense of being unable to breathe." He experienced another severe depressive collapse when this third girlfriend betrayed him with another man. He was unable to defend himself, and instead pleaded with her to stay with him in what he then felt to be a humiliating manner.

Although all his therapies alleviated him, "none of them cured him".

He is married to a woman from a non-European country, and has a son who was three and a half years of age at the beginning of his treatment. The last severe depression (one and a half years ago) was first triggered when his wife coldly, and without empathy, attacked him while he was in a state of exhaustion after a month-long two-fold burden in connection with the building of a house. Without any foundation, his wife accused him of endangering the life of his son because he had failed to stop the infant from crawling around dangerous objects. Mr. W. was incapable of defending himself against this unfounded attack. He awoke the next morning in a state of unbearable depression.

In spite of this, after a few weeks he attempted to start work again for the sake of securing the well-being of his family. However, after some time, he felt himself unable to persevere with his profession. He took a vacation. He then fell ill with acute bronchitis which developed into pneumonia. During his stay in hospital a tumour was discovered which had to be operated on. During the first interview he gave an impressive description of how he had wished to die during the operation "to

SIGNIFI.indb 61 1/31/12 1:11:10 AM

escape the misery". At the same time, he hoped the tumour had been a contributory cause of his depressions, something that proved to be an illusion. It was for this reason that several weeks after the operation he very unexpectedly submitted his application for a pension.

On the course of the treatment: changes of the manifest dream content: an indicator for the enactment of the trauma in the analytical relationship?[13]

An intensive relationship between Mr. W. and me began to show itself already during the assessment interviews; I began struggling with the fantasy that it would no longer be possible for me to transfer him to a colleague so that the patient would have a choice as to which analyst he would wish to begin a treatment—as is my common assessment practice. During supervision it became evident that in my countertransference I would most likely experience myself as the "saving father", who took the patient away from the home, namely, an irreplaceable primary object. Mr. W. established an apparently almost symbiotic proximity to the object of love and experienced a separation from it as a life-threatening danger: this world of inner fantasies tallies with my countertransference fantasies being strongly absorbed from the outset of the treatment with the question as to whether or not we would manage to draw near to the core of the chronic depression. It seemed almost a fantasy of omnipotence to me such that, in contrast to many of Mr. W.'s previous therapists, I could be successful in such an attempt.

> *"… it was war …" (Mr. W.)*

To my surprise, the first therapy sessions were filled by the most ferocious affects: Mr. W. was full of rage towards his wife and described the most terrible marriage scenes. His wife attacked him verbally and physically in front of his small son, with whom she would also become involved in the most heated affective confrontations. His child suffers from selective mutism: he talks only with his parents. Moreover, he continues to wear nappies.

It soon became evident during the sessions that due to his fear of being abandoned by her, Mr. W. is incapable of defending himself against his wife's onslaughts. He lives in an inner world of panic, desperation, and profound loneliness. When I sought to suggest a link between the affects and the trauma of separation he had experienced,

Mr. W. rejected this vehemently. "Other therapists would repeatedly make reference to my stay in the children´s home. I simply cannot believe that a three-week stay in a home at the age of four could exert such a long-term influence on me … this just all seems very contrived ….". Another initial fierce conflict emerged after I cautiously enquired about whether he might not be inclined to seek solace from the present intolerable marital conflicts, and the demands of his work in depression. Mr. W. erupted in fury and went on to explain just how offended he had been when the doctor who made the original assessment had described him as "a sort of hypochondriac who had no desire to work and who wished to escape into illness". "He had no conception of the existential dimension of my anxiety and depression. I am not a shammer!" These scenes revealed to me how important it was for Mr. W. during psychoanalysis that I take seriously and grasp his unbearable psychological suffering. Furthermore, in retrospect I came to understand these scenes as an indication that in the transference he was struggling with the reactivation of the traumatic experience he had had with his non-empathetic primary objects. As mentioned, both parents had suffered from a seriously disturbed empathy and were incapable of understanding, supporting, and containing Mr. W.'s affect outbreaks either during the latter's infancy or his early childhood in "good enough ways"—experiences of relationships which, in all likelihood, possessed a traumatic quality for Mr. W. (relationship trauma, type II, according to Terr, 1994). For this reason he appeared to carry within him an archaic, yet unappeased need for an (anaclitic) melting with a (symbiotic) primary object (cf. Blatt & Leuyten, 2009).

After the scenes as sketched in the above, Mr. W. recounted his initial dream in the tenth session:

> *"The context was war. I was in a concentration camp with my wife because she is a foreigner. I tried to protect her, but was overcome by a sense of panic."*

The associations led to a present, though helpless and threatened love object which the self is unable to protect, a self which, in a state of panic and powerlessness, is subject to a situation of inner war and persecution. Later in the night, Mr. W. had a further dream:

> *"Several people had barged their way into the courtyard of our house. I flew into a terrible rage and yelled out: 'What the hell do you want*

here! Go away.' … They actually did vacate the garden. My wife remarked how well I managed the situation."

In the psychoanalytic session we understand the second dream as an investment of hope in psychoanalysis: he wished to acquire the ability to apply his aggressive impulses for the protection of his "house", of himself, and the objects of his love so as to actively encounter danger rather than being passively subjected to it and inundated by anxiety and panic. This would empower his sense of autonomy and masculine identity and, also, so he hoped, win the acceptance and love of his wife who, in reality, would scorn and degrade him owing to his depression.

The staging of the traumatic loss of the object of love and "embodied memories" in the existentially threatening physical state during the stay at the home …

The subsequent weeks witnessed a dramatic escalation in the external realities of the analysand: his wife had fallen in love with someone else. Terrible scenes erupted, in one of which his wife revealed to the patient that she had never actually loved him, and was presently experiencing for the first time what a fulfilling sexuality really means.

For Mr. W. everything collapsed: he was flooded by a sense of panic and desperation, and could barely sleep. He felt completely degraded by the rival. It was shocking to observe the sheer extent to which he identified with the degradation heaped upon him by his wife. The sessions were filled by depressive self-accusations and ferocious self-loathing such that I finally confronted him by saying: "You experience this terrible slight and this abandonment probably in the same way you experienced it then, during the stay at the home as a young child, and you now see everything through the depressive spectacles you have since been wearing. Instead of defending yourself as you do in your second dream, you inwardly hand over house and home to your rival without even putting up a fight. Clearly, your wife then confirms the depressive self-image which you carry within yourself."

Thus, during this phase the sessions frequently took on the character of a crisis intervention: the traumatic separation anxieties shifted to the core of the work and disclosed their existential attributes. The massive rage and destructive aggression towards the love object

or the primary object were thematised. The perpetually recurring attempt during the sessions, to distinguish the inner objects from the painful experiences of loss and betrayal in the present reality, in the end enabled Mr. W. to overcome the paralysing passivity and sheer desperation. He booked a plane ticket for him and his son for a summer vacation to his wife's distant homeland. He left his wife behind with her lover. In spite of guilt feelings, he then had a surprising and fulfilling sexual encounter with an acquaintance, which he experienced as reconfirmation of his adult masculinity and, to a certain extent, as narcissistic restitution.

And yet the subsequent months signified a dire period for Mr. W., and marked dreadful wounds and humiliations: his wife lived with her lover and left the son with the patient. Mr. W. managed to care for his child with the support of his parents. His overall bodily pains have increased substantially, to the extent that he often feels like an "open wound". We suspect that such signs that for him represent an almost life-threatening physical condition are related to the "embodied memories" of the life-threatening illness experienced during his stay at the home. A certain amelioration of the symptoms as an answer to the corresponding interpretations apparently confirms this hypothesis.

Mr. W. refers to heady nightmares: for example, that in the woods he observes at a distance how a blazing helicopter plunges to the ground. In addition, during the sessions his existential anxieties about being abandoned become clearly evident, as well as his pathological bond to his parents.

Astonishingly enough, during these months, his child displayed a relatively composed disposition and, in the words of the kindergarten nurse, was presently developing positively, gradually overcoming its selective mutism, now being able to visit the toilet alone and is cautiously beginning to find its way out of its social isolation.

The extent to which the patient continues to be tied to the wife was revealed when the wife demanded to have the child returned to her custody: against the advice of his parents and his friends, he was unable to use the situation to separate from her and to apply for custody of the child. He persisted in reacting in panic at the thought of divorcing from his wife, hoping, thereby, that in spite of the injuries the marriage could be maintained. Similar fantasies appear in connection with the treatment: Mr. W. expresses anxiety about his becoming so dependent on me as an analyst that he will not be able to bear it when the treatment

SIGNIFI.indb 65 1/31/12 1:11:10 AM

finally comes to a close. Here we encounter his unconscious conviction that "nothing and nobody can really help me …".

In the subsequent session, Mr. W. recounted the following dream:

> *"I am in a wood close to X., and crawl through a long, dark tunnel. I then come to a hotel with a capacious terrace looking out across the Swiss Alps.*[14] *It is very pleasant and yet I am still gripped by the anxiety that I might topple from the terrace into the abyss. I thus do not dare stay on the terrace, and rather turn back, even though I know that at the other end of the tunnel, in my home village, things are no longer the way they were."*

His associations prompt a deep-seated doubt within him as to the value in embarking on a course of psychoanalysis—to crawl through the dark tunnel of depression so as to be able to behold the light, the distant Alps of Switzerland, and to orient himself on them, but also to gaze into the abyss without falling into it, or whether it is preferable to return to the familiar, albeit gloomy "security" of depression, the home village. Most probably attached to the additional, secondary illness is also the fact that Mr. W. flees into depression instead of once again resolving to venture into a relationship with the attendant risk of being abandoned and rejected by the object of love. A further aspect is vehemently rejected by the patient during this period, namely, the conflict of loyalty connected with distancing himself from the home village, the inner world of representation of the depressive primary objects, of leaving this behind him, and divorce. The existential dimension of divorce triggers thoughts of an early conflict in individuation and autonomy.

"The revenge on the traumatizing primary object"

By this stage in the treatment, it became clear what severe consequences the reactivating of the separation trauma—of being directed by the panic-ridden anxiety of being abandoned—was capable of exerting on the narcissistic basic self-esteem: towards his wife he feels akin to a helpless, dependent child permitting itself to be humiliated, wounded, and attacked. In this connection he recalled the following dream:

> *"I catch sight of a man lying at the side of the road severely wounded—his intestines are spewing out, and everything is saturated in blood …*

A helicopter appears. It is unclear as to whether the man is still being shot at, or whether one should go to his aid. Someone appears claiming that the man has now passed away. I notice that the man is still alive and he really does open his eyes and enquires, 'Why is nobody helping me?' The woman hands him a saucepan lid which he should hold over the open wound …. I then wake up riveted by panic …."

In the figure of the woman of the manifest dream, who in a cold, unsympathetic, and unhelpful manner hands a saucepan lid to the man suffering from life-threatening wounds so that he may cover them, I see an indicator that in the transference Mr. W. now experiences me as an unsympathetic, unhelpful, indeed perhaps even sadistic primary object. Approached cautiously, it then also becomes possible to address his debasing aggressive fantasies towards me. He observes his massive anxieties; like his mother, I was not able to bear such aggressive impulses: until today, his mother has responded fiercely to criticism most often in the form of a migraine.

Recognition and working through aspects of negative transference

Only once it had become possible to directly address his mistrust and his aggressive fantasies, also towards the analyst, did it appear—gradually, in the second year of the treatment—that changes were occurring. Mr. W. became somewhat more self-confident. He began a new love relationship with a more empathetic woman than his wife. More secure self and object boundaries began establishing themselves. Furthermore, it was now that archaic feelings of guilt became accessible to therapeutic work: in one session, he discovered the fantasy in being unable to leave his wife since he was somehow convinced that, by doing so, he would destroy her. The analyst offered him an explanation based on developmental psychology:

"If parents are not in a position to calm a crying baby, the baby then becomes subject to a condition of acute desperation. Psychoanalysts assume that this can stimulate early fantasies, which contain within them untamable destructive impulses, since the extremely aggressive fantasies that a child perceives in such a situation of desperation cannot be caught and thereby alleviated by the parents. The child then experiences his parents as powerless and impotent (indeed, in much the same way you experience me in relation to your depression).

SIGNIFI.indb 67 1/31/12 1:11:10 AM

A further consequence is that the aggressive-destructive fantasies remain excluded by other psychological developments. They then occasionally appear in such unreal convictions as those you have just mentioned."

In the next session, Mr. W. reported the following dream:

> *"I dreamt that, full of anxiety, I was suspended over a deep chasm. Two women are above me; they do not come to my assistance, but instead proceed to cast a white ribbon across the chasm in a strange way. Clasping the ribbon, they then attempt to cross to the other side of the chasm. I cannot help being astonished about this stupid idea, and then witness how they really do fall into the chasm … I wake up in a state of utter panic."*

A: "You often complain of the 'stupidity' of your wife—and the previous session focused on your sometimes having the impression that I am too limited and unhelpful to build a bridge across the chasm of depression. Do you think this was to some extent taken over into the dream? The women were unable to help you out of your life-threatening situation, but then also finally plummeted to their own deaths due to their own idiocy."

Technically, it is not easy to express the fact that these catastrophic dream images probably encapsulate his enormous rage towards women. Often humour proves helpful in such contexts. When, after the above-mentioned session, Mr. W. by chance discovered that I had a technical problem with my car, I then intuitively said, "Yes, perhaps I really am a stupid woman." Mr. W. responded with an outburst of laughter at this remark, most probably an indication that I had just hit the nail on the head.

The subsequent months centred over and again on his wrath towards women. Working through the unconscious fantasies and conflicts connected with this led to further transformations: the slack attitude improved substantially, such that the patient then dared to reduce his medication (dosage of Lyrica). He rediscovered an increased sense of joy in life, and developed more creativity in his work. Despite massive anxieties about failure, he took on an important private work contract, which, in his financial situation, was a ray of light, and which offered important narcissistic fulfilment.

"Taking the 'black dog' out on a lead"[15]

Over the following months, his struggles in dealing with his panic-driven anxieties of abandonment, and with not allowing the self to be passively inundated with this, increased. Occasionally, he succeeded in putting a leash on the "black dog", as he would refer to it. The content of his manifest dreams also visibly changed: the dream self became more active, and less susceptible to passive catastrophes and mortal dangers, but was often aggressive and involved in conflicts important for survival. We understand the following dream to be a key dream for this inner transformation:

> *"I am in the car with my father, but am barely able to control the vehicle. It drives faster and faster. Suddenly, a high tower stands in the middle of the road. The car drives wildly up the wall of the tower and down the other side again. Although I am terribly anxious, nothing happens to us. We are able to continue driving. We then notice how another man likewise races up the tower and, similarly, slumps down the other side again. Nothing happens to him, either … We follow this man and then get out. He then transforms into a man with a slippery surface, like Delta in* Star Trek: Enterprise*. I do not know whether he is man or robot. He had a black dog. It becomes bigger and bigger, rests its paws on my shoulders. I begin panicking; the dog could bite through my throat. And then I suddenly see that the dog has the face of a woman which also appears to be frightened. I then say to it that it is not as dangerous as I had thought and compliment it, which it clearly finds pleasing."*

The associations to the dream lead to several references which Mr. W. takes up and pursues in the subsequent sessions: for example, in the identification with the father, the attempt to regain a piece of his masculine phallicism (dream pictures with the tower), the experience of dissociation and of not being quite anchored in this world (the robot man in the dream), his existential anxiety when in front of an affectionate object of love (dog-woman), etc. However, above all, it has to do with the active overcoming of his panic and anxiety. In the dream he does not disavow the dangers and the extreme feelings that are consequently released, but instead dares "to look the dog straight in the eye". He discovers the anxiety of the other by way of his own activity, and is no longer flooded by his own panic: namely, while the ego is unable to inhibit the reactivation of death anxiety and panic, it is able

SIGNIFI.indb 69 1/31/12 1:11:10 AM

to actively counter it somewhat, by looking at it and by understanding. What I found interesting was that Mr. W. had been processing my own feelings of insufficiency in his dream (dog with woman's face, which is itself in need and is anxious); during this period, I was often gripped by doubt as to whether it really would be possible to modify the depression by means of our psychoanalysis: the "black dog" often assumed a disproportionately large size that it was barely possible to subdue.

To each of us, this dream thus assumes a symbolic function for the presently occurring therapeutic work—an attempt, together, within the psychoanalytic relationship, to look the terror of traumatisation in the eye, to not repudiate its reality, or dismiss it, but rather to psychically accept its existence: to actively counter it with something so as not to be flooded by panic, desperation, and anxiety, and hence to thereby allow oneself to be unconsciously determined by it.

After the reactivation of the trauma could be thematised, above all in outer reality (in relation to his wife, for example), it then become more possible for Mr. W. to experience and comprehend the traumatic separation anxiety directly in the transfer. This was during the third year of psychoanalysis.

The reactivation of the trauma in the transference[16]

Mr. W. reacted with increasing vehemence to situations of separation from the analyst. During a vacation, he underwent a problematic orthodontic operation, which led to intolerable headaches. He was unfit for work for over two months, and unable to come to the analytic sessions. Finally, I telephoned him. Several crisis interventions then ensued by telephone, which saw him gradually emerging from "the black hole". Evidently, Mr. W. was acting out his early separation trauma and brought me, as analyst, into the situation of the "rescuing father object" (who took him away from the home). When I referred to this fantasy directly, in the next telephone call Mr. W. recounted the following dream:

> *"I am gazing at a group of people all smeared with clay and who are working together on the shell of a house. A cold wind blows—the work is torturous, arduous, and barely tolerable. And yet, in the dream I have the certain sense that the men will succeed: at some point the house will be*

built and provide them with a warm home. I then turn to my wife and say: "You see, one can do it—one just has to stay together ...."

The associations led to a fundamental sense that "My house cannot be repaired: it will always remain a draughty, dangerous shell … but, perhaps a spark of hope remains in the dream: I am convinced that the building of the house will finally be completed." We draw a comparison to the way he depicted himself at the beginning: "I am like a fine house, though without a foundation."

Half a year later, just before a one-week vacation, he seemed really confident. And yet, afterwards, he appeared at an analytic session in a state of complete desperation[17]. He was convulsed by sobbing on the couch. "I am completely finished—my overall bodily symptoms are unbearable. I can't take it any more, I cannot live any more." He had overlooked to take his medication one evening, and broke down the next morning. "I noticed just how dependent I still am on medication—without them I am simply unable to live." The analyst also felt distressed, powerless, and helpless, and once again doubted her ability to really help Mr. W.

A: "This relapse was certainly a bitter disappointment to you—and I was once again not available to you. Were you also tortured by thoughts that the psychoanalysis also amounted to nothing?"
W: "Yes, that's right: everything that we covered here in discussion seemed to me to be so far away, so theoretical …"
A: "Did you lose the inner connection to me?"
W: "Yes, I felt utterly alone—I was unable to imagine you any more: you were foreign to me and in some sense entirely unreal …"
A: "Probably similar to how Little John felt when his parents left him for several weeks in the home."[18]

At this point Mr. W. wept uninhibitedly and was in great distress throughout the duration of the session … The psychoanalyst also felt herself inundated by powerful emotions and a sense of helplessness and powerlessness.

The next day Mr. W. came to the session with greater composure.

W: "In some way it did me some good to be able to weep here, in spite of the fact that I continue to feel very distressed. In the days

before this incident, I felt myself as if in a cage—I felt absolutely nothing, everything was dead within me. At night my body began reacting chaotically—everything was painful and I was unable to sleep at all."

A: (After a pause): "We frequently return to the thought that your body remembers the unbearable pains and fear of death, which you had experienced most likely during your stay at the home."

W: "I am really unable to say whether this is true … in any case, the pain is utterly intolerable."

After a lengthy pause, during which I sense the analysand's distress and hopelessness, as well as my own perplexity, I then say: "Perhaps it is very important for you to show me here the full extent of your distress and sense of panic. Quite some time ago you said to me that you are convinced that nobody, but nobody at all, is capable of understanding you in your misery, and consequently you feel profoundly alone. You were also unable to really show your distress to your parents after the stay at the home—you simply went silent. As a result, your body was unable to relax; it could not be calmed. You remained alone."

Mr. W. silently wept for a long time.

During the next session Mr. W. still seemed distressed and in a state of panic.

W: "I really have no idea. Last night I must have briefly dropped off to sleep. I had two dreams which bear no relation to my present state. I first dreamt that a woman fell in love with me. I wondered, and I was unsure about whether or not I felt attracted to her. And yet she said that this was not important and that everything would turn out well …. I then dozed off again and continued to dream. I was seated in a lecture hall. An especially desirable looking woman began caressing my thigh. This I found extremely agreeable. She revealed to me that she was in love with me; that I am so charming and so calm. I was very fond of this woman. However, in the dream I then thought that I ought to tell her that I am not calm, but rather depressive and that she ought to know this."

A: "Yes, here you have often mentioned that you no longer wish to act a part—neither in a love relationship nor here during psychoanalysis."
W: "Yes, this is true. Do you really think that the dream might contain a spark of hope?" Mr. W. now remains silent for quite some time and appears relaxed.

Over the following ten days, he appeared visibly relaxed, though to some extent particularly ill at ease. Mr. W. oscillates between hope and profound desperation also during the sessions.

A: "The depressive dog seems to be defending itself against any form of change, attempting to make the spark of hope disappear again."
W: "And then the depressive holes and the bodily pain seem to become far more difficult to endure."

After the weekend, Mr. W. explained that he had had two anxiety dreams, but that he could only recollect one since his wife had woken him up owing to his terribly loud yelling.

W: "The dream resembled a horror film. Strangely, I had a brother who 'mutated into a dangerous and ominous entity that would kill other people. I observed all this aghast, thinking to begin with that since he was my brother I would be spared the same fate. But I then discovered that my execution had, indeed, not been overlooked. I was filled by terrible anxiety, and ran away as fast as possible, finding myself in a square. I then gazed upwards into a building to my mother's window. I yelled and yelled, but she still did not hear me. The dream was interrupted at this point by my wife awaking me."

After a lengthy silence, Mr. W. made the following associations: "The first thing that occurred to me was the home and the yearning I felt for my mother, who was unable to hear me when I yelled out and felt distraught …. Strange that I had a brother here."

A: "Who mutated into a dangerous, ominous entity."
W: "And triggered a fear of death."

A: "And as you noticed in the case of John, the inner picture of your parents also changed during the stay at the home—they probably became dangerous and threatening; Little John could no longer keep hold of the loving inner image of his parents, which, shattering, now revealed itself as a "murderous", persecuted inner image—a terrifying, life-threatening experience."

W: "Yes, and afterwards nothing was what it once was."

A: "The trust in your parents was repeatedly broken—although you apparently seemed to be normal again."

W: "Though nothing was normal again … like with my body—nothing was right, everything hurt."

In the next session Mr. W. reported, almost amused, that he had dreamed of his neighbours and a concrete mixer:

"Like me, my neighbour had also been extending his house, and I would often hear the noise of his cement mixer during the summer. I had often had occasion to admire him since he appeared to have an abundance of energy, and that he was somehow successful in his family life. Perhaps I do have a spark of hope after all, and I'll be able to get my cement mixer working again."

This sequence in the psychoanalysis could mark a turning point in the treatment: had Mr. W. re-experienced his trauma in the transference, and consequently been able to, at least in part, understand and psychically accept it?

In any case, after the Christmas break he returned and in the first session reported that during the separation he had struggled fiercely against the "black dog", and with varying degrees of success. He had had, he found, an astonishing dream:

"I dreamt of a couple—they were most likely not lovers, and yet their relationship was genial. They had a business with flowers in Africa … (it then occurred to me that the day before I had watched a television programme about a couple in Africa who planted and cultivated Christmas stars and had established a successful business from this). I felt particularly attracted towards the two people and their charming manner and asked them fervently to allow me to take a share in their business. They accepted me—and the woman even embraced me. I sold my house and dared to make a new beginning … I was so happy when I awoke that all I wanted to do was to go back to sleep and continue the dream … Perhaps something is changing in me after all."

Discussion

The close connection between early traumatisation and severe, chronic depression became clear in the course of psychoanalysis with Mr. W. It was especially the separation trauma suffered at the age of four years during his stay at a children´s home and without an empathetic substitute relationship that had, to a large extent, remained unresolved, and which then triggered depressive reactions after the separation from his love persons. These reactions were significantly exacerbated following the separation: the depression became increasingly chronic. It was striking to note during treatment how the traumatic experiences had been retained within the body: decoding these "embodied memories" led to a certain alleviation of the symptoms, through which Mr. W. was able to actively approach his condition without making them disappear altogether. For quite some time Mr. W. refused to acknowledge the "historical reality of the trauma" as a part of his own biography: that this exerted a sustained effect on his depression, as well as inducing a fundamental mistrust towards close persons of reference due to the traumatic collapse of his basic trust (*Urvertrauen*) in "good helping, inner objects". Only once this profound mistrust and the unconscious truth, that "nobody, but nobody, can really understand and reach me in my psychic misery and so contribute to alleviating my intolerable condition", had become tangible and to some extent understandable in the transference to the analyst, was the "power of the trauma" relativised and no longer determined present thinking, feeling, and action as a dominating, unconscious belief system. This initially revealed itself in the transformation of the manifest dream content, which, as indicated, constituted keys for successively understanding the unconscious fantasies and conflicts—as reaction to the analytical work.

The transformations in the manifest dream content and their latent (unconscious) dream thoughts were selected as Ariadne's thread for this case report since, in my view (as also in the case of other indicators), they are able to provide clues about whether the work of analytic interpretation was unconsciously understood by the analysand, and experienced as "true". This was illustrated both in the narrative summary of the treatment, as well as by way of the detailed sequences from four consecutive sessions.

As touched upon in the preliminary remarks, with this case report, I sought to formulate a defence for the revaluation of the narrative tradition of psychoanalysis as a unique, valuable form for

communicating the results of clinical-psychoanalytic research. With the aid of the *method of psychoanalytical expert validation*, the quality of such narrations can be enhanced, whereby it is possible to systematically encounter the danger of subjective distortion in clinical observations as indicated at the outset. This can be achieved, moreover, without destroying the advantages of the clinical case report (the compression of observations and "truths", the communication of unconscious semantic structures by readable "histories", as well as the proximity to metaphor, literature, and art).

However, in the contemporary age of the internet, the difficulties relating to attitudes to discretion and the protection of privacy—something which has always been connected to comprehensive case summaries—are tending to become greater. As is often the case in the context of the LAC depression study, the analysand is able to sufficiently identify with the analyst's research interests such that through the codified summary of his treatment he has the impression of being valued and taken seriously. Several of the analysands declared themselves prepared to read and comment on the case report. This is a unique opportunity for (externally) validating the "truths" by the analysand himself.

However, owing to ethical and psychoanalytic considerations, it is not always possible to acquire former analysands for this cooperation. In such cases, one might attempt casting the summary of the treatment report in relatively abstract terms and with active codification, and assign greater weight to the depiction of sequences of sessions (cf. the last section of this case report). Often adding additional biographical data which does not distort the "narrative truth" (e.g., number of siblings, similar but not "real" professional positions, etc.) may help to protect the anonymity of the analysand. Naturally, the reader must be adequately informed of this attempt in order to be convinced of the author's wish that, while protecting the intimacy of the psychoanalytic treatment belongs to the specific professional ethics of the analyst, it is also one of the outstanding characteristics of psychoanalysis as a clinical science to convey experience and knowledge to the scientific community, the essential aspects of which "can only be narrated and not measured".

Notes

1. There is an extensive discussion on "narrative", "historical", and "empirical" truth in psychoanalytical literature (see, e.g., Leuzinger-Bohleber, 1989, 2001, 2010; Spence, 1982; Thomä & Kächele, 1985).

2. LAC stands for the short- and long-term results of psychoanalytical as compared to cognitive-behavioural long-term therapy among sufferers of chronic depression: a prospective, multi-centric therapy effectiveness study which is currently being conducted (project directors: M. Leuzinger-Bohleber, M. Beutel, M. Hautzinger, and U. Stuhr), supported by the DGPT, the Heidehofstiftung, and the Research Advisory Board of the International Psychoanalytical Association. See www.sigmund-freud-institut.de
3. Horst Kächele summarises in his contribution in this volume my empirical study investigating the changes of the manifest dreams as well as the psychoanalytic work with dreams in five psychoanalyses comparing the first and the last hundred sessions of the psychoanalyses (see Leuzinger-Bohleber, 1987, 1989). In my chapter I am concentrating on my clinical observations. The changes of the manifest dream contents of Mr. W. are also investigated by extraclinical research methods. Tamara Fischmann et al., in their chapter in this volume, will report some of the first results of this empirical study.
4. Detailed summaries of sessions from the assessment period, the first, second, and third year of psychoanalysis, also have been presented at the workshop of the Project Group for Clinical Observation in order to illustrate our "Three Level Model" for Clinical Observation (see website of the IPA).
5. The concept of "Embodied memories" takes up Freud's original idea that the trauma is "engraved in the body" but offers a new, interdisciplinary explanation for Freud's clinical observations. The embodiment of psychic processes has been fruitful in many different contemporary scientific disciplines after having been empirically tested in the so-called "embodied cognitive science" (see e.g., Edelman, 1987; Pfeifer & Bongard, 2006; Pfeifer & Leuzinger-Bohleber, 2011). To make a long story short: due to "embodied cognitive science", memory does not result from an activation of "statically stored contents somewhere in the brain" but is the result of sensomotoric coordinations in the here and now of a current interactional situation—memory thus has a dynamic, creative, and "constructive" quality as was illustrated by concrete clinical cases elsewhere (see Leuzinger-Bohleber, 2008; Leuzinger-Bohleber & Pfeifer, 2002; Pfeifer & Leuzinger-Bohleber, 2011).
6. Bleichmar (1996, p. 940 ff.) differentiates between three forms of aggression in depression:
   a. Aggression and deterioration of the internal object: the subject feels as though he destroyed the object. The most speculative theory in this context is Freud's concept of the death drive which is seen to be responsible for the fact that the patient does not return to life after a loss of an object, but remains attracted by death (see also Steiner,

2005, p. 83). Mr. W.'s self-observation of having been depressed ever since he can remember would describe the phenomena Freud has in mind: for years he has been absorbed by suicidal tendencies, the "longing for death".

b. Aggression directed at the external object: the subject not only displays aggression against the representation of the object, but also acts it out in the external world (destroying friendships, family relations, etc.).
c. Aggression directed against the self: due to a rigid superego, aggression is turned towards the self (see, e.g., role of masochism in depression or in introjective depression: one of the two basic types of depression described by Sidney Blatt (2004)).
d. Guilt through introjection of aggression against the object: the self is reproached in the conscious, the object in the unconscious.
e. Guilt due to the quality of the unconscious wish: guilt may be the product of the existence of certain sexual and hostile desires.
f. Guilt due to the codification of wishes: the (sadistic) superego codifies the wishes as aggressive and destructive for the object.
g. Guilt through identification: there is an unconscious belief of a global identity of being bad, of being aggressive, of a self of being harmful.

7. Although it is fascinating to note how new epigenetic research adds a new dimension to this knowledge, the results of the epigenetic studies remain controversial. "In sum, we conclude that the totality of the evidence on G x E is supportive of its reality, though more work is needed to properly understand how 5-HTT allelic variations affect response to stressors and to maltreatment" (Rutter, 2009, p. 1288).
8. Thus I agree with Goldberg's (2009) formulation: "It is time that the dialogue of the deaf between psychiatric geneticists and psychotherapists came to an end: exciting progress has been made in understanding the interaction between our genetic constitution and social environment that either allows genes to manifest themselves in the phenotype, or suppress them altogether" (p. 236). His conclusions, having provided an overview of the contemporary state of research in this field, are highly relevant: "In humans, the effect of maternal care on hippocampal developments have so far been demonstrated (in females, but not in males). The effects of the environment in promoting gene expression appear to be supported by work showing that the extent of abnormalities in a particular gene responsible for the metabolism of an important inhibitory neurotransmitter (serotonin), can be shown to be responsible for the sensitivity of the adult to external stress. This gene is also related to the likelihood of secure attachment. Thus the abnormalities observed

in the rat also appear to apply to the human. Similarly, abnormalities in another gene responsible for the neurotransmitter monoamine oxidase A are associated with the sensitivity of the infant to the harmful effects of physical punishment: with the normal gene, the relationship is fairly weak, though when abnormal antisocial behaviour results …" (pp. 244–245).

9. Following the Hampstead Profile, staged observations and important scenes drawn from the first interview, transference–countertransference reactions as well as the symptoms, the motivation behind treatment, and the socio-economic context examination are presented here. Mr. W. agreed to publish material from his psychoanalysis. In order to protect confidentiality some biographical and socio-economic data are actively changed, although without destroying the "narrative truth".
10. Robertson and Robertson published films observing children during early separation, e.g., John during a ten day stay in a children's home due to the birth of his sibling.
11. Again following the Hampstead Profile, important information on early object relationships, important biographical events, the socio-economic background on the dynamic structural assessment of the conflict, the developmental level, etc. are summarised in narrative form).
12. In the case study the attempt is made to provide in narrative form a highly plastic impression of the analytic process and the course of treatment, and yet also to depict several clinical key scenes as close as possible to the concrete interaction in the analytic session. In these narrative summaries, the clinicians of the LAC survey select various foci (e.g., handling suicidality of the patients, the role of medication, the "psychic retreat" of the analysands, etc.). They all have been trained by David Taylor applying the "Tavistock Manual for Depression". Here, emphasis is placed on the transformations in the dream content or the acquisition of knowledge by way of the analytical work with dreams in the transference to the analyst.
13. I am a Swiss national!
14. Mr. W. caught sight of the impressive illustrated book by Matthew Johnstone (2005) entitled *I Had a Black Dog* lying in my office, and purchased a copy. Occasionally, reference is made to the book in the psychoanalysis.
15. As is known, in the specialist psychoanalytic literature of recent years an interesting controversy is taking place on the question as to how the life-threatening truth of the trauma bears in on the analytic process (cf. Bohleber, 2010; Fonagy & Target, 1997; Leuzinger-Bohleber et al., 2010).

SIGNIFI.indb 79 1/31/12 1:11:11 AM

16. The specific interactions between analyst and analysand in the following are, in part, recorded verbatim.
17. Mr. W. has meanwhile watched the CD of John from the above-mentioned Robertson films, which we had discussed in earlier stages of the treatment.

References

Abraham, K. (1911). Notes on the psychoanalytic investigation and treatment of manic-depressive insanity and allied conditions. In: *Selected Papers on Psychoanalysis* (pp. 137–156). New York: Basic, 1953.

Abraham, K. (1924). A short study of the development of the libido, viewed in the light of mental disorders. In: *Selected Papers on Psychoanalysis* (pp. 418–501). New York: Basic, 1953.

Balint, M. (1968). *The Basic Fault. Therapeutic Aspects of Regression*. London: Tavistock/Routledge, 1989.

Baranger, M., Baranger, W. & Mom, J. M. (1988). The infantile psychic trauma from us to Freud: pure trauma, retroactivity and reconstruction. *International Journal of Psychoanalysis*, *69*: 113–128.

Bibring, E. (1953). The mechanism of depression. In: P. Greenacre (Ed.), *Affective Disorders. Psychoanalytic Contributions to their Study* (pp. 13–48). New York: International Universities Press.

Bifulco, A. T., Brown, G. W. & Harris, T. O. (1987). Childhood loss of parent, lack of adequate parental care and adult depression: A replication. *Journal of Affective Disorders*, *12*: 115–128.

Blatt, S. (2004). *Experiences of Depression. Theoretical, Clinical and Research Perspectives*. Washington, DC: American Psychological Association.

Bleichmar, H. B. (1996). Some subtypes of depression and their implications for psychoanalytic treatment. *International Journal of Psychoanalysis*, *77*: 935–961.

Bleichmar, H. (2010). Erneutes Nachdenken über krankhaftes Trauern-multiple Typen und therapeutische Annäherungen. In: M. Leuzinger-Bohleber, K. Röckerath & L. V. Strauss (Eds), *Depression und Neuroplastizität* (pp. 117–137). Frankfurt, Germany: Brandes u. Apsel.

Blum, H. P. (2007). Holocaust trauma reconstructed: Individual, familial, and social trauma. *Psychoanalytic Psychology*, *24*: 63–73.

Bohleber, W. (2000). Editorial on trauma. *Psyche—Z Psychoanal*, *54*: 795–796.

Bohleber, W. (2005). Zur Psychoanalyse der Depression. *Psyche—Z Psychoanal*, *59*: 781–788.

Bohleber, W. (2010). Editorial. *Psyche—Z Psychoanal*, *64*: 771–781.

Bokanowski, T. (1996): Freud and Ferenczi: Trauma and transference depression. *International Journal of Psychoanalysis*, *77*: 519–536.

Bokanowski, T. (2005). Variations on the concept of traumatism: Traumatism, traumatic, trauma. *International Journal of Psychoanalysis*, *86*: 251–265.

Bose, J. (1995). Trauma, depression, and mourning. *Contemporary Psychoanalysis*, *31*: 399–407.

Bowlby, J. (1980). *Loss: Sadness and Depression. Attachment and Loss, Vol. 3*. London: Hogarth.

Bremner, J. D. (2002). *Does Stress Damage the Brain? Understanding Trauma-related Disorders from a Mind-body Perspective*. New York: W. W. Norton.

Brown, G. W. & Harris, T. (1978). *Social Origins of Depression*. London: Tavistock.

Caspi, A., Sugden, K., Moffitt, T. E., Taylor, A., Craig, I. W., Harrington, H., McClay, J., Mill, J., Martin, J., Braithwaite, A. & Poulton, R. (2003). Influence of life stress on depression: Moderation by a polymorphism in the 5-HTT gene. *Science*, *301*: 386–389.

Denis, P. (1992). Depression and fixations. *International Journal of PsychoAnalysis*, *73*: 87–94.

Edelman, G. M. (1987). *Neural Darwinism: the Theory of Neural Group Selection*. New York: Basic.

Ehrenberg, A. (1998). Das erschöpfte Selbst. Depression und Gesellschaft in der Gegenwart. Frankfurt, Germany: Campus, 2004.

Fergusson, D. M. & Woodward, L. J. (2002). Mental health, educational and social role outcomes of adolescents with depression. *Archives of General Psychiatry*, *62*: 66–72.

Fonagy, P. (2010). Attachment, trauma and psychoanalysis: Where psychoanalysis meets neuroscience. In: M. Leuzinger-Bohleber, J. Canestri & M. Target (Eds.), *Early Development and its Disturbances. Clinical, Conceptual and Empirical Research on ADHD and other Psychopathologies and its Epistemological Reflections* (pp. 40–62). London: Karnac.

Fonagy, P. & Target, M. (1997). The recovered memory debate. In: J. Sandler & P. Fonagy (Eds.), *Recovered memories from abuse. True or false?* (pp. 183–217). London: Karnac Books.

Freud, A. (1965). *Normality and Pathology in Childhood*. New York: International Universities Press.

Freud, S. (1917). *Mourning and Melancholia*. *S. E.*, *14*. London: Hogarth, pp. 243–258.

Freud, S. (1926). *Inhibitions, Symptoms and Anxiety*. *S. E.*, *20*. London: Hogarth, pp. 87–174.

Goldberg, D. (2009). The interplay between biological and psychological factors in determining vulnerability to mental disorder. *Psychoanalytic Psychotherapy*, *23*: 236–247.

Haynal, A. (1977). Le sens du désespoir. Rapport XXXVIe Congrès de Psychanalystes de Langues Romanes. *Revue Francaise de Psychanalyse*, *41*: 5–186.

Haynal, A. (1993). *Psychoanalysis and the Sciences: Epistemology—History*. Berkeley, CA: University of California Press.

Hellman, I. (1978). Simultaneous analysis of parent and child. In: J. Glenn, (Ed.), *Child Analysis and Therapy* (pp. 473–493). Northvale, NJ: Jason Aronson, 1992.

Hill, J. (2009). Developmental perspectives on adult depression. *Psychoanalytic Psychotherapy*, *23*: 200–212.

Hill, J., Pickles, A., Burnside, E., Byatt, M., Rollinson, L., Davis, R. & Harvey, K. (2001). Sexual abuse, poor parental care and adult depression: Evidence for different mechanisms. *British Journal of Psychiatry*, *179*: 104–109.

Jacobs, K. S. (2009). Major depression: revisiting the concept and diagnosis. *Advances in Psychiatric Treatment*, *15*: 279–285.

Jacobson, E. (1971). *Depression. Comparative Studies of Normal, Neurotic and Psychotic Conditions*. New York: International Universities Press.

Johnstone, M. (2005). *Mein schwarzer Hund. Wie ich meine Depression an die Leine legte*. Munich, Germany: Kunstmann, 2008.

Joffe, W. G. & Sandler, J. (1965). Notes on pain, depression and individuation. *Psychoanalytic Study of the Child*, *20*: 394–424.

Kendler, K. S., Gatz, M., Gardner, C. O. & Pederson, N. L. (2006). A Swedish national twin study of lifetime major depression. *American Journal of Psychiatry*, *163*: 109–114.

Kernberg, O. F. (2000). Mourning and melancholia. Eighty years later. In: J. Sandler, R. Michels & P. Fonagy (Eds.), *Changing Ideas in a Changing World: The Revolution in Psychoanalysis—Essays in Honour of Arnold Cooper* (pp. 95–102). New York: Karnac.

Klein, M. (1935). A contribution to the psychogenesis of manic-depressive states. In: *The Writings of Melanie Klein, Vol. I* (pp. 262–289). London: Hogarth, 1985.

Klein, M. (1940). Mourning and its relation to manic-depressive states. In: *The Writings of Melanie Klein, Vol. I* (pp. 344–369). London: Hogarth, 1985.

Kohut, H. (1971). *The Analysis of the Self*. New York: International Universities Press.

Kohut, H. (1977). *The Restoration of the Self*. New York: International Universities Press.

Leuzinger-Bohleber, M. (1987). *Veränderung kognitiver Prozesse in Psychoanalysen, Band I: eine hypothesengenerierendeEinzelfallstudie*. Ulm: PSZ-Verlag.

Leuzinger-Bohleber, M. (1989). *Veränderung kognitiver Prozesse in Psychoanalysen, Band II: Fünf aggregierte Einzelfallstudien.* Ulm: PSZ-Verlag.

Leuzinger-Bohleber, M. (2001). The "Medea fantasy". An unconscious determinant of psychogenic sterility. *International Journal of Psychoanalysis*, *82*: 323–345.

Leuzinger-Bohleber, M. (2007). Forschende Grundhaltung als abgewehrter "common ground" von psychoanalytischen Praktikern und Forschern? *Psyche—Z Psychoanal, 61*: 966–994.

Leuzinger-Bohleber, M. (2008). Biographical truths and their clinical consequences: Understanding "embodied memories" in a third psychoanalysis with a traumatized patient recovered from serve poliomyelitis. *International Journal of Psychoanalysis*, *89*: 1165–1187.

Leuzinger-Bohleber, M. (2010). Early affect regulations and its disturbances: Approaching ADHD in a psychoanalysis with a child and an adult. In: M. Leuzinger-Bohleber, J. Canestri & M. Target (Eds.). *Early development and its disturbances: Clinical, conceptual and empirical research on ADHD and other psychopathologies and its epistemological reflections* (pp. 185–206). London: Karnac.

Leuzinger-Bohleber, M. (in press). Preventing depression: Transgenerational trauma—an unexpected clinical observation in extra-clinical studies. Paper given at the Meeting of the Canadian Psychoanalytical Association, June 2, 2010.

Leuzinger-Bohleber, M., et al. (2010). Psychoanalytische und kognitiv-verhaltenstherapeutische Langzeittherapien bei chronischer Depression: Die LAC Depressionsstudie. *Psyche—Z Psychoanal, 64*: 782–832.

Leuzinger-Bohleber, M., et al. (in press). Psychoanalytische und kognitiv-verhaltenstherapeutische Langzeittherapien bei chronischer Depression: Die LAC Depressionsstudie. *Psyche—Z Psychoanal*, *64*: 782–832.

Leuzinger-Bohleber, M., Engels, E.-M. & Tsiantis, J. (Eds.) (2008). *The Janus Face of Prenatal Diagnostics. A European Study Bridging Ethics, Psychoanalysis, and Medicine*. London: Karnac.

Leuzinger-Bohleber, M. & Pfeifer, R. (2002). Remembering a depressive primary object? Memory in dialogue between psychoanalysis and cognitive science. *International Journal of Psychoanalysis*, *83*: 3–33.

Leuzinger-Bohleber, M., Rüger, B., Stuhr, U., Beutel, M. (2002). *"Forschen und Heilen" in der Psychoanalyse. Ergebnisse und Berichte aus Forschung und Praxis*. Stuttgart: Kohlhammer.

Leuzinger-Bohleber, M., Stuhr, U., Rüger, B. & Beutel, M. (2003). How to study the "quality of psychoanalytic treatments" and their long-term effects on patients' well-being. A representative, multi-perspective follow-up study. *International Journal of Psychoanalysis*, *84*: 263–290.

Markson, E. (1993). Depression and moral masochism. *International Journal of Psychoanalysis*, *74*: 931–940.

McQueen, D. (2009). Depression in adults: Some basic facts. *Psychoanalytic Psychotherapy*, *23*: 225–235.

Mills, J. (2004): Structuralization, trauma and attachment. *Psychoanalytic Psychology*, *21*: 154–160.

Morrison, H. L. (Ed.) (1983): *Children of Depressed Parents: Risks, Identification and Psychotherapeutic Technique*. Northvale, NJ: Jason Aronson, 1991.

Ogden, T. H. (1982). *Projective Identification and Psychotherapeutic Technique*. Northvale, NJ: Jason Aronson.

Pfeifer, R. & Bongard, J. (2006). *How the body shapes the way we think: A new view of intelligence*. Cambridge, MA: MIT Press.

Pfeifer, R. & Leuzinger-Bohleber, M. (2011). Minding the traumatized body—clinical lessons from embodied intelligence. Unpublished paper given at the Neuropsychoanalysis Congress, "Minding the Body", June 25, (see www.sigmund-freud-institut.de).

Rado, S. (1928). The problem of melancholia. *International Journal of Psychoanalysis*, *9*: 420–438.

Rado, S. (1951). Psychodynamic understanding of depression. *Psychosomatic Medicine*, *13*: 51–55.

Reerink, G. (2003). Traumatisierte Patienten in der Katamnesestudie der DPV. Beobachtungen und Fragen zur Behandlungstechnik. *Psyche—Z Psychoanal*, *57*: 125–140.

Rohde-Dachser, C. (in press). Depression bei Borderlinepatienten. *Psyche—Z Psychoanal*, *64*: 862–889.

Rosenfeld, H. (1964). On the psychopathology of narcissism: a clinical approach. In: *Psychotic States. A Psychoanalytic Approach* (pp. 169–179). London: Maresfield Reprints, 1984.

Rutter, M. (2009). Gene-environment interactions. Biologically valid pathway or artefact? *Archives of General Psychiatry*, *66*: 1287–1289.

Schulte-Körne, G. & Allgaier, A.-K. (2008). Genetik depressiver Störungen. *Zeitschrift für Kinderund Jugendpsychiatrie und Psychotherapie*, *36*: 27–43.

Skalew, B. (2006). Trauma and depression. *International Journal of Psychoanalysis*, *87*: 859–861.

Spence, D. (1982). *Narrative Truth and Historical Truth: Meaning and Interpretation in Psychoanalysis*. New York: Harper.

Spitz, R. (1946). Anaclitic depression. *Psychoanalytic Study of the Child*, *2*: 313–341.

Steiner, J. (2005). The conflict between mourning and melancholia. *Psychoanalytic Quarterly*, *74*: 83–104.

Stone, L. (1986). Psychoanalytic observations on the pathology of depressive illness: selected spheres of ambiguity or disagreement. *Journal of the American Psychoanalytic Association*, *34*: 329–362.

Suomi, S. (2010). Trauma and epigenetics. Unpublished paper given at the 11th Joseph Sandler Research Conference: Persisting Shadows of Early and Later Trauma. Frankfurt, Germany, February 7.

Taylor, D. (2010). The Tavistock Depression Manual. *Psyche—Z Psychoanal*, *64*: 833–861.

Terr, L. C. (1994). *Unchained Memories: True Stories of Traumatic Memories, Lost and Found*. New York: Basic.

Winnicott, D. W. (1965). *The Maturational Processes and the Facilitating Environment*. London: Hogarth and the Institute of Psycho-Analysis.

SIGNIFI.indb 85 1/31/12 1:11:12 AM