

Dialogues with Schizophrenia

The Art of Psychotherapy

THE THREE LEVEL APPROACH
TO PSYCHO-DYNAMICS
AND SOME REFLECTIONS ON COUNTER-
TRANSFERENCE AND SUPERVISION

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Fourth, revised edition
ISBN 965-90450-1-6 ? ´«”

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To Joyce,

Listen to the patient. He is telling you the
interpretation.

(After Frederick Christopher)

Life is a tale, told by an idiot, full of sound and
fury, signifying madness.

(After Shakespeare and Faulkner)

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Preface

By Joyce McDougall, D.ed

It is my privilege to be able to preface this work, which represents the fruit of Dr. Rafael Springmann's numerous contributions comprising over thirty years of reflection, to the clinical and theoretical issues involved in treating patients suffering from delusional states.

In the first part of the book the author, an experienced psychiatrist (who for several years was chief psychiatrist of Israel's defense force and later director of mental health in the Israeli ministry of health) describes a theory of interpretations developed primarily by Henry Ezriel of the Tavistock Clinic in London and subsequently applied and extended by Dr. Springmann to various clinical situations, such as brief psychotherapies, group (especially large group, such as ward meetings) therapies and so on. His reflections include all clinical entities - from simple secondary male impotence to chronic schizophrenia - and the author applies this interpretative approach to many theoretical axes of development, including the Freudian (psycho-sexual) the Kleinian-Kernbergian (integrational) axis, the Kohutian (grandiosity to mature self-confidence) approach, as well as Piaget's theory of cognitive development. Springmann then goes on to examine the mutual influence of these different perspectives on each other.

The second part of the book deals with the differential approach to, and the implementation of many issues involved in the experience of countertransference. In this latter section, the author combines his theoretical and clinical perspectives with a theoretical approach to the problem of supervision. In this part special attention is mentioned concerning the treatment of

countertransference problems arising in therapists who deal with mass trauma, a topic that has, unfortunately, become relevant again these days.

Springmann's book is unique in that he does not follow one developmental theory or another, but offers a solution for integrating the various axes into one consistent system, in which each developmental axis may influence the others. The Freudian axis may influence the one suggested by Piaget, the Kleinian-Kernbergian axis of integration may be influenced by the Mahlerian axis of separation-individuation etc. All this is richly illustrated by clinical vignettes, thus enabling the reader to discover that each new theoretical position has its clinical counterpart.

It is a notable fact that during the decades preceding his retirement from public service Dr. Springmann was head of an open ward in a large psychiatric hospital, responsible for the in-service training of interns, nurses and psychologists, as well as the training programs of students of various categories (medical students, advanced psychologists, art therapists, etc.) He also was invited to supervise the psychotherapeutic work of wards other than his own. Furthermore, at the "Sackler" Tel Aviv University, in the role of senior clinical lecturer, in the department of psychology and supervisor of psychotherapy, Dr. Springmann was also responsible for a course dealing with the psychotherapy of schizophrenia, at the school of psychotherapy of the same University.

In view of this breadth of professional experience and its fertilizing effect upon theoretical propositions, and in addition to his highly readable style, his often intriguing clinical vignettes and his underlying sense of humor, Rafael Springmann's work will be read with

interest and profit by all mental health professionals, beginners as well as supervisors. It is innovative and psychoanalytically valid, and will also be enjoyable reading material for the cultivated layman interested in the subject of psychoanalysis.

Joyce McDougall

PART ONE

THE THREE LEVEL APPROACH TO PSYCHO-DYNAMICS

A Tribute to Henry Ezriel

Introduction

I first met Henry Ezriel during my stay at the Tavistock Center in London as a W.H.O. fellow during the years 1969-70. For that period I participated in his seminars and was supervised, among others, by him. He was a very secluded person, who shared very little about his personal life except for the fact that he had immigrated to the United Kingdom from Vienna. He had done so at about the same time Freud had, and for similar reasons. At the time we met he was at the end of his career as Consultant to one of the adult department at the Tavistock Center.

One of the few topics he did often speak about that concerned him was his wish to collect his data and ideas to publish them as a book. This present book should therefore have been written by him. Failing this, he should have had the opportunity to foreword it.

Both these options have, however, become obsolete by his rapidly deteriorating health and early demise. I had only two chances to see him before his death during brief stays in London. During the last one of those he was already blind, due to a stroke.

His work and ideas have, nevertheless, been of such fundamental impact on my own way of thinking that I have decided to collect my ideas and publish them in the form of this present book. Previously, these ideas had been written in the form of articles in various journals under the direct impact of his influence. I have decided to re-enforce those articles with further clinical material collected from the literature and from my own

experience and integrate them into the developing framework of concepts, all this to enhance the recognition of Ezriel's work. This work, I believe, has never received the recognition it deserves.

Two points need to be mentioned here. The first is that the terms psychoanalysis and psychoanalytically oriented psychotherapy will be used in this book interchangeably. This is a result of my belief that the two methods differ more in technique than in the basic mechanisms they are founded on. The second point is that the informed reader will notice the virtual absence in the first part of this book of references to countertransference and its counterpart, supervision. These two entities are cornerstones of contemporary psychoanalysis. The absence has two reasons. One reason is that countertransference and the theory of supervision played a very minor role in Ezriel's work. I believe that a book dedicated to his memory should not overstep these boundaries. Nevertheless, it has to be mentioned that it was Ezriel who first pointed out to me the importance of Heimann's (1950) fundamental work on this topic. The second reason is that the second part of this book is dedicated exclusively with some ideas of mine that concern countertransference and supervision. I believe these entities to be closely related.

An apology seems to be in order for those readers who will find well-known terms re-defined. This is due to the fact that the book is intended both to mental health professionals and to interested laymen.

This book leans to some extent, but by no means exclusively, on previously published material. This would be the appropriate opportunity to thank the editors of the various journals and books who

generously allowed me to borrow both ideas and clinical material published by them.

Deeply felt gratitude is due to those patients and mental-health practitioners, such as the psychiatric residents, psychologists, psychiatric social workers, art therapists, clinical criminologists and many others. They opened their hearts to me and thereby enabled me to participate as an invisible (ex parte), like Ogden's (1994) Analytic Third, participant in their intimate interactions with their patients. Without their sincerity, the formulation of the concepts and ideas presented, especially in the second part of this book, would not have been possible.

Last, but not least, special gratitude is due to Rachel, my wife, for sacrificing many conveniences in life to make time both for the articles and for their integration in this book. Without the constant moral support of Dr. Joyce McDougall, this work might not have come into being. Ronen and C.E., accomplished in the intricacies of the computer, deserve to be mentioned too. Special thanks are due to Ms. D. F. Without being asked, she put my English under her scrutiny and helped me turn it into better reading for those whose English is better than mine.

List of books and articles from which material has been taken:

Part One

I. Contemporary Psychoanalysis

- 1. Three Level Interpretations.** Vol. 10, pp. 453-464, (1974)

2. **Fragmentation as a Defense in Large Groups.** Vol. 12, pp. 203-213 (197
 3. **Negative Countertransference & Negative Therapeutic Reactions.** (Conjoint with A. Aviv M.D.) Vol. 20, pp. 692-715, (1990)
- II. **The Israel Journal of Psychiatry & Related Disciplines.**
- . **Account of the Analysis of a Delusion & some Theoretical Comments on Non-interpretative Psychotherapeutic Interventions.** Vol. 9, pp. 170-177, (1971)
 - . **Some Remarks on the Relationship between Delusions, Reality Testing Reality.** Vol. 16, No. 2 pp. 150-160 (1978)
- III. **The International Journal of Group Psychotherapy**
1. **A Large Group.** Vol. 20 No. 2 pp. 210-218 (1970)
 2. **The Application of Interpretations in Large Groups.** Vol. 24, pp. 333-341(1974)
- IV. **Constable Publications In *The Large Group, Dynamics & Therapy.*** Ed. L. Kreeger, London, (1975)
1. **Psychotherapy in the large group,** pp. 212-227.
- V. **Pergamon Press: The Journal of Psychiatric Treatment & Evaluation**

1. **Some Remarks on Psychotherapy by a Single Interpretation.** Vol. 4, pp. 327-332. (1982)

IV. **Harefuah**

1. **Once upon a Time there was a Schizophrenic.** Vol. 129, pp. 316-319 (1995) (In Hebrew).

VII. **Solving the Puzzle (The three level approach to psychodynamics)**

1. Papyrus Publishing House, Tel Aviv University. (Owned by Dionun, Inc.) ISBN 965-306-128-3 (1996). (In Hebrew).

Part Two

I. **Contemporary Psychoanalysis**

1. **Countertransference, Clarification in Supervision.** Vol. 22, pp. 252-277, (1986).
2. **Countertransference as an Indicator in Victimology.** Vol. 24, pp. 341-349, (1988)

II. **The British Journal of Medical Psychology**

1. **Reflections on the Role of the Supervisor.** Vol. 62, pp. 217-228, (1989).

It goes without saying that every effort has been made to disguise and distort identities, without at the same time tempering with the essential dynamic features

Once upon a time...

Four patients will be presented here as an introduction for the following chapters. In these patients it could be proved empirically that psychological factors have significant influence on the schizophrenic process. This influence can be both positive as well as negative. These cases indicate that intra-psychoic conflicts may participate in the creation of psychotic symptoms. The solution of such conflicts by suitable interventions may cause the disappearance of such symptoms.

The biologic infrastructure of schizophrenia cannot be denied. It would be pointless to refer here to all the research that discovered physiologic

or anatomic changes in the brains of schizophrenics; suffice it to mention that no non-psychotic individual could tolerate the amounts of psychotropic drugs a psychotic person had to swallow every day. Nevertheless it is my intention to show that thoughtless use of anti-psychotic drugs, that does not consider intra-psychic and inter-personal constellations, is liable to cause psychotic breakdown. In two cases it was possible to demonstrate that long-term psychotherapy, conjoint with rational medication, might cause the post-psychotic defect to be reversible.

The therapeutic techniques used in these cases, those based on interpretations as well as those based on non-interpretative interventions will be expounded in the following chapters.

Case A

Once upon a time there was a schizophrenic called Adam. Because of previous suicide attempts, he was hospitalized in a closed ward. Taking advantage of circumstances, that later were the cause of an investigation committee, he escaped the ward. He jumped from a tall building, injured his spine and remained confined to a wheelchair for the next few years. After he had been somatically rehabilitated, still in a wheelchair, he was returned to the ward he had escaped from. As there were no more suicidal thoughts, he was transferred to an open ward.

His parents were divorced and his father acted as his guardian. Adam's mother did not visit him until his father passed away. His father agreed not to sue the hospital. In return he was assured that his son could stay in the hospital as long as he needed. Adam was a very secluded person. He participated in ward meetings very unwillingly, his

interventions, however, when asked directly, were always to the point and showed a capacity for deep insight. For several years he was free of psychotic symptoms. For lack of another solution he was finally transferred to a chronic ward. Several times during his stay in the open ward, psychotherapy was attempted. Adam resisted these attempts passively.

Then a young female art therapist joined the staff of the open ward. She decided to attempt psychotherapy despite previous failures. Either by putting new, non-verbal means of expression at his disposal, or because of her own outstanding personality, she found the key to his inner life and caused him to open up. In return, he rewarded her by allowing her to gain a deep insight into his internal life. Dark childhood secrets emerged and Adam's inner life was enriched. The scope of his interest, as well as that of his activities increased. A very intense inter-relationship formed and Adam expected his therapeutic sessions eagerly. In order to understand future developments, it is important to point out that the art therapist was not a member of the team of the chronic ward. This enabled her to keep an optimal distance from her patient.

After some years Adam's father passed away and his mother, who had carefully kept distant, started to visit him frequently. She decided to exploit her son's invalidity. At that time Adam was already free to come and go as he saw fit, and seduced by his mother he signed a complaint.

At her next meeting with Adam, his therapist was surprised that he had become psychotic, the first time this happened in years. He was now transparent; people were reading his mind, etc. This was the first time for the therapist to see the

development in *statu nascendi*, of active psychotic symptoms. She panicked and turned to the psychiatrist in charge. Without giving the matter another thought, Adam's medication was tripled. Adam perceived this as a narcissistic injury and in his next session he accused his therapist of having betrayed him. "I always regarded you as someone who could contain my fears. Now, at the first time something is wrong I see you running to the doctor in panic."

It has to be mentioned here that Adam's very ability to accuse his therapist without apparent fear of losing her, constituted proof that considerable intra-psychic repair had already been achieved.

Nevertheless, these expressions of rage and disappointment were very painful for the therapist and she decided to present the case for supervision. In the supervisory session a causal relationship between the outbreak of the psychosis and the events that had preceded this outbreak was suggested. It was postulated that by suing the hospital, Adam indirectly and probably unconsciously also sued his beloved therapist. This must have caused a conflict and this conflict was surmised to be the cause for the psychotic outbreak. There was as yet no definite knowledge that might concern the contents of the psychosis. Speculations were uttered that feeling transparent was some form of intra-psychic transformation of Adam's ability to understand other peoples' thoughts. This, however, was at this stage, mere speculation and much too early to be included in the therapy.

This speculation could be substantiated much later in the therapy, when it transpired that Adam felt guilty because by foreseeing tragic events, such as his parents' divorce or a friend's death of cancer, he had caused them.

At the present point, the therapist was advised to confront her patient and explain to him the development of events. In her next session she did so, Adam's symptoms subsided, his medication could be reduced to its previous, minimal dose and the therapeutic venture continued as before.

About five years after these events Adam became psychotic once more. This happened when his therapist was transferred from a different ward to the ward he stayed in. This proximity meant the overstepping of a boundary he was not yet prepared for and created the phenomenon that will be defined in the next chapter as the spontaneous negative therapeutic reaction. As soon as this situation was explained to him, the psychotic symptoms disappeared once more.

Adam won the lawsuit, now liberated from its conflict. He asked for a guardian to be appointed so that his mother could not put her hands on the considerable sum he received and spends his money cautiously.

At the present time, about fifteen years after the events described here, Adam is a free man. He weaned himself of the wheelchair and uses public transportation. He is self-employed as the owner of

a small computer business. He keeps contact with his therapist and still receives a minimal dose of anti-psychotic medication. In my opinion this is no longer necessary, but I have no more say in the matter.

Case B

Once upon a time there lived a twenty-five year old bachelor named Ben. For most of his life he lived on the thin line that divides the low-level borderline personality organization from the schizophrenic. He carefully kept an elegant external appearance but lived on the fringes of society in rented rooms financed by his mother. He did nothing to provide for his livelihood and frequently threatened to commit suicide. These threats never resulted in a serious suicide attempt.

Ben persisted in accusing his mother for having caused the untimely death of his father, without having proof for any of these accusations. When his mother despaired, she turned to an ambulatory mental-health facility. She was given the advice to stop supporting her son and thereby to force him to stop being a parasite. This advice did not turn out well. Ben began to sleep in open, forsaken buses or, when given the opportunity, in friends' homes. Finally, he turned up in an open ward of a psychiatric hospital.

Upon first being examined he was found to be well mannered, well dressed, probably beyond his financial means. No gross psychopathology could

be detected besides very delicate disturbances in his thought processes. These disturbances could also be easily understood to constitute attempts to evade embarrassing questions. He kept a meticulous external appearance that prevented him from being identified as a patient who is forgiven minor trespasses. He also had a sharp, deadly critical capacity for observation, mainly of staff behavior, and did not keep quiet about the things he observed. His behavior turned him into the target of petty vengefulness on part of the nursing staff.

After about half a year, he was coming and going as he pleased, infringing ward rules and thereby enraging the nursing staff even more. Despite his freedom he cleverly eluded all attempts to release him from the hospital, probably because he knew that he could not survive in the outside world.

In these circumstances one of the psychiatric social workers undertook intra-psychic therapy. She was not excluded from Ben's corrosive criticism, and was able to persist only when intensively supported by group-supervision. Nevertheless, the therapy thrived until, some minimal basic trust was established and the psychotherapy seemed to be going well.

At this stage a senior ambitious psychiatrist intervened. He could not put up with such a prolonged, ostensibly futile stay in the hospital, as the situation seemed when looked at superficially. He put pressure on the social worker not to be satisfied with intra-psychic repair and demanded that the social worker push her patient to be rehabilitated in the community. The social worker recognized these two tasks to be mutually contradictory, like Ben's mother withdrawing her support. Unable to withstand the senior

psychiatrist's pressure, she gave up on the therapy.

The same psychiatrist who had demanded the change in the therapeutic strategy was now up to the task. At first, Ben was pleased with this change. Instead of a weak, criticized mother figure, he now had a prestigious psychiatrist, a strong father figure. This change made him feel much better. Young female patients in the ward, however, disliked the psychiatrist. These patients constantly taunted and ridiculed him. Ben attempted to defend his new father figure and when he failed, he physically attacked the taunting patients.

Without delving deeper into the meaning of his patient's act, the psychiatrist interpreted it as the final overt breakthrough of his psychosis, which had hitherto been covert. He consequently ordered Ben to be injected with a massive dose of anti-psychotic drugs. Immediately after having been injected, Ben did indeed start to show psychotic symptoms, such as ideas of reference.

This sequence of events was also brought to supervision. It was postulated that the physical attack against the taunting women was not necessarily an expression of Ben's condition deteriorating, a sign of the eruption of a psychotic process, but rather an attempt to protect the downtrodden dignity of his "father." It was also pointed out that the psychotic symptoms had become apparent after the injection that must have been felt by the patient as a narcissistic insult, an unjustified punishment meted out by a beloved father for having defended his honor. As had been in the case of Adam, the therapist was advised to admit his misunderstanding, to unfold with Ben the chain of events and its significance

as now understood. In this case, however, the therapist did not possess the inner strength needed to admit his mistake. He shunned further supervision and the therapy gradually petered off.

Ostensibly it would seem that I have chosen these cases because they contained similarities: in both cases therapists made psychological mistakes. Further insight will, however, reveal that this similarity was merely superficial. In the case of Adam the mistake, which consisted of the therapist's panic driven address to the medical authority and incurred the increase of drug treatment, was made after the psychotic breakdown had already occurred. The conflict itself was based on extra-therapeutic circumstances that involved the therapy only secondarily. The therapist's mistake merely complicated the transference in the therapeutic interaction and made the resolution of the extra-therapeutic conflict more difficult. Nevertheless, undoing the mistake enabled the resolution of the conflict and the disappearance of the psychotic symptoms.

In the case of Ben the situation was different. The therapist's double mistake constituted the very essence of the conflict, a direct cause for the psychotic breakdown, whereas his inability to admit his mistake prevented him from any possibility of reversing the process. (The double mistake consisted of the therapist's inability to differentiate between an aggressive act and a psychotic breakdown and his hasty use of psychotropic drug treatment, before having understood the psychodynamic significance of this very aggressive outburst).

The real reason for choosing these two cases lies in their dynamic transparency. This transparency

had its roots in the fact that in both cases psychotic symptoms appeared in circumstances that could be observed and followed closely. Thereby they enabled the discovery of the direct relationship between the evolvement of each of the psychoses and the conflict that lay at its basis. I tend to refer to this kind of situation, as I did above, as a psychosis in *statu nascendi*. Experience has taught me that in such circumstances it is frequently relatively easy to see the direct relationship between underlying psychodynamic factors and the creation of psychotic symptoms. These factors can then be analyzed, the conflicts resolved and the psychotic processes involved be stopped.

All the above suggests a conclusion that whatever the biological infrastructure for schizophrenia be, purely psychological factors ought not to be ignored as significant factors in the outbreak of the disease, as well as in its arrest. In both cases it was not an internal, inexorably ticking, biologic clock, nor Leff's (1985) high E.E. (expressed emotion) that caused the outbreak of the psychosis. As described, in each case psychological conflicts, with which the patients involved were unable to contend for lack of sufficient defense mechanisms at their disposal at that time, were the immediate cause for the outbreak of the psychotic symptoms. This means that these patients constitute a representative sample of at least some patients, with psychological structures that react to intolerable psychological circumstances with psychotic symptoms.

It is rarely easy to recognize these circumstances with such relative ease, to uncover the underlying conflicts, as described here. The opportunity to

observe morbid processes as they initiate, thus being able to understand the pathogenic processes at their basis, is most infrequent. In most patients who arrive at mental health facilities, especially hospitals, the psychotic symptoms had fully developed a long time before a diagnostician could observe them.

Furthermore, in quite a few patients a covert, denied, unconscious covenant exists between patient and family, a covenant the purpose of which is to conceal the relevant psychological factors. (C.F. Katherine & Paulette). This is on top of sheer forgetting, the result of time. In these cases the psychosis constitutes a mechanism to maintain intra-family equilibrium, that had been unbalanced and its solution might re-endanger this unstable equilibrium. These circumstances result in the fact that even when a psychotherapeutic venture in a case diagnosed *a priori* as schizophrenic is invested at all, long periods of time will be needed to pinpoint the underlying conflicts and their solution. These long periods are to be measured in years.

In this context the following incident seems to raise some questions as to the merely biological components of schizophrenia in general. A new psychiatrist had just joined the staff of the hospital I was working at. He was a newcomer to the country, an immigrant from an English speaking country and had not yet learned a word in Hebrew. He was assigned to one of the wards where the inmates were particularly disturbed. As soon as he first entered the ward, he was accosted by one of the paranoid schizophrenics and inundated by his complaints in Hebrew. The new psychiatrist now opened up in English: "I'm sorry. I don't understand a word you say. I came to this

country only a week ago and have not yet learned any Hebrew.” The patient's frozen face turned into a warm, welcoming smile and he opened up in English: “Oh, I’m sorry. I didn’t know you spoke no Hebrew. Welcome to Israel. I am so glad that you could make the decision to come here, and hope you will find it easy to acclimate in the new surroundings,” etc., all in a matter of fact tone, with correct intonation and without any sign of thought disturbance, neither in content nor in formal thought process.

Psychiatry taught in most institutions today, in which more and more emphasis is put on the biological aspects of almost any mental disorder, implicitly caused the creation of two almost automatic reflexes:

- a. Any unexpected and superficially examined, unexplained, aggressive outbreak unequivocally means a deterioration in the patient’s condition, probably the first sign of the outbreak of a psychosis.
- b. Such an aggressive outbreak, and even more so, the real outbreak of psychotic symptoms, signifies insufficient, inadequate or not intensive enough drug treatment and must automatically be followed by increase or replacement of drug treatment.

No wonder that such an automatic attitude may lead to apparently paradoxical results, so that the damage of automatic drug treatment might outweigh its benefit. Turning the attention of psychiatrists to the possible mistakes inherent in this mono-dimensional attitude is a further,

important motivation underlying the choice of the cases of Adam and Ben for presentation.

So far only the positive aspects, the psychotic productions (referred to above, for the sake of convenience, as Schneiderian signs) of schizophrenia have been discussed. These symptoms, that include delusions, hallucinations of various types, etc., are generally typical for the acute, initial phase of the disease. Henceforth the negative symptoms of the disease will be discussed. These are typical for the chronic state, generally considered to be irreversible, results of the pathological process and referred to as post psychotic defects, a kind of psychic scar, the leftovers of the acute phases. In rare cases they are known to appear without being preceded by acute phases. Patients lose their functional capacities, narrow their scope of interest, etc. The following presentation will focus on two typical such negative signs: the lesions afflicted to the affect and those afflicted to cognitive ability.

The affective lesion is characterized by a flattening of feelings, loss of their more delicate modulations that make the emotional tone fit the cognitive contents of communications, typically accompanied by intense outbursts, out of proportion to negligible stimuli.

From among the cognitive defects, the loss of abstract thought is relevant in the present circumstances. This is usually tested by the patient's interpretations of proverbs. Whereas a healthy individual would interpret the proverb "to bite the hand that feeds one" as referring in one way or another to ingratitude, the defected schizophrenic would answer in a concrete way, such as 'biting being dangerous because it might cause infection.'

Case C

Once upon a time there was a schizophrenic called Caleb. He developed schizophrenia in his early twenties and had been in hospital many times, often after having viciously attacked one or another member of his family. In one of these hospitalizations, after having calmed down, he was transferred to an open ward for continuation of his treatment. His affect was by now severely defective; he spoke in a monotonous tone, interjected frequently by unprovoked, earsplitting screams, and now and then by laughter that could not be put in coherent connection to the content of his words. Despite these unpromising symptoms one of the mental health professionals in the ward decided to attempt deep-reaching psychotherapy.

The first period of this therapy was most frustrating. For many a month Caleb agreed to discuss nothing but his anti-psychotic drugs and haggled endlessly about their dosage. Making elegant use of her countertransference, the therapist finally succeeded in penetrating this defensive wall and soon the therapy, which also involved family meetings, turned from being tedious to being intensely interesting and even dangerous. (The specifics of this countertransference intervention and its immediate results will be spelled out in detail in Chapter Five of the second part of this book). Caleb became aggressive and on one occasion attempted to physically attack his therapist. The following sessions were characterized by the therapist's demand that her supervisor be present or at least sit in the next room during the meetings to enable her to feel secure enough in the presence of her patient.

Subsequently Caleb was able to explain his aggressive behavior. It happened when the therapist had tried to intervene by an interpretation in a conversation the patient was in the process of developing with his mother. As he explained, the therapist's intervention enraged him regardless of its content, because it raised a deluge of memories of nannies that constantly stood between him and his mother, whose closeness and warmth he yearned for in vain because she was always covertly keeping her distance from him by those nannies.

In time, however, Caleb's emotions gradually refined. They ceased to be primary, raw, and the gamma of his emotions expanded and matured. After about two years of therapy the therapist noticed that he never dared to keep in eye contact with her. She now made use of her intimate acquaintance with Caleb's parents. A mother who had not wanted him in the first place, and now regarded him with hostile, rejecting looks and a father who at best communicated in self-contradictory sentences. He would say that he would do anything for his son to get well. When asked for specifics he answered that he would not mind his son, Caleb, to take drugs all his life, despite knowing very well that Caleb hated his drugs intensely (and, from his own point of view justly, as it blunted his affect even more). On another occasion he admonished his son to always obey his doctors' orders and with the same breath boasted how he had cheated his own doctor by drinking alcoholic beverages that he had been forbidden.

Based on this knowledge of the parents, and on Kohut's (1971) theoretical contributions, ("the sparkle in the parent's eye") the therapist now

asked Caleb a question. Were it perhaps possible that he avoided eye contact with her for fear that he would meet the same cold, rejecting, smiting look he had met whenever he looked into his parents' eyes? He answered this question as follows: "I remember walking between my parents, a small child, each of my hands in one of theirs and desperately searching for a pair of warm eyes among the people in the street." The emotional depth that accompanied his being inundated by this childhood memory, the yearning that could be heard in his voice and the tears that threatened to choke him, all seemed to constitute evidence that the flattening of his affect was in the process of disappearing.

After another two years the therapist was forced to leave her job for personal reasons, and Caleb's therapy was transferred to another therapist in an outpatient public facility. This transfer was by no means easy and had to be supported by intensive relevant interpretative work. Despite these intense interventions, Caleb was unable to form an intimate relationship such as he had had with his original therapist. The therapy gradually extinguished.

Caleb had several further brief incidences of having to be hospitalized, in all of those, however, he was insightful to his condition and its reasons and his emotional capacity remained intact. At present he lives independently providing for his living by senior clerical work.

During his psychotic period, Caleb used to inscribe biblical quotes on every surface he could locate. In fact, there was hardly an open space in the hospital not covered by his quotes. About fifteen years after the episodes described here, Caleb now lives in my neighborhood. Occasionally

I meet him on the street, and he greets me with a smile, ensuring me that he remembers everything that had been done for him. Recently, his name, spelled backwards and meaning one of the names of the Lord appeared here and there on walls. I asked him if it was his doing and he answered with one of his gentle smiles: "You have helped me, (meaning especially his therapist and myself as supervisor and participant in his family meetings), to give up all this nonsense." At the time these lines are being written, I still meet Caleb in the bank in which both of us have our accounts. His smile is always friendly and gentle; he never forgets to ask about my health and that of his first therapist, even that of my wife whom he met when we were walking on the street which all of us live on. During one of our encounters I asked Caleb about his medication. He said that he still needed it and that he was now taking it willingly. "Otherwise," he said, "I will once more start with the old nonsense" I believe that if his original therapist could have carried on his therapy as long as necessary, the final result in Caleb's case would have been better, like that of Adam's.

Case D

Once upon a time there was a schizophrenic called Doris, one of non-identical female twins. She was born with a dislocated hip joint, and spent the first year of her life incarcerated in a cast. The first signs of her illness appeared in her early youth, mainly in the form of a gradual decline of her achievements at school.

The illness openly erupted during her service in the army, where she consistently claimed that a senior officer was in love with her and was about to leave his family in order to live with her. When

finally confronted by reality, her condition further deteriorated. Following a brief period of holding temporary jobs, she ceased to provide for herself, lived in a small room rented for her by her family, eating at her father's table. She underwent several unnecessary plastic operations to repair imaginary somatic defects and when those failed to achieve the imaginary results she had expected, she threatened to sue the surgeons. All this time attempts to persuade her to undergo any kind of therapy were refuted by her claims that she was totally sane. Nevertheless, her family asked for advice at an outpatient mental-health facility and received the same advice that had been given to Ben's mother, to entirely stop supporting her and thus force her to fend for herself. The results, however, were even more devastating than those of Ben. Doris neglected herself completely, slept in forsaken houses or under the sky, ate from what she could collect from garbage-bins, and forsook all means of basic personal hygiene. This extreme self-neglect finally overtly endangered her life and she had to be hospitalized.

This stay in the hospital achieved only partial results. The previous situation, her being supported by her family was re-instituted. She was to live in a tiny room provided by her father and offered food provided by her mother. While in the hospital, she expressed various delusions and admitted the existence of auditory hallucinations. Nevertheless she refused to admit that she was mentally sick and accused all those surrounding her of conspiring to define her as such in order to rob her of the opportunity to sue all those who had wronged her. Among those she now included the mental health administration.

Despite these accusations, she deliberately found excuses to delay her being discharged, even after preparations of the previously external existential conditions had been re-instituted. It is reasonable to assume that these excuses, which resulted in her first hospitalization which extended for over two years, were the same reasons as those of Ben. Before long, indeed, the need for re-hospitalization arose, based again on life endangering self neglect.

In both hospitalizations psychotic productions were diagnosed, but the lesion to her abstract thinking was especially prominent. This was not officially tested, but stood out in all her verbal communications in every-day conversation. Consequently it precluded any attempt to engage her in deeper interactions, to reach the inner significance of what had happened to her.

Following a brief stay in an acute ward, she was transferred into a chronic, rehabilitation-ward. Despite all previous failures of attempted psychotherapeutic interventions, one of the therapists in the chronic ward decided to initiate a further attempt. This time the result was better. Attributing special, magic properties to her therapist, Doris agreed to explore her depth. The therapy was like that of Caleb, extremely stormy, albeit not as dangerous. There seems to be no point to unfold the content of this therapy here. In order to focus on the relevant point, Doris's cognitive defect and her inability to think abstractly or symbolically, only one example will be referred to here. Delilah's father was her mother's second husband, having seduced her away from her first one. In one of Doris's sessions she mentioned that her twin sister had also seduced her husband from his previous wife. Doris commented on this: "you see, dear therapist,

the apple falls not far from the tree.” This appropriate use of an idiom provided evidence that her abstract cognitive defect was at least on the verge of being reversible.

Arriving at this point required several long years of therapy. Doris’s second stay in the hospital lasted for over five years. Her therapy had to be terminated when her therapist left the hospital because she was expecting a child. Soon thereafter Doris was discharged.

As had been the in the case of Caleb, the reconstruction of the capacity for abstract thought was accompanied by the maturation and refinement of her affect. At the climax of her illness her hatred for her mother was so intense that she often refused to accept food because her mother delivered it. This behavior had contributed significantly to the need of her being forced into the hospital for the second time. These intense feelings were modified in therapy, and towards the end of her hospitalization Doris received her mother warmly whenever she came to visit or sent her greetings cards towards each approaching holiday.

Recently I met her therapist. To the best of her knowledge Doris was never overtly psychotic again. She now lives with a roommate in a small apartment. Her social skills are somewhat impaired and she is suspicious of people. Nevertheless she goes out to the cinema and seems to enjoy it.

Occasionally she meets her therapist on the street. At first she tended to ignore her, but gradually she developed a mutually friendly relationship, not unlike the one Caleb harbors for me. She asks her therapist for her well-being and even reminds her,

without evident envy, of her pregnancy, the reason for the therapy being discontinued.

I am quite aware that I have made no new discoveries here. As early as 1952 Rosenfeld discovered that psychic conflicts could be at the root of psychoses. Searles (1965) elaborated on the supposition that both the affective as well as the cognitive defects might be regarded as complex defenses, and implied that he considered the post-psychotic-defect to be reversible, as it constituted an extreme strategic shortening of defensive lines, constructed in order to avoid unbearable psychic pain. He also emphasized the length of time needed for intra-psychic reconstruction. Even the disturbances in associations, in thought process, culminating in so-called word-salad, considered by Bleuler (1950) to be the basic pathology of schizophrenia, were described by Arlow and Brenner (1969), by Giovacchini (1969) and recently by Draznin (1993) as functional disturbances, the expressions of defense-mechanisms, that may be corrected by appropriate psychotherapeutic interventions. Draznin's examples are especially convincing. He describes circumstantially, incoherent jumps from one topic to another and other formal thought disorders as being amendable by interpretations, and if these prove to be correct, the patient usually regains ordinary thinking.

All these authors, however, emphasize, overtly or implicitly, the length of time, measured in years, needed to establish intra-psychic rehabilitation. This is so even for establishing the primary basic transference bond that enables the use of transference interpretations, the only ones that are really efficient in these situations. (C.F. especially Chapter Six).

Some further information seems to be in order here. All the patients described above were, at one time or another, inmates of an open ward in a psychiatric hospital. I was in charge of that ward for about thirteen years, until I retired from public service. While in charge of this ward I persistently adhered to three main principles. Besides seeing the patients at their initial diagnostic interviews, and besides running the ward meetings, to be described in greater detail in Chapter Five, I made a point of not undertaking the individual psychotherapy of any single patient. This was done in order to prevent the situation of the special patient.

Being Consultant to this ward, I was well aware that the manpower at my disposal was limited. I was, therefore, in no position to provide intensive individual psychotherapy for all patients, at least for the length of time such a therapy requires for the deeply disturbed patients I was in charge of. I made it a point, however, that each of the mental-health professionals who had tenure at the ward, such as junior psychiatrists, psychologists, social workers, art therapists and some of the sophisticated nurses who had had psychiatric training be allotted one or two patients. These patients they were allowed to treat for as long as they found necessary, even after either the patient or the mental health professional had left the ward. This enabled the psychotherapies described above and many more.

Furthermore, I allowed no mental-health professional who stayed at the ward for a limited period of time to do psychotherapeutic interventions unless they committed themselves to continue this psychotherapy for as long as this was necessary, even after they had left the ward.

Any shorter period of more intensive involvement would only frustrate, disappoint and discourage their patients and make the work of the next therapist that much more difficult.

The basic reason for placing all this material at this initial point of this book is that in the present state of affairs a large proportion of schizophrenics are sacrificed to conditions that differ little from vegetative existence. This situation will not change unless mental health politics will allow for long term psychodynamic therapies to be carried out in prolonged hospitalizations, such as those presented here. This requires sufficient adequately trained and motivated personal to be put at the disposal of mental-health facilities. I believe that only these conditions enable the post-psychotic defect to be reversible. The present condition, in which exclusive drug treatment is the first and preferred choice and hospitalization is kept to possible minimum will, unfortunately, not provide for this option.

This seems to be a good opportunity to attempt to quantify the problem of hospitalization. If E_1 is taken as the equivalent of the amount of energy needed to hospitalize a psychotic patient against his will and E_2 is the equivalent of the amount of energy to be invested in order to later discharge (i.e. expel) the same patient from hospital against his will, experience has shown that the equation $E_2 = E_1$ is almost regularly valid.

In other words, experience has shown that the amount of energy needed to discharge a psychiatric patient from hospital against his will is almost regularly equal to or bigger than the amount of energy invested in hospitalizing him against his will in the first place.

The problem of Negative Therapeutic Reactions¹

In order to correctly introduce Ezriel's contribution into the theory and practical application of psychoanalysis, a detour must first be undertaken via a discussion of the problem of the negative therapeutic reaction. Freud (1918) was the first to call attention to this phenomenon when he stated: "The patient tended to develop temporary 'negative reactions' whenever a certain issue had been finally clarified. The patient attempted to nullify these achievements for brief periods by intensifying the relevant symptoms." At that time Freud attributed the phenomenon to a kind of childish rebellion on part of the patient: "Just one more time." In "The Ego and the Id" (1923) he attributed it to unconscious guilt feelings and in 1937 to the destructiveness of the death instinct.

An attempt to screen current psychoanalytic literature for unequivocal definitions of negative therapeutic reactions will usually result in a wide continuum of definitions. This continuum begins with a broad, general definition that contains everything that happens inside or outside the analytic situation and does not contribute to progress in treatment. It ends with quite narrow definitions, such as Kernberg's (1984), who described the negative therapeutic reaction as an aggravation, represented by negative feelings reflected in the transference, despite the fact that

¹ This Chapter is based on an article written conjointly with A. Aviv, M.D.

the analyst was regarded at the same time by the patient as a good hearted object who wanted to help.

For the purpose of this book the following definition of negative therapeutic reaction will be adopted, namely that the therapist's intervention results in one of the following:

1. Aggravation of symptoms
2. The appearance of manifest anxiety or that of another intense negative affect
3. Change of transference from positive to negative, unless this is a desired result
4. Acting in
5. Acting out

Many authors have attributed importance to negative therapeutic reactions. Several of them, however, such as Sandler (1973) and Rosenfeld, (1975), have expressed surprise at the fact that despite the general recognition of its importance to psychoanalytic practice, relatively very little had been written on it. Subsequently the subject remained relatively in the dark. The following is a brief, incomplete summary of the relevant literature.

Karen Horney (1936) emphasized that negative therapeutic reactions usually followed "good interpretations." She offered several explanations:

1. The patient regarded the "good interpretation" as an incentive for competition with the analyst and needed to prove his superiority over him.
2. The patient experienced the "good interpretation" as a blow to his self esteem

because it forced him to admit his weakness.

3. The "good interpretation" might trigger off success and success was accompanied by fear of failure.
4. The interpretation, despite being "good," was experienced as an accusation.
5. The patient feared that he might improve and consequently be abandoned by the analyst

In "Envy and Gratitude," Melanie Klein (1957) attached importance in the creation of negative therapeutic reaction to envy and its concomitant defenses. Fairbairn (1943) claimed that it might result from the refusal to part with repressed objects. Others, such as Olinik (1964), Valenstein, (1973), Asch (1976) and Loewald, (1971) attributed an important role to masochistic components and self-destructive tendencies with pain fixations, the origin of which was to be found in pre-genital periods. Rosenfeld (1971, 1975) claimed that narcissism played an important role in the creation of negative therapeutic reactions, stressing at the same time the part of envy. Kernberg, (1984) described destructive drives directed at the therapist resulting from feelings of envy and guilt.

All these authors highlighted the patient's intrapsychic structure as the source of negative therapeutic reactions. Some of them went so far as to claim that the therapeutic obstruction it caused might lead to situations in which the patient had to be declared as un-analyzable. Negative therapeutic reactions seem, indeed, to have been perceived as clearly negative prognostic indicators. [Kernberg (1984) and Woolcott (1985).]

Wilhelm Reich (1934) was probably among the first to propose that negative therapeutic reactions might be the result of faulty technique, especially in the analysis of negative transference. Rivierre (1936) expressed a similar opinion and questioned the quality of interpretations that had led to it, especially in patients to whom she attributed narcissistic properties.

In the present book I wish to join these latter authors and represent a view, according to which negative therapeutic reaction can be attributed at least in most patients to interpretations regarded as incomplete. In so doing I will be following in the footsteps of James Strachey and Henry Ezriel.

Strachey, (1934) in his by now classic article, approached the problem from a new angle. He argued that whenever material was repressed, this was done with good reason; that repression had become necessary because the material to be repressed had become associated with an anxiety. The following is an example for the creation of such an association.

Ella was a healthy, four year old girl observed by her mother, a clinical psychologist. A baby brother had just been born. When the little girl first witnessed the baby being nursed at the breast she turned to him saying: "go on, bite her, for my sake and for your own." When asked the following day while witnessing the baby being nursed again whether she still wanted him to bite his mother, she answered: "Oh, no, not any more." She also admitted her reason for having changed her mind: it was "because if mummy's baby bites mummy, my babies will bite me." Later the whole incident lost its importance.

In the present context it is relevant to note that it was not immediately forgotten, (i.e. repressed). The object-relationship "baby bites mother" had become causally associated with the anxiety "my babies will bite me" and hence became a topic to be avoided. In accordance with Ezriel's theory, as expounded further on, the avoidance of a certain object-relationship is the primarily important goal, and repression is but one of the various means of achieving this goal.

Ella was a healthy young individual, reared in a facilitating environment that gradually enabled her to ameliorate the intensity of her oral aggressive impulses and her fear of retaliation. The conflict could thus be easily integrated into her psychic apparatus. Had this not been so, had one of the components of her conflict remained intensely cathected, further, potentially pathogenic defenses would have been called into operation. First and foremost among these mechanisms would probably be repression and a point of fixation for future psychopathology would have been created. (It seems to be needless to add that both components of the conflict would represent but two faces of the same coin).

The choice of other defense mechanisms, such as reaction-formation, displacement, projection or conversion, to be deployed in such a hypothetical situation would depend on the degree of Ella's maturity along the various axes of psychic maturation, as postulated by various theoreticians, on the question whether regression was called for and upon the intensity of anxiety attributed to the original trauma. In a future hypothetical situation, associated with the original conflict, (e.g. Ella breast nursing her own baby) symptoms, such as involuntary contraction the

muscles of her jaw, phobic fear of sharp objects etc. might have necessitated psychotherapeutic intervention.

According to Strachey's argumentation, an interpretation given to Ella in which her symptoms were exclusively attributed to her oral aggression, without adding an explanation of the reason for this aggression not to be recognized, would result in the appearance of overt anxiety or in the implementation of further defenses, in other words, an intensification of her symptoms. A negative therapeutic reaction would have been created.

Felicity and Ethan are actual clinical examples of the negative therapeutic reaction resulting from pre-Stracheyan incomplete interpretations given in real therapies.

Felicity suffered, among other things, from sexual inhibitions, including frigidity. She "had to hold herself in check" whenever sexual fulfillment was at hand. At a particular session she spoke about her hatred for poets. This hatred she attributed to the fact that poets had to be liars. How, otherwise, would they be able to express the intensity of their emotions and at the same time incarcerate and choke these emotions in the rigid formal rules of rhyme, rhythm and verse? She then spoke of her own need for fulfillment, how she would like to browse through "those big shops and buy all the beautiful dresses on display there."

Some of these elements were combined into an (incomplete) interpretation that compared her imaginary buying spree with her wish to liberate her sexuality, which she had to incarcerate, like the poets, by imposing rigid control. At the following session she reported a change: she had

started to notice men looking at her on the street and felt attracted to them, but on the other hand, whenever this occurred she was seized by acute anxiety.

In this case the (incomplete) interpretation had apparently evoked dormant sexual impulses and brought them to the surface. ("I like men, I want to be noticed by them and let myself go in their presence"). It had, however, not dealt with any anxiety that had necessitated the repression of these feelings in the first place and at this point this still unidentified and therefore nameless anxiety became (re) activated.

Ethan was a young schizophrenic who was being seen conjointly with his mother. In these sessions, as everywhere else during that period, the (identified) patient made all coherent communication next to impossible by filling every free moment in time with stupid, pointless jokes. At a certain point his mother was asked for some item of information about his past and it transpired that she was incapable of putting two sentences together in a coherent, meaningful way. Ethan was now addressed and some concern was expressed about his having to cope with this kind of garbled communication throughout his formative years. It was also pointed out to him that he might be doing his best by his constant, time consuming jokes to conceal his mother's incoherence. This intervention had a double effect. On the one hand Ethan's overt behavior immediately changed and his communications became surprisingly coherent and insightful, revealing an impressive capacity for introspection and the analysis and understanding intra-psychic and inter-personal transactions. On the other

hand, however, when seen that same day on evening rounds, he was in a state of acute panic.

Here, again, temporary negative therapeutic reaction was achieved. Although the patient's constant silly joking had improved perceptively, the therapist had not gone deep enough into the reasons that had necessitated this behavior. [These could include guilt feelings for having ostensibly been the cause of his mother's madness in the first place, etc. (Searles, 1959)]. This failure resulted in the appearance of the acute panic.

Strachey actually proposed a new kind of interpretations, the "mutative interpretations." These should not merely evoke repressed (avoided) material, such as Ella's oral aggressive impulses, attributed to the baby. Instead, they ought also to contain, (preferably in the "Here and Now" of the transference) the reasons, i.e. the anxieties that had necessitated this repression in the first place. Ella's fear of being avenged by her babies or be punished in any other way by the representatives of her objects in any "Here and Now" are suitable examples for this inclusion of the anxiety in the interpretation. Strachey argued that failure to include the latter part of the interpretation was bound, as a matter of course, to result either in the re-appearance of the original anxiety or in the re-enforcement of defenses against it, i.e. intensification of symptoms. [For further examples for amplification of symptoms in these circumstances, C.F. the cases of Ethan, above, and Gilbert, (first session) in this chapter.] It goes without saying that not all adverse developments in a patient's states are necessarily true negative therapeutic reactions. In the case of Professor Hugo and in that of Igor, both of them deluded paranoids, described in detail in Chapter Eight,

suffered schizophrenic de-compensation. In the first case it resulted from an unfortunate therapeutic intervention other than an interpretation and in the second one from an adverse life situation, created in that case by the patient.

A mutative interpretation ought to result in net improvement. The aggravation of symptoms or the appearance of overt anxiety, those negative therapeutic reactions that were considered by Freud as signs predicting the correctness of his interpretations, were now considered by Strachey as signifying their incompleteness.

In the meantime psychoanalytic theory and practice had developed considerably. Object-relations theory was being developed and the emphasis of psychoanalytic endeavors shifted more and more towards the analysis of the "Here and Now" situation within the framework of the transference. With the uncovering of long buried memories losing its primary importance, Freud's comparison of psychoanalysis to archeology gradually lost its meaning and "predicting the past" could be replaced by "predicting the future." The new process developed a theory of technique in which spontaneously produced material was to be used mainly as indicators for forces operating in the "Here and Now". The re-appearance of hitherto repressed memories was regarded as indicators for the forces operating in the "Here and Now". When this re-appearance occurred after an interpretation, it was regarded as a by-product (albeit generally an important, confirmatory by-product and proof of the validity of the analysis) of the psychic reality of the "Here and Now".

Ezriel (1960, 1967, and 1972) adopted Strachey's ideas and contributed further concepts that ought

to facilitate their incorporation into the framework of object-relations theory. I have found these concepts very helpful in various treatment modalities and would like to sketch them briefly here. Ezriel emphasized the almost exclusive importance of references in the interpretations to the "Here and Now" of the transference and coined the term "calamities." He reserved this term for those aspects of object relations, fraught with anxiety, for fear of which other aspects of object relations had to be avoided. These "calamities" included fear of castration, annihilation, being castigated by the object (e.g. by the analyst) and even being killed by him, etc. These latter aspects of object relations, the ones to be avoided for fear of the "calamities" he named "avoided relationships." In the case of Ella, the oral aggressive object relationship of "baby will bite mother" was subsequently avoided, i.e. became an "avoided relationship" because it had become associated with the calamity "my babies will bite me."

In order to be able to function in life with an acceptable amount of satisfaction without at the same time constantly arousing the fear of the calamities, a third set of relationships was evidently required: the "required relationships." The terms "avoided relationships" and "calamities" partially coincide with Strachey's "repressed material" and "the anxiety that had necessitated the repression in the first place," respectively. As shown in the case of Ella, repression was not necessary in order for an object relationship to become avoided, whereas the term "calamity" attributed a definite content to "anxiety."

The set of Ezriel's three relationships, "required relationship," "avoided relationship" and

“calamity” is more or less congruent with the set of “defense,” “impulse” and “anxiety,” as used e.g. by Malan (1979). Here again, it should be mentioned that avoided relationships are not necessarily impulses. They may be regression in service of the ego towards the basic fault (Balint 1968), such as in analysis, which has to be avoided for fear of nobody being there to pick up the pieces and integrate them once regression had occurred. Even maturational processes sometimes have to be avoided for fear of one calamity or another.

Ezriel's concepts fit themselves conveniently into the theory of object-relations from an operational point of view. They seem to be applicable to any theory of developmental maturation. They are applicable in the Freudian axis of psychosexual development and in the Kleinian-Kernbergian axis of integration. As in the case of Arnold to be described in Chapter Six and that of Leonard in Chapter Eight, both schizophrenic patients, they were useful in Kohut's axis of infantile grandiosity versus adult self respect. Kohut's “Two analyzes of Mr. Z,” to be referred to more extensively later on in this chapter, is another relevant example in this context. These concepts are also applicable to Mahler's axis of separation-individuation, as well as in Piaget's formulation of the development of intellectual capacities.

Indeed, they seem to be applicable to any maturational axis formulated by others in the future. Any such developmental thrust might become associated with fear of a real or imaginary calamity on the same axis of maturation or on another one, and will consequently have to be avoided, (to become an avoided relationship). It will be excluded from being integrated into the repertoire of normal psychic development and

replaced by a required relationship. The psychic distance of this required relationship from the original avoided one, would be in direct correlation with intensity of the anxiety incurred by the calamity and the nature of defense-mechanisms invoked.

As might be understood from the above, even intelligence might succumb in the same way. Herbert, a practicing male homosexual, initiated his analysis by complaining that his intelligence might not be sufficient for such a complex enterprise. He remarked at the same time that this might, perhaps, not be a disadvantage after-all. This was because I, the analyst, might be intimidated were Herbert more intelligent than he perceived me to be and this might have a detrimental effect on the analysis, perhaps causing the withdrawal of my affection and empathy.

Many months later it transpired that Herbert's mother had allowed him to play with her exposed breasts until he stopped referring to them as "balls" and started calling them breasts. This differentiation of his intellectual capacities resulted in his mother forbidding the game. Intellectual development had thus become associated with the calamity of loss of object-libidinal pleasure and turned from being an asset into being a liability. Following this disclosure Herbert remembered others. In each of them an intellectual development, or indeed, several other maturational thrusts in various directions were negatively re-enforced. After these facts had been revealed and Herbert had been repeatedly re-ensured by interpretations that being more intelligent than me would have no evil consequences, he was able to unfold the full scope

of his sharp intelligence, acknowledge his ingenuity and participate actively in the therapy by self-analysis. The final outcome of this analysis was very satisfactory, not in the least as a result of Herbert's applying his intelligence. (Springmann, 1970, a).

Another fact about Herbert deserves to be mentioned. After he had been partially separated from his mother in circumstances that are described in the original article, he built a little hut. There he used to imagine that he was once more united with his mother. He called this hut the Hebrew equivalent of joy. "Joy" and "gay" are, psychologically, not far from each other. This seems to imply that underneath the joy of being gay, at least in some homosexual individuals who call themselves "gay," there might be an unresolved tragedy, e.g. of separation.

Herbert is an example in which not an impulse, but a thrust towards maturation, along, in his case, the Piagetian axis was met by a calamity along the psychosexual (Freudian) axis. Consequently it had, at least partially to be avoided, to become an avoided relationship. In this he was not unlike Ethan, described above, who also had to avoid his intellectual capacities for fear of a calamity.

Returning to negative therapeutic reactions, it may be maintained with Ezriel, that it will result especially in either of the two following instances.

1. When a "correct" interpretation either invalidates or threatens to invalidate a required relationship, without at the same time dealing correctly with the avoided relationship and its concomitant calamity. (Put in traditional terms: when an

interpretation destroys or threatens to destroy a defense).

2. When a "correct" interpretation activates or liberates an avoided relationship without dispelling at the same time, preferably in the "Here and Now" of the transference or else in any other environment, the fear of the calamity.

In both instances, failure to do the latter part of the interpretation makes the "correct" interpretation an incomplete one; the avoided relationship has been exposed or has threatened to be exposed (first instance) or else it has been activated, (second instance). In both instances this will have happened without the reason for the avoidance, i.e. the calamity which was causally connected with it, having been nullified. The exposed or activated avoided relationship now activates the fear of the calamitous results that remain connected in the patient's unconscious fantasy to these avoided relationships. This will either evoke overt anxiety or force the patient to re-enforce his defensive formations. A negative therapeutic reaction will have been achieved.

It may be stated here parenthetically, that free floating anxiety may appear whenever an avoided relationship either threatens to be activated or actually is activated spontaneously in circumstances other than therapy.

Felicity and Ethan can now be formulated in Ezriel's terms. In the case of Felicity it seems that while some aspects of the avoided relationship, ("I like men, I want to let myself go in their presence") had been elicited by the "correct" interpretation, no calamity had been elaborated. The result was that the partial re-awakening of her sexuality was

accompanied by the re-awakening of an anxiety, aroused the fear of the same as yet not identified calamity, which had probably caused its becoming avoided in the first place.

The dynamics structure of Ethan seems to be as follows:

Required relationship: In an attempt to conceal my mother's incoherence, I have to fill every vacant moment in time. The best way I know of doing this in this particular dynamic situation is to keep being the silly fool myself.

Avoided relationship: I can be as rational as the next man, possibly even possess even more acute introspective and analytical capacities, however, I have to avoid implementing these capacities because...

Calamity (at this moment in therapy only guessed, later, however, completed at evening rounds) I will feel excruciating guilt for having exposed my mother's "craziness," because deeply inside I feel to have been the cause of her "craziness" in the first place.

In the conjoined session only the avoided relationship had been exposed and activated but the patient was left without the calamity having been explained and disqualified. This resulted in the acute panic attack described above, a typical negative therapeutic reaction. Fortunately, the assumed calamity was explained to the patient that evening. It proved to be correct and the panic subsided instantly without Ethan having to give up his newly regained rationality. The completion of the interpretation had turned the negative therapeutic reaction into a positive one.

These points have been elaborated here in detail because they may be considered to be of important operational significance. They imply that whenever a negative therapeutic reaction is detected, efforts ought to be made to look for missing components in the intervention, the avoided relationship (or important parts of it) and especially the calamity.

Once these components have been divined from hints in the material randomly presented by the patient, the interpretation ought to be completed. If this is successfully accomplished, the hitherto avoided relationship, now liberated of the fear of the calamity, (“detoxified”), may manifest itself freely and the hitherto required, pathological, relationship be relinquished, having become expendable.

This point is to be considered to be of central significance in the presentation of Ezriel’s ideas and will consequently be demonstrated by a further clinical example.

Gilbert was a thirty year old patient with high-level borderline personality organization. At the relevant point he had been in therapy for exactly one year. He arrived to the first session of the two to be presented here all excited and upset, complaining that his colleagues at work kept taunting him to a point he could no longer hold himself in check and so he attacked them. “I have no luck. Whatever I do, I always end up finding a job where someone drives me mad and then I explode and have to quit.” At another point during the session he mentioned, ostensibly in passing, that he had by now been in therapy for a whole year. These elements were used to construct an interpretation:

³Despite having been in therapy for a whole year by now, you sometimes feel as if no real progress

has been achieved; you are still unable to withhold your impulses and consequently keep on making the same mistakes. You lose control and as a result you keep losing one job after another, either by having to quit or by being fired. This makes you feel deeply disappointed not with yourself, as you seem to be implying, but with me and with the therapy"

Although it seemed that the patient accepted the interpretation and left the session in a somewhat calmer mood, he contacted the therapist's office two days later, demanding to be put in contact with him immediately because he was contemplating suicide. When contact by telephone had been established some hours later, he did not mention suicide but told his therapist that he had lost control at home and had beaten up his wife. His next therapeutic session was scheduled for the following day.

In the meantime a supervisory session took place and the material was presented and analyzed. It was surmised that the (incomplete) interpretation had threatened to disqualify the required relationship: "I am disappointed with myself," which had been created by the defense mechanism of turning against the self it had also elicited the avoided relationship "I am disappointed with you." All this had been done without offering the patient a calamity, a possible reason that might have made the latter statement ostensibly dangerous for Gilbert to make. Consequently he must have fortified his defenses, (deployed less adaptive, more pathological required relationships) lest this avoided relationship become manifest in the "Here and Now" of the transference. This had probably been accomplished both by turning the intensified

anger against himself (suicidal thoughts), subsequently also understood to be a component of the calamity, and by displacing it on his wife. The following (complete) tentative interpretation was worked out:

Required relationship: I am disappointed with myself because I cannot control myself at work and explode either there or at home, against my wife.

Avoided relationship: I am angrily disappointed with you, therapist, and with the work we have been doing for a whole year by now, because I see that so little has been accomplished. I cannot, however, acknowledge this angry disappointment because:

Calamity: If I do express my anger in the "Here and Now" of the transference, I might feel tempted to explode at you and leave therapy, or else, you might also feel disappointed with the job you have been doing with me and quit my therapy, just as I quit my jobs. Both alternatives might be felt to be tantamount to suicide.

Provided the assessment of the material had been correct, it was expected that this interpretation would enable Gilbert to express his angry disappointment in the "Here and Now" with impunity. It would prove to him that the manifestation of the avoided relationship did not inexorably incur either of the calamitous alternatives. This would, consequently, obviate the need to intensify defensive measures (activation of further non-adaptive, pathological required relationships). The negative therapeutic reaction would thus become expendable and dissolve, as had been in the case of Ethan. Fortunately, this proved to be the case.

Gilbert opened the following session still quite agitated. Expressing his indignant surprise at the therapist's "allegations," he claimed: "How could I have been disappointed with the therapy? Have I, after all, made any real suicidal attempt even once during the whole year?" On one hand, this could be understood as further denial of the avoided relationship. On the other hand it also contained a disguised confirmatory hint at one aspect of the surmised calamity. The interpretation was now spelled out again, this time in full, with all three components. Gilbert immediately relaxed, his agitation disappeared and it became possible for him to discuss his fear of being abandoned if he ever dared to speak out his disappointment in his objects.

It seems safe to assume that the negative therapeutic reaction, the exacerbation of symptoms that had followed the interpretation in the first of these two sessions might have at least endangered the continuation of the therapeutic relationship. This would have happened unless the interpretation had been completed in the second session. It also seems safe to assume that if some version of the full interpretation were given in the first session, the negative therapeutic reaction would not have occurred at all. Be that as it may, the completion of the interpretation in the second session turned the negative therapeutic reaction into a positive one. This was accomplished via the reality testing in the "Here and Now" of the transference of the imaginary, atavistic, causal relationship between the avoided relationship and the calamity. (Being angrily disappointed with the object and being forced to leave the object/being abandoned by the object, respectively). Thereby the former became detoxified. Therapy in this case has now been

going on for several further years and quite considerable progress has been accomplished. (For a further case of a negative therapeutic reaction being turned into a temporarily positive one by completion of the interpretation in the following session, this time in a psychotic patient, C.F. Leonard in Chapter Eight).

One further particularly relevant situation deserves to be mentioned in the present context, a phenomenon that seems to be quite prevalent and that frequently misjudged often leads to erroneous consequences. It concerns patients with psychotic personality organization, who, especially upon being discharged from hospital in remission of an acute psychotic episode are in the initial stages of analysis or dynamically oriented psychotherapy. In these circumstances these patient quite frequently develop further psychotic symptoms, sometimes involving the therapist and sometimes in such severity that re-hospitalization, or at least intensified drug treatment have to be considered. This scenario often leads to the conclusion that these patients are un-analyzable, even that in these patients dynamically oriented “uncovering” psychotherapy is counter-indicated.

Both experience and theoretical considerations have shown that this is not necessarily so. They have shown that this phenomenon is to be considered a typical (albeit a spontaneous) negative therapeutic reaction, no more an evil omen to the final outcome of a dynamic psychotherapy or an analysis than any other negative therapeutic reaction.

Theoretically it seems logical to assume that the impending intimate relationship with another person, the therapist, often constitutes a covert unconscious promise of fulfillment and intimacy

for patients with neurotic or borderline organization. Therefore it leads to initial amelioration of symptoms, the transference cure. This constellation of implied intimacy actually represents a threat to the patients with psychotic personality organization. For fear of calamities, such as being merged with the object's personality, invaded, annihilated or inevitably ultimately abandoned by him etc, such close, intimate, trusting relationships are something these patients had previously made every effort to avoid.

This avoidance is almost regularly accomplished by deft deployment of schizoid mechanisms: "I have always surrounded myself by a wall of false sincerity" was the way one such patient described his particular required relationship. Another psychotic patient could initially relate to his therapist only by invoking a further, imaginary patient, in another ward as the one desperately in need to be listened to and understood. The circumstances of therapy, implying as they do closeness and intimacy, are consequently experienced as avoided relationships that are in danger of being activated, forced, as it were, on the patients. This is done without any reference to a calamity being possible at this early stage. As pointed out above, this kind of situation seems to make some kind of re-activation of a (psychotic) required relationship mandatory and a negative therapeutic reaction is, in these circumstances, almost inevitable.

This ought not, however, lead to the conclusion that these patients could not too undergo dynamic therapy. In many cases it could be shown that gentle persistence on part of the therapist, such as respectful empathic references to the patients'

need for seclusion and their apprehension of their intimacy being violated, not infrequently lead to promising results. This phenomenon can be observed even if re-hospitalization sometimes becomes necessary.

Carefully handled by therapists who feel well contained in supervision, such psychotic outbreaks quite regularly prove to be abortive, and once abated, the therapeutic endeavor can be continued with the same amount of cautious optimism as in any other case.

Jane and Katherine may be used as examples for this constellation, which I refer to as an initial spontaneous negative therapeutic reaction.

Jane will be described in greater detail in Chapter Six. She was a young woman of eighteen, just discharged from hospital where she had been treated for several months by electro-convulsive therapy and massive doses of anti-psychotic drugs because of acute catatonic schizophrenia. When she remitted and became communicative, she was referred to outpatient psychotherapy. Shortly after this therapy had been initiated she developed a new delusion; she was now constantly being hypnotized by people in the streets to take off her clothes in public. In therapy this was interpreted as her fear of the therapist forcing his way into her mind against her will in order to make her disclose her intimate secrets. After this had been conveyed to her, the delusions subsided. The reason for referring to secrets will be further discussed in the full description of this therapy in Chapter Six.

Katherine had been a chronic paranoid schizophrenic for many years. One of her central complaints was that certain sophisticated technologies had been implanted into her body

without her knowledge and against her will. No information about the nature of these technologies was available, and when asked about them she gave elusive answers, sometimes mentioning the names of towns in Poland in which her by now deceased father had stayed during the holocaust, before her birth. She referred to these towns as possible places in which these technologies might have been manufactured. She was now in a rehabilitation ward and despite the chronic nature of her condition one of the therapists there (the one who also treated Doris) decided to attempt dynamic psychotherapy.

From the very initiation of this therapy Katherine fought off almost all of the therapist's advances. In despair, the therapist tried to convince her that she might be able to help her if she, the patient, would stop to repulse her. This intervention was rewarded by a temper tantrum that lasted for more than a week. Resumption of the therapy, of the brittle relationship that had been established prior to the temper-tantrum demanded a great effort on part of the therapist. Only after many weeks of infinitely patient work did it finally transpire that any attempt at closeness was experienced by Katherine as a danger of being swallowed up by the object, in the present circumstances, the therapist.

After this calamity had been clarified and disqualified, the therapeutic relationship underwent a complete change and a first glance could be gained into the dynamics of Katherine's delusions.

This started when she requested permission to water the plants in her therapist's room. After this wish had been granted, Katherine commented that she had grown up in an environment she could

only define as a stinking, festering dunghill. In a group session that I supervised, this sequence of events was brought up. As the case was being presented, it suddenly dawned on me (Being "one step removed" {C.F. Part Two}) that the sophisticated technologies implanted in her might represent a process of purification, the task of which was to extract life-giving water from toxic dung. This would be the equivalent of the toilet breast, (Meltzer, 1973) but in a peculiar way, working in reverse, Katherine doing the chores traditionally attributed to the toilet breast.

Several weeks later, when Katherine brought up the topic of the implanted technologies once more, she was asked if these technologies might be a purification plant. She retorted: "A purification plant? Of course it is a purification plant! What else do you think I have been talking about all these years?"

This was but the beginning of a long therapeutic journey that became possible only after the hurdle of the initial negative therapeutic reaction, activated by the therapist's attempt to overthrow her patient's schizoid required relationship, had been overcome. Katherine ceased to mention the sophisticated technologies, started instead to complain that she was being linked to a giant computer, which controlled and mainly inhibited her volition and initiative. The keys for activating and de-activating this computer were in the hands of her therapist. This delusion also gradually subsided side by side with Katherine gaining understanding of the connection between the implications of being controlled by a computer and being in control of her own volition, of having the freedom to say "I want" or its equivalent and "I don't want." This freedom had been destructively

crushed by her mother in Katherine's childhood and was now gradually beginning to bud again.

It is intriguing to compare this process of the destruction of Katherine's volition to Friedland's (1974) analysis of Schreber's "soul murder," signifying the brutal destruction of Schreber's will by his father. It is also comparable to the references to the creations of deserts, often discovered in young schizophrenics. These allusions may be understood to constitute hints pointing to the existence of the calamity of annihilation. These fantasies will be briefly discussed in Chapter Three and seem to indicate a pathogenesis similar to that of Katherine, as well as that attributed to Schreber in "Soul Murder." (Shengold, 1998).

During the time that has elapsed since these lines were first being written, Katherine began showing initial indicatory signs of the purification process assuming its proper direction. For months on end she had refused to change her clothes, particularly one cardigan that gradually acquired an unbearable stench. When finally convinced by the nursing staff to have this cardigan cleaned, she insisted that before being sent off to the laundry, it first spend some time with her therapist: "Let her brood on it for a few days," were her words. This was tentatively understood as an indirect expression of a disguised, symbolized wish that her therapist now be part of the purification system, in other words, that the toilet breast now begin to function in its proper direction.

Later this became even more un-ambiguous. For hours on end Katherine horribly abused her therapist verbally. The therapist withstood this abuse with great anguish, sometimes having to resort to reminding herself that the abuse was

actually not aimed at her but rather through her at Katherine's persecutory internal objects. And in fact, at the conclusion of many such an abusive session, Katherine addressed her therapist most ceremoniously, asked her forgiveness for having abused her. This, she explained, was the only way open to her to cleanse her psyche of all the filth that had been implanted in her during her formative years. The purification plant had now turned into a figure of speech, well on its way to becoming a metaphor. As Katherine put it in one session, "I still have a long process of purification in front of me before I dare face the outside world."

Recently I spoke with Katherine's therapist. She told me that the management of the hospital had changed. Under the policy implemented by the new management all chronic patients were discharged. Among them was Katherine. By now she was too far along in her therapy to react by becoming psychotic. This was despite having been left by her therapist a long time before. If information I received is correct, Katherine now lives at home. During the therapy it had become clear that she had been using her psychosis to protect her brother. This seems to be an example of the denied, covert covenant, intended to keep up intra-family equilibrium, mentioned in Chapter One.

Both Jane and Katherine reacted negatively when psychotherapy was initiated. In the first case it turned out to be the result of fear of the calamity of being intruded. In the other it was the result of fear of the calamity being ultimately lost, swallowed up in the personality of the therapist. In both cases these reactions could be related to unintentional violation of the required relationship that demanded distance. The "imposition" of the

hitherto successfully avoided closeness had necessitated the re-deployment of psychotic required relationships. In both cases these initial negative therapeutic reactions (delusions, temper-tantrum) receded, either immediately or else eventually, when the relevant imaginary calamities could be understood. Dr. Kid, also a schizophrenic patient to be described in further detail in Chapter Eight, was another example of such initial spontaneous negative therapeutic reaction. In that case this happened for fear of the calamity being inevitably and ultimately abandoned by any object he attempted to approach.

Not all initial negative outcomes at the initiation of therapy of schizophrenic patients are true negative therapeutic reactions, as defined here. Deterioration may sometimes be attributed to blatant mistakes on part of the therapist. These mistakes may be understood in the context of the ideas posited in these pages.

Moses was paranoid schizophrenic who had been hospitalized several times. At the relevant time he harbored the delusion that all mental health practitioners were involved in a conspiracy to help him. In an attempt to encourage them in their work he regularly visited every mental-health institution he could think of and loaded the workers with gifts of sweets that he insisted they eat in his presence. When hospitalized at his own request, the Consultant of the open ward in which he was hospitalized immediately forbade this activity. Notwithstanding this injunction, Moses did his best to persist in his "good deeds," taking care not to be discovered for fear of being transferred to a closed ward.

At this time one of the residents decided that such a preserved patient deserved dynamic

psychotherapy. During the first several sessions the patient presented his therapist with his self-made sweets and cookies, and otherwise filled the sessions with material that the therapist considered unworthy of interpretation. He referred to this communication in supervision as “empty blabbering.” Later he did try an interpretation, asking Moses if perhaps he felt it necessary to fill the sessions with continuous “blabber” in order cover up a feeling of emptiness inside him.

Regarded from Ezriel’s point of view, two mistakes had been made. Bribing the psychiatric institutions constituted a required relationship, the deeper dynamic structure of which could not be understood at the time. It had been endangered and Moses had now to undertake it under the threat of being penalized. Thus, even if nothing else, at least an unnecessary conscious conflict had been created. The feeling of emptiness had also to be considered as a required relationship. The avoided relationship and the calamity it covered could not be guessed at that time. The therapist’s intervention disqualified this required relationship without providing the patient with a clue for its necessity. At a much later stage, such an intervention would have been justified, but only in case the avoided relationship and its calamity had been divined from hints in the material and could be spelled out in one way or another.

The challenging of the feeling of emptiness at the early stage it was done, an intervention that would be tantamount to its disqualification was, therefore, undertaken much too early. No wonder that the patient surprised his therapist by saying: “What is it with you, Doctor? Do you want me to commit suicide?”

Fortunately this situation was also brought to supervision shortly thereafter, and the resident was helped to find ways to retract his extremely premature intervention before permanent, irreversible damage had been done.

The notion of negative therapeutic reaction has accompanied the development of psychoanalytic theory from Freud onward to object-relations theory. In recent decades it has been re-examined by various theoreticians. A considerable portion of the 1979 Third Conference of the European Psychoanalytic Federation was dedicated to new perspectives of the phenomenon. One of the more prominent of the accomplishments of this Conference was a change in attitude towards its negativity. Pontalis, (1979) pointed out, among others, its legitimate positive aspects in treatment. Some optimism concerning its outcome has also started to appear in the literature. Levy, (1982) referred to it as "amenable to analysis" in some cases. Kohut, (1971, 1977) was notably among those who maintained that it be iatrogenic, that it did not exclusively express the patient's resistance, but might be the result of transference interpretations. Limentani, (1981) stressed that it would be one-sided to regard the patient's pathology as the exclusive cause of negative therapeutic reactions, to ignore the sense of stress and danger the patient felt as a result of the analytic work. The patient's hostility could, after all, also be regarded as an expression of his being threatened, a signal intended to draw the analyst's attention to something not understood in all its implications: "It has not been sufficiently worked through."

Danielian (1985) went further, defining negative therapeutic reaction as basically a "crisis in

theory,” adding that it ought to be regarded optimistically, as an expression of the preservation forces of the self. Kohut’s article “the two analyses of Mr. Z (1979), mentioned above, would be a case in point here. In this article Kohut demonstrated the extent to which a different, more positive therapeutic approach to resistance, a change in technique based on a change in theoretical conceptualization, could be beneficial to the analysis. Thereby he implied that his previous approach, which had been based on previous theoretical concepts, must have contributed to the creation of negative therapeutic reactions (intensified narcissistic rage against the analyst, defended against by suppression) and ultimately to disappointing results that were not recognized at the time as such.

Careful study of Kohut’s material will reveal that in his first analysis, Mr. Z. was repeatedly admonished and urged to relinquish his narcissistic character traits. In the second analysis these character traits were later revealed to be required in order to fend off deeper fears. In Ezriel’s terminology, Mr. Z.’s narcissistic required relationships were consistently disqualified in the first analysis without the calamities, related to the consequences of Mr. Z’s mother’s earliest empathic failures being considered. In the second analysis, these narcissistic required relationships were respected until the avoided ones, such as growth and separation, based on transmuting internalization could be severed from their calamities, such as merger or abandonment, with ultimate dissolution of the self. Once this had been accomplished, narcissistic required relationships became expendable and could be relinquished without incurring negative therapeutic reactions.

All the above seems to indicate that Ezriel's formulation is relevant to the creation of negative therapeutic reaction and its dissolution. It is operationally relevant and applicable to various therapeutic modalities. It constitutes a succinct conceptualization of the theoretical assumptions stated by the various authors mentioned in the preceding paragraphs.

Three Level Interpretations²

The previous chapter started with an attempt to sketch the development of Ezriel's contribution (1956, 1959, 1967) to the theory and practice of psychoanalysis. This was done with emphasis put on the problem of negative therapeutic reactions. The present chapter will further elaborate these points, putting the emphasis this time on the components and structure of complete interpretations, as postulated by Ezriel. The following Chapters will be devoted to some specific therapeutic applications of these concepts in specific therapeutic situations. These will include topics such as individual dynamics, single session psychotherapy, group, (especially large group, such as ward meetings) analysis, application of these concepts to paranoid and schizophrenic individuals etc.

As has already been indicated in the previous chapter, Ezriel adopted Strachey's ideas and incorporated them into the framework of the technical and theoretical developments, using them as starting points for his own concepts. Ezriel presented the following argument: correct application of the rules of psychoanalysis to the material presented in a psychoanalytic session by an individual or by a group of individuals, could usually detect the presence in the "Here and Now" of the transference of three distinct types of object relations. This could be done even when the material was presented ostensibly at random and

² The term "Three level Interpretations" was suggested by Arthur, .H. Feiner, Ph.D.

not necessarily in one session. As described in the previous chapter, he coined the term “**calamities**” for those aspects of object relations that aroused anxiety, for fear of which other aspects of object relations could not manifest themselves and had to be avoided. These calamities may be of mainly three types:

1. Paranoid calamities signified the fear of the object or its representative retaliating if the object relations destined to remain avoided were to be implemented. Ella's fear of her babies biting her would be an example of a paranoid calamity. Other paranoid calamities would be the fear of being ridiculed, castrated, castigated, banished, or even killed. In psychotic patients they might be, as already demonstrated in the cases of Jane and Katherine, the fear of being intruded or swallowed up by the object, respectively. In the case of Kohut's Mr. Z the ultimate calamity was dissolution of the self.

In the previous chapter the allusion to the formation of deserts was also mentioned. This was especially prominent in the case of a young schizophrenic, who incessantly pestered his therapist with questions of this sort. At the same time he would not tolerate even the slightest divergence of the line of thought of his therapist from that of his own. In this he resembled quite a few patients with similar pathology. He did quiet-down somewhat after the therapist gave an interpretation. The gist of this interpretation was that a desert might symbolize a devastated mind, the result of

a very young developing child's budding spontaneous, autonomous thoughts being constantly wiped out by contradictory ideas emanating from an authority figure. This figure, usually the mother, is perceived as hostile, and provided that this wiping out is done before internal psychic mechanisms had become strong enough to withstand such attacks, the child's mind is perceived as being devastated.

This line of thought is somewhat akin, from a different angle, to Chassgett-Smirgel's views (1986) about calamitous ideas concerning the formation of deserts. In her view, these calamitous ideas stemmed from imaginary destruction of mother's abdomen, the result of the infant's envious attack. (1986.) Chassgett-Smirgel's ideas and the ones expressed above are, of course, not mutually contradictory. Her ideas belong, however, to the depressive calamities, to be discussed below. In groups, the paranoid calamity often consists of fear of mutual attack on and destruction of group members by each other, or fear of retaliation by the group leader resulting from an attack on him. (C.F. Chapter Five).

2. Depressive calamities: These consist of the fear of the individual causing irreparable damage to the object, rendering it useless as a source of security or incapable of giving satisfaction. In more severe forms it even constitutes fear of total destruction of the object, resulting in its death. This may

be exemplified by fear of destroying the breast by greedy attacks or by female individuals' fear of castrating their partners during intercourse, in case they lose control. This may be considered the cause of many a case of frigidity. In psychotic patients, as well as in large groups, such as ward meetings, again to be extrapolated further in Chapter Five, it consists of drawing the therapist into the general bedlam, thus rendering him useless as a dependable object. In regular groups it might take the form of fear of the group's united attack on and destruction of its leader, thus, again being left with nobody to depend on.

3. Confusional calamities: These have been postulated as consisting of the fear of the individual (and in certain cases of the group) being forced to regress from the already achieved depressive position into the schizoid-paranoid one. (Winnicott, 1945, & C.F. Chapter Five, "Fragmentation").

For fear of these calamitous aspects of object relations other aspects of object relations have to be avoided, (e.g. by being repressed) in any given "Here and Now", just as had happened in the original anxiety arousing situation. Ezriel's term, **avoided relationships**, was a natural outcome of these deliberations.

Avoided relationships and the calamities they are associated with are always causally connected. They are always joined with each other by "because clauses." In the case of Ella this would be: "I have to avoid wishing Mummies baby to bite Mummy **because** my babies will bite me." In the

case of Ethan it would be: "I have to avoid being rational and insightful **because** I will have to face the consequences of having betrayed my mother." Another common example is: "I dare not tell my therapist that I felt his recent interpretation to have been stupid **because** he will throw me out on my face." This last, not uncommon occurrence is intended to introduce the notion that the formal therapeutic contract does not free the patient within the therapeutic situation from being unconsciously afraid of calamities emanating from the therapist. (C. F. Example Four in Part Two) In the case of Adam, mentioned in the previous chapter, there were even two **because** clauses: "I cannot let anyone come in too close contact with me, **because** anyone I am approached by might come to harm and I will be responsible for it **because** I foresaw it." These calamities could include being castigated, castrated, banished from therapy (see also Gilbert, above), or even killed or annihilated by the analyst (paranoid calamities). Otherwise they might consist of the fear of depressive ones, such as depleting the therapist's resources, blunting his capacity for empathy, etc.

These deliberations can, in fact, be carried further to the point of re-defining the therapeutic alliance as an imaginary covenant, a manifest that is constantly to be composed in the process of the analysis. Each overcoming of the fear of a calamity constitutes one paragraph in this imaginary covenant being formulated and agreed upon. "In this session it has been established that you may be angrily disappointed with me without being afraid of either me or you being tempted to abandon the therapeutic process." (Gilbert); "Today it has been established that you are allowed to fantasize about my wife/mate/secretary and I will do nothing even remindful of castration,"

etc. Finally, when the time has come for this covenant/manifest to be completed and signed, the analysis will have fulfilled its purpose and can now be terminated.

Reviewed from this perspective, some further classical terms of psychoanalysis possibly deserve to be reconsidered as well. Avoided relationships are constantly defended against and unless liberated from their calamities their overt re-appearance will be resisted. This would imply that the analyst constantly has to overcome resistances, and that the specific term “resistance” itself loses a certain need of being specifically defined. It might be suggested perhaps, that resistance constitutes that particular kind of defense (required relationship) that a particular therapist might find more difficult to contain than other defenses, perhaps for countertransferential reasons. Another therapist, with another constellation of countertransference, or even the same therapist, after his countertransferential difficulty has been resolved (Springmann, 1986, 1989, & C.F. Example Four, second part of this book), might find this very required relationship (defense - resistance) not to constitute a resistance at all.

The term interpretation itself might also deserve reconsideration. According to Strachey, as adopted by Ezriel, the task of an interpretation would be not so much to explain or translate, as Bion (1957) would have used it, but rather to mutate. As pointed out by Strachey, the result of a mutative interpretation ought not to be as Freud had put it, “Where there had been Id, let there be Ego.” This ought to be changed into “Where there had been harsh, archaic punitive Superego, let there now be reality oriented Ego.” Ezriel went

further. He demanded that the result of a (complete) interpretation ought to be: "Where there had been non-adaptive, defense oriented required relationships, let there be the option to deploy newly liberated, mature, hitherto avoided relationships. These are not to be inhibited by fear of imaginary, atavistic calamities, but governed by the assessment of the requirements and opportunities of external reality." I use the term option as a result of questions I am frequently asked when lecturing on the topic just presented. Someone in the audience almost regularly asks: "By liberating avoided relations from their concomitant calamities, are we not turning our patients into superego-less individuals? Will they not give full, uninhibited liberty to their hitherto avoided relationships?" My answer to such questions is that we do not create psychopaths, but open hitherto prohibited options to be implemented in accordance with the assessment of external reality.

The net result of an interpretation would consist in the abolition of an anxiety with a specific content and hence, the reduction of the total amount of the anxiety in the psyche. This point will be returned to and expanded in Chapter Seven.

Norbert was a senior mental health practitioner in his early fifties, who finally decided to go into analytically oriented psychotherapy with the intention of "putting some order in his personal life." Despite external career oriented successful achievements he felt that this aspect of his life had always been standing on shaky legs. He was a heavy, compulsive smoker and I was allergic to cigarettes. An agreement was struck that in return for his not smoking in my presence a hot cup of

coffee of a special brand would await him whenever he arrived for his session. Needless to say, this cup of coffee acquired symbolic meanings of all kinds. After about three years of therapy, during which considerable progress had been achieved in various areas, Norbert told me that he had quit smoking altogether several months ago. He had, however, been afraid to tell me about this for fear of my depriving him of his coffee.

Norbert severed the combination between his fear of losing the cup of coffee and all it stood for on one hand and his maturation, symbolized by his being able to quit smoking, on the other, in the "Here and Now" of the transference. Nevertheless, it opened the way for him to recover childhood recollections concerning the ways he had had to hide and stunt his emotional growth in order not to lose his parents' affection (i.e. turn this growth into an avoided relationship). One paragraph of the therapeutic covenant had been formulated: "You may wean yourself of the regressive need of oral satisfaction, smoking, and this will not cause the withdrawal of my affection, symbolized by the special cup of coffee." Beside the evocation of these childhood memories, this liberation of the avoided relationship in the "Here and Now" of the transference, resulted in the fact that he now was able to stand up to his wife and refute her outbursts. For fear of losing her love and adoration, of the existence of which he was consciously convinced despite these occasional outbursts, this had formerly been impossible to him.

A common derivative of this kind of required relationship, of avoiding full-blown inherent talents from being unfurled for fear of various calamities, is surprisingly not infrequently met

with in young therapists. They are discovered in supervision to be afraid to surpass their own analysts, as they had perceived and experienced them. This might concern both their empathic understanding as well as their intellectual recognition of the significance of the material presented to them by their patients. I fell into this trap as will be demonstrated in the case of Leonard in Chapter Eight. I also remember myself for along time not daring to charge my patients more than my analyst had charged me, despite the running inflation at that time. (C.F. among others: Example Eighteen in Chapter Ten, Part Two).

Avoided relationships can be of libidinal and/or aggressive, anti-libidinal nature. The aggressive aspect of such a combined libidinal/anti-libidinal avoided relationship frequently incurs the (usually depressive) calamity, especially in early, pre-Oedipal dyadic relationships: "I have to avoid loving my mother and her substitutes. This is not necessarily because love itself is forbidden and therefore punishable, but because this love, especially if frustrated, will create such terrible aggression in me that I might endanger her"

Avoided fantasies and their concomitant calamities do not usually appear openly in the material spontaneously presented by the patient in analysis. They are constantly defended against, so that they have to appear as disguised hints, which have to be reconstructed by customary analytic methods. In the case of aggressive avoided fantasies of particular violence, total destruction of the object need not be mentioned at all, since it is implied by the very violence of the avoided relationship. This might be the case when violence is hinted at by associative reference to atomic weapons. (C.F. Chapter Five).

Ezriel was not the first to point out that situations in which repressed material was left unguarded would be intolerable. He maintained that the constant wish for fulfillment of avoided relationships would cause constant fear of calamitous results — an unbearable situation indeed. As mentioned above, he argued therefore that a further set of relationships was required. These he called, as will be remembered, the **“required relationships,”** – a term akin to, but more inclusive than Freud’s counter-cathexis. The task of these **required relationships** was to hold the avoided ones in check. This was sometimes accomplished by providing sufficient vicarious satisfaction so that the need for satisfying the avoided relationships would not arise. In other cases it was accomplished by shifting attention to different areas of interest and sometimes by providing false warnings, cautionary tales, and warning of pseudo-calamities that would cause the avoided relationship to be abandoned before real, much more intensive anxieties, connected with internal calamities had been aroused. A common example for this situation would be the fear of venereal disease, which will prevent sexual activity, while the real calamity would be castration.

Required relationships may often be derived from the avoided ones by implementation of various defense mechanisms, such as displacement, reaction formation, projection etc. In other cases they contain the avoided relationship in an attenuated form, such as sarcasm instead of physical aggression, and in still further cases unrelated fantasies are used as required relationships.

Bion, for instance, described basic-assumption behavior in groups as defensive maneuvers intended to keep at bay (i.e. avoid) painful subjects (Bion, 1955). His basic assumptions can consequently be regarded as required relationships. (This topic will be discussed in greater detail in Chapter Five). The same holds true in regard to some of Eric Berne's "games," e.g. "if it were not for you" (Berne, 1961).

Required relationships are by no means always consciously acknowledged as such. The following is an example to illustrate this point. This example is also intended to exemplify the way in which, in certain group or family situations, the psychotic patient is the one who senses the fear implied by implementation of the avoided relationship and provides for the required one. Later, once the situation had been interpreted he, (or in this case she), takes it upon himself/herself to express the avoided relationship.

Olivia was a paramedical practitioner in her mid twenties, hospitalized because of a psychotic state, probably schizophrenia with catatonic traits. Her central complaint was that she would never be able to resume her professional activity because she had forgotten everything she had ever learned. After some time she became mute, so that in family sessions that were instituted she used to sit in her corner without ostensibly showing any interest in the proceedings. After several months of therapy had elapsed, my co-therapist happened to be late for a session. This fact caused the loss of a major part of that session.

It was on this occasion that Olivia chose, for the first time in many months, to open the session by lamenting her situation, "What will become of me? I have forgotten all I ever knew. I will never be a

practitioner again” etc. for many a minute. These lamentations made it impossible, at first, for any other subject to be discussed. (The resemblance to Ethan in the previous chapter comes to mind). Some wonder was expressed by family members and by Olivia about her being willing, or even able, to participate in the therapeutic exchange, albeit by her usual, lamenting manner. Then it crossed my mind that the issue of the co-therapist’s being late and its consequences, (the family being deprived of the major part of their session,) had been avoided. When this had been said it became clear that the family was incapable of criticizing authority figures for fear of losing their sympathy. These elements (Required relationship; [supplied by Olivia at the cost of temporarily giving up her presenting symptom] "Let us talk about something else; Avoided relationship: criticizing authority figures; calamity: losing their sympathy) were clarified. After this had been done, Olivia, the identified patient, assumed responsibility again and mumbled, “I think it is the responsibility of therapists to see to it that the sessions take place on time and not be late.”

Analysis of this situation shows that the patient who had, probably unconsciously, sensed the inability of other family members to cope properly with a situation that demanded criticism of an authority figure, had provided them with a required relationship. Her lamentation being chosen to be implemented at that particular moment in time made it indeed possible for them to evade the issue. After the situation had been clarified by the interpretation and criticism of authority figures had been liberated from the fear of being punished in one way or another, Olivia again assumed responsibility for the avoided relationship to become overt.

At the beginning of this session none of the participants, including myself, was aware of the significance of Olivia suddenly being able (or willing) to speak again. The general feeling was “thank God, she must be improving; she has started to speak again.” Only after it became possible to review the whole situation and put this willingness (or ability) to speak in its context, was it also possible to recognize it as a required relationship, intended to fit this situation. The fact that “not being able to speak,” just as “not being able to remember,” probably constituted required relationships in her own intra-psychic constellation, could only be surmised. In any case it was irrelevant at that time.

Much later, when Olivia was already participating actively in the sessions, her mother related the anguish she had had to suffer when Olivia was a baby. Unable, as in the session just described, to withstand authority, she had been obliged to follow the then *in vogue* medical instructions to the letter. She used to hear her daughter cry and lift her, feed and comfort her only after the prescribed four hours had passed. At the following session Olivia presented a dream, the only one she presented during the whole therapy. In her dream she was angry with me for going into private practice. Her anger was directed, however, not at the fact that she now would have to pay for her sessions. It was directed at the “fact” that I had arranged my schedule in such a way that it was next to impossible for her to reach me at a convenient time. This sequence of events, mother’s story and Olivia’s dream highlighted two points. On the one hand, her specific sensitivity for an object being late now acquired deeper significance. On the other hand, it proved again, as had been done many times before, that Freud’s assumption

about psychotic patients being incapable of forming transference had been misconceived.

Even later in her therapy, when she had already taken over the lead in her therapy, Olivia told us that in her work as a physiotherapist her patients frequently asked her to discontinue their post-operative painful exercises. She never obeyed them, as she knew that these very painful exercises, even though they did make the patients suffer momentarily, ultimately helped them to recover with a straight spine. I interpreted that our interventions, which by now regarded extremely painful issues in Olivia's life, were causing her almost unbearable pain and that on the surface she was covertly asking us to desist. On the other hand, she was warning us not to desist, because if we did, she would forever remain with a crooked mental spine.

Then, at the very end of her therapy, when she had already regained everything she had "forgotten," she asked the inevitable question, "Doctor, am I schizophrenic." This is a very awkward question for a therapist to answer honestly, because most intelligent patients are aware of the ominous prognostic consequences usually attributed to this diagnosis. So I answered, "You presented us with a series of problems, some of them very painful indeed. We picked up the glove and in working together we solved your problems so that now you feel prepared to resume your profession. Now you tell me, are you schizophrenic or are you not?" Olivia no more felt the need for her question to be answered.

Both Ethan and Olivia assumed the role of scapegoats in order to protect other family members of situations that would be, at least,

embarrassing for them. This seems to be no coincidence. It is probably connected to the covert covenant that supposedly exists between the identified (psychotic) patient and his family, of possible pathogenic significance, as mentioned in Chapter One.

It may be concluded that required relationships enable and facilitate the avoidance, by individuals or by groups of individuals such as families, of certain other object relationships. The avoidance itself is necessary because of fear of calamities. In this context mental health might be a function of the adaptability to external reality of any individual, or group of individuals' defensive structures (required relationships). Dynamic psychotherapy might be defined as a process that enables patients to relinquish non-adaptive, pathological required relationships, such as neuroses, personality disorders or psychoses, in order to replace them with the option to implement more adaptive, previously avoided ones. This is accomplished by liberating the latter from their calamities.

Herbert, described in the previous chapter, differed from Norbert, described in this one. In the case of Herbert the significance of the various relationships was divined via memories of the past, whereas in the case of Norbert it was the other way around. Nevertheless, in both cases liberation of the avoided relationship, in the first case, the free use of intelligence, in the second one the liberation of the free use of assertiveness from their respective calamities, put these very attributes at their disposal. Now they could be implemented in accordance with external circumstances.

According to Ezriel (1956) this therapeutic goal can be achieved by applying what he termed “complete interpretations,” (three level interpretations, as I prefer to refer to them). These should contain all three aspects of the current object relationship, namely:

1. The current required relationship. (This, in my eyes, is the least important component of the interpretation.)
2. The avoided relationships, and if possible, the defensive maneuvers by means of which they had been created or derived from the required ones.
3. A complete spelling out of the imaginary, atavistic calamity and especially its causal connection with the avoided relationship, by use of the term “because.”

If this is done in the context of the “Here and Now” of the transference, the avoided relationship may be discharged towards the therapist and reality tested in the “Here and Now”. In this way the imaginary mandatory causal connection with the calamity is disrupted. When this reality testing has been successfully and safely accomplished, the fear of the calamity has been dispelled. Now the hitherto required relationships have become redundant and can be displaced by the avoided ones, as had happened in the cases of Herbert and Norbert, albeit the interpretations were not constructed in the context of one session.

Ezriel defined this liberation, in the “Here and Now” of the transference of the avoided relationship of its calamity, as the corrective emotional experience. This was in contrast to the definition of this term by its founders, Alexander & French (1958), who had declared the behavior of

the therapist in a way opposed to the one adopted by the patients' parents to be the corrective emotional experience." In the context of Ezriel's conceptualization, such behavior on part of the therapist would constitute a non-interpretative intervention. (C.F. Chapter Seven).

The usefulness or un-usefulness of an interpretation would be assessed by the appearance, or non-appearance in a more explicit form of the avoided relationship after the interpretation has been given. Once previously avoided relationships have been reality tested and proved harmless, this leads by a process of generalization to improvement in extra-transference relationships as well.

A young female patient, Pamela, was shown that she had to assume a frozen posture in the presence of her therapist, for fear of his being attracted to her. If this were to happen, she would be afraid that she might castrate him. After this had been interpreted, she could unfreeze, blush and show other signs of her awakening sexual feelings. As will be shown later, this same patient could later improve her relationship to extra-transference objects as well.

Two minor reservations have to be expressed here. One is that clinical material will be presented, in the case of Quentin below, and especially in Chapter Four. This evidence will point out that the dispelling of the causal connection of the avoided relationship with the calamity need not always, exclusively, be done in the "Here and Now" of the transference. This latter context simply seems to be the safest place to do this. The other reservation is that, especially in psychotic patients, the ability to relinquish psychotic required relationships such as delusions, the up

keeping of which had hitherto been indispensable, can become redundant without the avoided relationship necessarily becoming more overt.

The structure of the interpretation given by the therapist to Caleb, who would not maintain eye contact with his therapist as described in Chapter One, will now be spelled out in Eziel's conceptualization.

Required relationship: I can't look into your eyes.

Avoided relationship: I want desperately to maintain eye contact with you and thus weld our therapeutic bond even further. I cannot do so because

Calamity: I am afraid of discovering the same cold, rejecting, smiting look I used to see whenever, as a child, I tried to look into my mother's eyes.

Besides the highly, (and adequately) emotionally cathected memories he was inundated with, this interpretation resulted in the patient being able to maintain eye contact with his therapist and the therapeutic bond intensified.

The following are examples of the rules of psychoanalysis being implemented, thus rendering ostensibly randomly presented material amenable to being arranged into three level interpretations, resulting in the avoided relationship becoming manifest.

Pamela, briefly mentioned above was a young amateur dancer, treated by brief therapy in D. H. Malan's workshop at the Tavistock Clinic, under his supervision. She arrived for her thirty-fifth session running up the stairs to the fourth floor, on which my consulting room was located. She started the session by requesting her next session to be re-scheduled, because otherwise she would

not be able to participate in the final rehearsal of an important dance-performance of her group. After her request had been granted, she remarked that she would have come to the session anyway, even if I had not obliged her by re-scheduling it. She would do so not necessarily because the session with me was of any importance, but because it would provide her with a valid excuse not to participate in the rehearsal and consequently in the dance-performance, of which she was terribly frightened. At the same time she visibly cringed with fear whenever a sound outside the door of the consulting room could be heard such as passing footsteps, doors being opened or shut etc.

These data were formulated into an interpretation, the gist of which, even though not put into these exact words, was:

Required relationship: I don't care about coming to see you. Even if I do so in difficult circumstances, it is not because the session with you would be of any importance to me, but because it serves me elsewhere.

Avoided relationship: It is very important to me to come to your sessions, this is why I come up running all these stairs in order not to lose even one minute. Furthermore, I want you to see me display my beauty, as in the dance, so that you admire it and be attracted to me. I cannot do so. However, I have to pretend that I don't care because:

Calamity: I am frightened of being surprised and overcome by powerful female (Oedipal) rivals, represented at the performance by the women in the audience and in the "Here and Now" by the noises outside.

Following his interpretation Pamela immediately relaxed and showed no more signs of her being frightened by the noises outside the door. Several sessions later she told me that she had enjoyed participating in the dance-performance very much. (For a fuller description of this therapy, C.F. Malan, 1979, [Divorced Mother], also Springmann 2004).

Quentin was a thirty years old man who had recently re-enlisted in the professional army as quartermaster, with the rank of Major. He came for therapy because of impotence that had appeared shortly after he had re-enlisted. This therapy consisted of one single interpretation.

After some preliminary questions he told the following story: He had left the professional army several years earlier and had worked for a large delivery firm, where he was in charge of a large fleet of lorries. He described himself as a very resourceful organizer, so successful at his job that he managed to bring the firm from the brink of bankruptcy to a healthy financial state. In doing so, however, he often found himself in conflict with the junior owners of the firm. These, in turn, felt threatened and had to defend themselves for fear of being dispossessed. Consequently they discredited the patient and complained about him to their seniors. The situation deteriorated until finally Quentin had to resign his lucrative job and rejoin the army in an equivalent position but with a considerably lower income.

Based on this information I equated success with sexual success, especially potency. Success and its dynamic equivalent, potency, had now become associated with a calamity, the anger of authority figures that would cause the loss of income. Translated into dynamic terms this would mean

loss of an emotional-abundance providing, desirable object, such as wife or, in childhood, mother. Mother was not included in the interpretation, as there seemed to be no indication in the material that would concern her. Nor was there any material that would allow for the “Here and Now” of the transference to be mentioned. The patient was told that he now had to avoid any symbolic equivalent of success (such as sexual potency) because it had become associated with the calamity mentioned above. Impotence was interpreted as a defense, a required relationship, implemented in order to avoid symbolic success.

The patient replied that he had never considered the matter from this angle and associated about his fear of being evicted from his apartment because of some disagreement about the rent. The next session he reported that potency had been re-achieved. [For further examples of psychotherapy by a single interpretation, given in one or two sessions, C.F. Chapter Four and Springmann, (1976 & 1978).]

In the case of Pamela there was no confirmation of the usefulness of the interpretation in the overt, verbal post interpretative material. In both cases, however, the ability to re-institute the avoided relationship seemed to be sufficient proof of this usefulness. This consisted in the ability to exhibit beauty, Pamela, and in the re-institution of sexual potency, Quentin.

The following example is intended to illustrate the relatively disappointing results achieved in many cases unless the “Here and Now” transference situation is included in the interpretation.

Rubin was a young mental health professional in analysis. During a certain session he mentioned

that without being impotent he had refrained from having sexual relationships with his wife for many a month. From further associations it transpired that he intensely envied his wife for the emotional richness she had in store for him. This envy incurred murderous fantasies against her, and in order to contend with these fantasies he had reversed the dependency situation. In his mind his wife was now dependent on him for sexual satisfaction instead of the other way round. Depriving her of sex enabled him to fantasize himself as being the one in control of supplying or denying satisfaction at will. In other words:

Required relationship: by withholding sex I can keep up the fantasy that it is not I who is dependent on her abundance but rather she is the one dependent on me for satisfaction. (This role-reversion is a manic defense).

Avoided relationship: I am desperately in need of the good emotional satisfaction she holds in stock for me and I intensely envy her for it. I cannot confess this need and envy to myself because:

Calamity: This envy might lead to destructive attacks on her, thus destroying any hope for future satisfaction. (This would be a depressive calamity). Rubin accepted the validity of this interpretation but it resulted in no change in his behavior.

He opened the following session by stating that nothing had changed. Then he added that he had come across some very disturbing gossip about me, his analyst. He was unable, however, to disclose this gossip and share it with me because it would be inappropriate in this situation. Now it was clear that he was behaving towards me in the same way he had been behaving towards his wife.

First he aroused my curiosity, wetted my appetite and then withheld the relevant satisfaction by refusing to share the intriguing information. In this way he had again succeeded in turning the table so that it was I who was dependent on him for satisfaction instead of him depending on me for “good interpretations.” This implied that he was envious of the “good” I might have in stock for him and that in his eyes I was latently in danger of being destructively attacked by him. This state of affairs was clarified in an interpretation that was a copy of the one given in the previous session, except for the exchange of myself for his wife. He now admitted that whenever I had made an intervention that was “worthwhile” in his eyes, he used to have devastating fantasies about me. Then he resumed normal sexual activity at home. (For further unfortunate results of failure to put the interpretation in the context of the “Here and Now” of the transference, C.F. Jane’s fuller description in Chapter Six.)

Later on in his analysis Rubin suddenly, unexpectedly announced that he wanted to terminate the process. This happened after some very delicate, intimate matters had been discussed. In the same session he brought up memories that concerned himself as a young adolescent. He related that on one occasion he had been baby-sitting the baby daughter of some neighbors, and not being able to control himself, he touched the baby’s genitals. I interpreted that now, after those delicate, intimate matters had been discussed, he might have felt himself totally in my hands. In these circumstances he was afraid that I might exploit this situation not for his benefit, but for fulfilling some desire or any other interest of mine. His answer was, “You win. I will continue.”

These examples have been chosen for three reasons.

1. Just as the examples in Chapter One, the clarity, transparency and virtual in-ambiguity of the presented data, rendered them ideal for the purpose of presentation.
2. The immediacy of the therapeutic results of the interpretations constituted proof of the causal relationship between the usefulness of these interpretations and their results. This was especially so in the case of Quentin. In that case one single interpretation was the only psychotherapeutic intervention.
3. The required relationships employed by Pamela, the amateur dancer, and by Quentin, the impotent major, were typical ones. Pamela used devaluation of the (male) object. The opposite would be idealization. In some subjects both attitudes may exist, either split between different objects or else used alternatively, as two faces of the same coin, against the same object. Nancy alternatively idealized and devaluated me and thereby exemplified this situation. (A fuller description of this case will be found in Chapter Seven). This two-sided attitude turned out to be a defense against being on the same level with me, a situation that might lead to our becoming a couple, causing intercourse and pregnancy to be avenged by an Oedipal rival. Another common required relationship is used in order to prevent true consummation. It consists of holding a secret, sometimes imaginary lover, who acts as the reservoir

for libidinal wishes. The latter are to be avoided in reality for fear of one calamity or another, such as total or partial destruction of the object, fear of retaliation by Oedipal rivals, etc. Even falling in love with the therapist is sometimes a required relationship, especially when this love is openly declared and highlighted, making it impossible to ignore. One young female patient of mine behaved in such a way, until it transpired that it was the unfulfilled interminable yearning and hopelessness of this love that she was after. This she experienced as a constant self-punishment, to avoid the even deeper fear of being punished for having caused the abortion of her sister by wishing it.

4. Impotence, the required relationship used by Quentin is also a common required relationship, akin to the common, conscious or unconscious assumption of sexual inferiority, such as the complaint of having too small a penis. The structure of this symptom is frequently as follows:

Required relationship: I have to distort my fantasy about the size of my penis by constantly thinking of it as being small.

Avoided relationship: My deeper fantasy is that my penis is bigger and stronger than that of my Oedipal rival, (generally father or his substitute in any circumstances), but I can't afford to sustain this fantasy because:

I will be punished by having it chopped off.

Two patients exemplified this, one of whom fantasized all penises in the world

laid out along each other in a row, all those exceeding a certain length to be chopped off. The other harbored the fantasy that his penis was in danger of castration only when erect.

It seems plausible that young therapists' fear of surpassing their original analysts, as mentioned above, is a distant derivative of this required relationship.

Despite all that has been said so far, it cannot be stressed strongly enough that the schematic representations of all the interpretations presented so far is just that, a schematic representation. The exact wording of the interpretation need not be in the order described; it ought to be expressed in the softest available words, preferably the patient's own vocabulary without the use of terms that would alienate him. In fact, I have learned and taught my students to put interpretation in the form of questions. "Is it perhaps possible that you behave in such and such a way, whereas you would rather behave otherwise, but cannot afford to because you are afraid of these or those consequences?" Sometimes I say to a patient: "Listen, please. While I was listening to you, an idea occurred to me. It might seem odd at first; nevertheless I would like to share it with you in order for us to contemplate it together." In this way the patient experiences the interpretation not as dictate, *ex-cathedrae*, but as a shared idea to be given the benefit of being contemplated.

Required relationships can be life-long attitudes. This could be exemplified by one patient's life long cult of revenge. He venerated it above anything else to avoid deep guilt feelings of having driven off his father who had left the family when the patient was at the summit of his Oedipal rivalry with him.

In other cases they may be fleeting, such as a patient's dream of my telling her my troubles instead of the other way round. This reversal of the dependency situation had to be instituted in order to defend me from the patient's oral destructiveness, inherent in her own dependency and expressed in the therapeutic session by nail biting.

McDougall (1986) has a somewhat similar example. In her case the patient was afraid that by his greed he had turned her into a void, as he had been afraid he had done to his mother. Now she could carry him no longer because he had become too heavy.

Recent literature has tended more and more to regard psychoses as defensive structures, (e.g. Arlow & Brenner, 1969), or in other words as required relationships. This matter has been expounded in Chapter One, and will be further expounded in Chapter Six and in Chapter Eight. In the present context it will be mentioned that Giovacchini (1969) has described a case in which he aborted an acute schizophrenic breakdown, consisting of total incoherence, bordering on word-salad, by interpreting it as a defense against depressive anxiety connected with the assumption of responsibility, namely of being in charge of a car pool and the fear that the patient might cause an accident in which children might be killed. Segal (1972) has described a delusional system required for similar needs: Warding off avoided relationships connected with calamitous results that reached back to very early childhood experiences. Searles (1965) has commented on formal thought disorder as a means "to conceal one particular thought amongst a host of irrelevancies." In my own experience as

supervisor, hinted at in Chapter One, such thought disorders, described by Draznin, turned out to constitute defenses against coherent expression of erotic feelings towards the therapist. This had to be done for fear of the intensity of aggression towards him in case these feelings were too bluntly ignored, leading in turn to the fear of being totally abandoned.

I find this an appropriate moment to describe this therapy in somewhat greater detail. It concerned a sixty year old obese, diabetic, chronic schizophrenic woman, who had spent the twenty years before psychotherapy had been instituted mostly passively in bed, hardly bothering to get up for meals. It was suggested to Draznin, then a fairly young psychologist, to take her up for psychotherapy mainly as a learning experience for him, with little hope of achieving any real results. Nevertheless, by the sheer form of his unique personal, infinitely patient approach, which was constantly aided by intense group supervision, he helped the patient shed her passivity by gradually proving to her that it was a required relationship that had to be installed in order to cover up for her potential aggression. After several years this ostensibly incurable patient could be discharged from the hospital. She lived at home for several more years in the company of a lover she had managed to acquire. Later, after the lover had died, she lived on her own in constant intensive contact with her therapist for six more years until she finally passed away, a free, active woman in charge of her life. The reason for having chosen this case for more detailed description lies in the fact that it constitutes a further substantiation for the ideas posited in Chapter One.

In another case of Draznin's, a thought disorder turned out to be an expression of the patient's envy of the therapist's capacity to understand, an attempt to undermine this capacity in order to avoid similar aggression instigated by envy. In both cases thought disorders promptly disappeared as soon as their significance was understood and interpreted. One particularly intelligent schizophrenic patient described "blocking" as a feedback mechanism, to be put into operation whenever his auto-destructive introspective activity threatened to reach a point of no return.

Mendelson & Silverman (1982) have presented experimental evidence that seems to point in the same direction. Schizophrenic thought disorder was shown by them to be influenced by psychodynamically relevant unconscious ideas. In their work they created an increase in these disturbances by subliminally presenting psychodynamically cathected material. Relevant points, having to deal with delusions, their creation and their disappearance, will be described in greater detail in Chapters Six and in Chapter Eight.

One further point has to be addressed here. It concerns the question of the timing of an interpretation. According to Ezriel, the right time for an interpretation to be given is the moment the therapist realizes that he had understood all three levels of the intended interpretation. That he could spell out in full the required relationship, the avoided one and mainly the causal connection between the latter and its concomitant calamity.

One of the implications of this chapter is the way the various developmental axes may interact and influence each other. In the present chapter the emphasis was put on the negative influence of one

axis on another in the form of calamities, but this mutual influence can be positive too. A mother, who kisses her infant for having learned a new word or for having learned to distinguish between two nuances of color, rewards him on the Freudian, psychosexual axis for an achievement on the axis suggested by Piaget. The same hold true for a wife who shows her pride for her husband's achievements by finding ways of pleasing him on the Freudian axis. A calamity need not be a specific single event. Long-lasting situations, such as marital dispute between parents can be calamities, provided the individual involved believes, at first consciously and later unconsciously, that the situation had a causal connection with his wishes, thoughts, actions or default real, as in the case of Herbert or imaginary, as in the case of Adam.

This line of thought might offer a possible solution for the different ways in which the borderline personality is described in various schools of thought. Whereas Kernberg describes this personality configuration as a result of failure to accomplish the depressive position because of excessive aggression that prevents integration, other schools of thought describe it as a failure in the Mahlerian separation-individuation process. Can these two schools of thought be reconciled? I believe that the above considerations allow for such reconciliation in the following way. It stands to reason and has also been observed that failure in separation-individuation generates excessive amounts of aggression in the infant. Now we can assume that it is this same aggression that prevents the infant from achieving the depressive position and leaves it dangling, so to speak, between the schizoid-paranoid position and the depressive one, just as Kernberg conceptualized

this personality configuration. This line of thought can be carried further. Kernberg defines one of the major deficiencies in the borderline as the incapacity to empathize. Hence an important question implied in his "structural interview" is: "Can you, patient, understand that I cannot understand you?" In Kernberg's argumentation an answer that implies that the patient cannot understand the interviewer's question implies that he cannot empathize and that this is a crucial element in diagnosing the borderline personality configuration.

In my experience, however, almost all schizophrenics, both in remission and often in the time of breakthrough of overt psychotic symptoms, when asked Kernberg's question, more often than not imply in their answers that they can understand the examiner's inability to understand them. If we put aside for a moment Bion's ideas about the psychotic and non-psychotic parts of the individual and think in original Kleinian concepts, we are almost inevitably led to the conclusion that the psychotic had at some point achieved the capacity to empathize, i.e. the depressive position and that for fear of some calamity or another had to abandon it and regress to the schizoid-paranoid position. In this he resembles a process to be described further on, the fragmentation in the large group.

Arnold, to be described in Chapter Six, might serve as an example. He showed his capacity for understanding unspoken plight in his very first session, in which he saved me from the unpleasant situation of having forgotten his name.

This very capacity for empathy, which in certain situations serves to secure sanity, might, in different circumstances, also be the undoing of the

infant. This is exemplified again in the case of Arnold, who first used this capacity to survive, but later, when he ran out of defense mechanisms, developed schizophrenia.

On The Specificity of Interpretations

(Psychotherapy by a Single Interpretation)

In the previous chapter I attempted to demonstrate the merits of interpretations as proposed by Ezriel. In Chapter Seven I will attempt to discuss the relative merits of interpretations versus non-interpretative psychotherapeutic interventions. In the present chapter I intend to present several cases in which a single interpretation could produce an important, lasting change in the lives and comfort of the patients involved. I will do so in order to further enhance the place of the interpretation as a major tool of psychoanalytic psychotherapy. These single interpretations were based, more often than not, on a single interview. Another purpose of this chapter is to prove once more the very possibility of producing such a lasting change by a single interpretation in the first place. A third purpose is to show that the transference is not necessarily the only environment in which such an interpretation can be effective but, as shown in Chapter Six, certain conditions given, it is more or less the only unconditionally safe one.

In presenting these cases I will be following in the footsteps of Ormeland, (1976), who described a case in which he was able to bring about the resolution of a speech disturbance of hysterical nature by a single interpretation. In that case, this interpretation was based, like some of the ones to be presented here, on a single interview. Ormeland called the article in which he described this case "A curious resolution of a hysterical symptom." He did not specify what he had in mind when he

referred to his case as “curious.” One is left with an impression that he was referring to the very fact that he was able to achieve an appreciable result in one single session. He pointed this out in his article and compared present day analyses with the very brief ones that had been *en vogue* in Freud’s days.

Authors such as Malan, (1975), Sifneos, (1977) and many others have reported that in favorable circumstances significant intra-psychoic changes of curative value may be achieved in a relatively short time, sometimes in a single dynamic therapeutic session. Nevertheless, current psychoanalytic literature deplores the relative rarity of reports of the success of such brief interventions as described by Ormeland. This creates the impression that psychoanalytic psychotherapy is by definition a protracted procedure. This information is frequently conveyed to prospective patients, who learn to expect it as such and a vicious circle is created. Ormeland describes in his article how he barely managed, for unconscious reasons, to escape such a trap.

I am far from claiming to be original in advocating that more attention be paid to the brief approach. Others, notably Mann, (1973), Malan, (1973 & 1977), Sifneos, (1977) and Davanloo, (1988), have done so before. However, if Ormeland still refers to his ability to achieve success in a single interview as curious, and if reports on the success of brief interventions are as scarce as they are believed to be, these authors do not seem to have received the proper attention they deserve.

Drawing further attention to the fact that very brief dynamic interpretative intervention that achieve lasting results are not a rare species in danger of extinction will consequently be a further

purpose of this chapter. By presenting the cases in which this achievement could actually be accomplished I hope to demonstrate that there is nothing “curious” about being able to influence the lives of the patients involved and changing their lives quite appreciably.

The technique used in these interpretative interventions was that of the “dynamic diagnostic interview,” as suggested by Malan. This technique aims at getting as complete and as deep an understanding as possible of the life circumstances that had preceded the appearance of the individual’s symptoms and attempting to understand the dynamic significance, psychosexual or otherwise, of these circumstances. This understanding is subsequently used to formulate what Malan (1963) referred to as the “minimal dynamic hypothesis,” a formula that combines the psychodynamic data into a meaningful sentence, using the barest possible minimum of theoretical hypotheses. This formula is later to be used as the focus around which Malan’s brief psychotherapy would evolve. The only deviation from Malan’s original procedure was that once having formulated this hypothesis (if possible, in the form of a three level interpretation), I incorporated it into the diagnostic interview in terms the patient could understand. In favorable circumstances the patient might then be able to use this formulation or in other cases, as will be demonstrated further down, transmit it to a third person.

This inclusion of the “minimal dynamic hypothesis” into the diagnostic interview would turn it into what might be termed a “dynamic therapeutic interview.” As will be demonstrated by the following examples, this technique proved to

give positive results at least in several cases. Quentin, described in the previous chapter would be an adequate example for the use of such a “minimal dynamic hypothesis” being incorporated into a diagnostic interview and producing therapeutic results. I feel, however, that in order to re-enforce the point intended for the present chapter, further cases need to be demonstrated.

Robert was a thirty-year old reserve officer, hospitalized in a surgical ward because of wounds he had suffered in battle a few weeks previously. He had suffered a compounded fracture of one of his legs and thirty percent of his body surface had suffered third degree burns. Despite the fact that no organic complication such as infection was present, he was rapidly deteriorating and had to be put on the critical list. This deterioration was attributable to an almost total inability to sleep and to an almost total refusal to take in nourishment. When examined he was lucid and co-operative. As he was willing and able to talk freely, I gave up my original intention to assist his abreaction by hypnotics and let him speak freely.

He ascribed his insomnia and lack of appetite, which he knew had brought him to the verge of death to a ruminatively recurring, self-incriminating thought that it had been his own fault that he had been so seriously injured.

He explained that as tank and platoon-commander he had been driving in his tank, the upper part of his body exposed the better to navigate and to assess the battlefield. At a certain moment a bullet nicked his helmet and he instinctively receded into the tank. While driving thus inside, his tank was hit by a bazooka he had failed to spot. Consequently, he maintained that it was due to his “cowardly” reaction that he had been wounded.

I reacted instinctively by saying that I was unable to comprehend his guilt; any other man would have reacted in the same, reflex-like way. Further exploration revealed that he always tended to feel responsible whenever anything had gone wrong in any circumstances and that in doing so he was emulating his perfectionist mother. By the end of this interchange he felt relieved and was later reported to have slept well that night for the first time in weeks. Despite not having entirely understood the situation, I felt satisfied and decided to leave well enough alone.

However, the improvement lasted only for a few days, all his symptoms flared up and I was summoned to see him once more. This time I knew that the matter had to be clarified fully, and asked about the fate of other members of the tank crew, and any special relationships.

It transpired that Robert did, indeed have a special friend in the crew, a young boy who had been killed by the same bazooka that had wounded Robert. Being childless, Robert had regarded this boy as kind of a substitute son and liked and preferred him to other members in the crew. However, he had found himself powerless to discipline this boy, much less to punish him when he neglected his duties. The boy soon learned to exploit this situation, neglected the cleaning of his weapons so that they weren't in proper condition when needed in battle etc. Robert then added that it had really been his friend's duty as machine gunner to spot and destroy the bazooka that had hit them. I could now point out that it was really the boy's (immediate) fault that he had been wounded. If Robert were at fault at all, this would be because he had been unable to assert himself and discipline his friend. Robert made immediate

use of this clarification. He recalled that his friend's weapon had been in poor shape, a fact he ascribed to his not having cleaned it properly. He remembered himself comparing its poor performance to that of others in his vicinity. More specifically he now remembered being extremely furious about his friend's sloppiness, and this memory enabled me to formulate a three level interpretation. The gist of this interpretation, although of course not spelled out in these same words was:

Required relationship: I have to blame myself for having been wounded.

Avoided relationship: My friend is to be blamed for his sloppiness and for not fulfilling his duty properly, thereby causing his death and my being injured. I cannot, however acknowledge this fact because:

Calamity: I will feel even deeper, if imaginary excruciating guilt for having "caused" my friend's death by having momentarily been mortally furious with him.

This interpretation resulted in the overt appearance of the full intensity of Robert's murderous fury with his friend, the last thing he now remembered to have felt before being hit and losing his consciousness. The emergence of this memory heralded the cure. After this second session the symptoms disappeared entirely and never returned. The rest of the convalescence was uneventful and there was no need for any psychiatric interventions.

I initiated a follow-up session about two years later. Robert remembered me as someone who had helped him, he could, however, remember no details. In any case he assured me that he had

returned to his previous normal, happy, functioning self and neither of us could detect signs of any psychiatric discomfort that would warrant further psychiatric intervention.

Tom was a thirty year old technician, married for seven years and father of one daughter. He was sent to me by a general practitioner who knew that secondary impotence in a man of Tom's age could be little else but of psychological origin. This impotence had appeared a few weeks earlier, when the patient was on leave from reserve duty in the October war of 1973. Exploration revealed that he had been sergeant major of his company, very strict and insistent on discipline, especially insofar as the safety of his men was concerned. He demanded that they dig in each night; that they wear helmets and protective, bulletproof vests at all times etc. By doing so he managed to keep the number of casualties at a minimum, but at the same time he irritated the men under his command. When the fighting was over, the company commander was replaced and the soldiers complained to the new commander about Tom's exaggerated strictness. Without further investigating the issue, the new commander immediately scolded Tom and divested him of his rank.

It was also discovered that at the beginning of his marriage, Tom's wife was very afraid of sexual intercourse and he had had to force himself on her. During the following years this problem had disappeared spontaneously, and the couple had enjoyed a fairly normal mutually satisfactory sexual life.

Based on this material the similarity between Tom's married life and his experience in the army could be pointed out. In both instances he had to

force his will on others for their own benefit. In his marriage, this had been eventually positively rewarded. In the army, however, it resulted in denigration and loss of prestige. I assumed that the trauma he had suffered in the army had caused him to feel unconsciously that acting in an assertive way in all circumstances was a punishable act. This, I assumed, included doing so in his sexual life, despite the fact that by now he no longer had to impose himself on his wife. In order to protect himself from such an imaginary punishment, he must have instituted impotence as a required relationship.

Tom showed up for no more sessions, but his general practitioner reported that he had resumed a normal, healthy sexual potency.

Uriah was a forty year old teacher, who was referred by the same general practitioner who had referred Tom, and for a similar reason: Impotence had set in a few weeks earlier. He was married, had two children and until recently had never suffered any sexual problem. Some time before the appearance of his symptom he had aspired to become a politician and had been relatively successful in his new position, reaching a relatively prominent rank. By being successful, however, he invoked the envy of his colleagues. They conspired against him and he finally lost both his new position as well as his job as a teacher. The resemblance to the case of Quentin, described in the previous chapter, was obvious and an interpretation was now constructed for Uriah following similar lines: Success equaled sexual potency. Success invoked a disaster, and hence impotence had to be instituted as a required relationship. In this case, however, it turned out that Uriah used his impotence also to test his

wife's loyalty. "Will she accept and admire me even when I am beaten, weak and impotent?"

He came for three sessions altogether, of which the latter two were dedicated to clarifying the unconscious statement: "If you (his wife) accept me only when I am strong and potent, I will not comply." Impotence had become an assertion. After this point was made and accepted, potency was restored.

Not in all cases in which the minimal dynamic hypothesis is clear and understood by therapist and patient alike, does this fact ensure the automatic disappearance of the symptom involved. Some patients have so much to lose by giving up their symptoms, that they would consider themselves "crazy" to do so. In some of these cases we are lucky enough to understand the reasons for the patient's refusal to depart from his symptom. Victor is an appropriate example. He was seen at a fertility clinic in which I worked as a liaison advisor.

Victor was in his early fifties, of middle-east origin. When asked about the reason for his coming to the clinic, he answered, "I suppose that I am here because my wife asked me to come. I have been impotent for these past few months." From this first sentence he implicitly indicated that coming to be cured of his impotence was not because of his initiative. This became even clearer when I asked him a few more questions. "What is this with all these questions? What benefit are you to gain by all this inquiry?" It seemed that he already had formed an initial transference, in which it was I, not he, who wanted to benefit from his therapy.

Nevertheless, he agreed to tell his story. Several months before the onset of his impotence he had

received a summons from the local equivalent of the IRS to prepare a declaration of his assets. He declared about twenty percent of what he really owned. A few weeks later his wife asked him for a new house. He attempted to explain to her that this would put him in jail, because it would prove that he had submitted a fraudulent declaration of assets. His answer did not satisfy his wife and when he persisted in his refusal despite her nagging she retaliated by refusing to have sex with him. This was the point in time at which he became impotent.

I explained to him that by becoming impotent he had found a perfect way of making his wife's threats ineffective. He replied by laughing in my face but confirmed my supposition by saying: "They (women) use it (sex, or its deprivation) as a pistol constantly aimed at our heads." All my further attempts to explain to him that he used his impotence in order to deprive his wife of the opportunity to use her "pistol" were again laughed off. This patient had to be declared a failure. It ought to be added here that he had not deprived himself of sexual relief altogether. In his work as an usher in a cinema theater that specialized in pornographic movies, he had been able to stimulate himself to having orgasms at will without establishing an erection, simply by watching the films. (In this context, C.F. Springmann, 1976, 1978, 1982).

Despite the unique nature of Victor's dynamics, I still retrospectively regard the two following cases as the most intriguing. This is because the ultimate patient, the one who received the interpretation and benefited from it and the therapist, who originated the interpretation, never knowingly set eyes on each other. In fact, the non-

identified patient in the next case was not even supposed to know that any psychotherapy was going on at all.

Wanda was a registered nurse in an orthopedic ward of a hospital at which I was stationed temporarily during the second chronic phase of the October war in 1973. She approached me complaining of what she referred to as a mild depression. Psychotherapy took place at an irregular schedule, in very brief meetings that presented themselves occasionally, such as coffee breaks, accidental meetings in the corridors etc. Each sentence of the following passages corresponds to the information gathered in one such "session."

Her depression had started shortly after the end of the fighting. Her husband, Steve, had slightly injured his back when he fell off an armored vehicle in non-combatant circumstances. Following his injury, he had been hospitalized in the ward his wife, the identified patient, was working in. Nothing serious had been diagnosed. Since his injury the relation between the spouses had deteriorated. Steve had become morose, irritable, and spiteful. Previously they had had a harmonious relationship. Wanda had at first tried to be patient and understanding, but this was perceived by Steve as a sign of her trying to patronize him. Now she was close to despair and could attribute her depression to this deterioration in the couple's inter-relationship.

My suggestion that Steve look for help was turned down as Wanda supposed, probably rightfully, that this would be understood by Steve as another condescending attempt on her part to "change and manipulate" him. In fact, she had found it necessary to conceal the very fact that she was

consulting someone. Subsequently, the following information could be gradually gathered. Wanda, the (self) identified patient had had a slightly better educational background than Steve who had originated from a family of thirteen siblings. This had played no deleterious role in their relationship prior to his injury. On the contrary, he had actually been able to benefit from his wife's guidance and consequently made fairly rapid progress in his own professional career. All this had changed now; where previously he had perceived guidance and advice, he now perceived superiority, dominance and condescendence.

The summing up of all this information led to a minimal dynamic hypothesis, consisting of the following assumption: Steve could accept his wife's guidance and advice lovingly only as long as he was able to perceive himself as her only, exclusive and preferred object. While hospitalized in the ward his wife was working in, he had to see her share her attention among all the other patients (siblings) and this must have shattered this concept. The rage connected with the unconscious thought that he was no longer her "only and preferred object" but just "another patient" must have been the cause for his not being able to accept her love anymore. This surmise was explained to Wanda, and she was given the task of transmitting it to her husband without revealing its source.

When we next met she was beaming. Steve had been able to understand the meaning of what had happened and harmony was restored. There was no need for any further intervention, and the cure persisted for at least one year, as long as I was able to obtain information.

Steve's negative reaction towards his previously loved and admired wife might be dynamically compared to a spontaneous initial negative therapeutic reaction, as described in Chapter Two. The required relationship that had enabled him to accept his wife as a surrogate mother figure, guiding and advising him from a position of ostensible authority was that she was exclusively his. This required relationship was unwittingly violated when he found himself, just as in his childhood, in a situation in which he had to compete for her attention with all the other "children/patients," his "siblings/rivals." Like the net infraction of any required relationship, which is not accompanied by a completion of an interpretation, the result was the equivalent of a negative therapeutic reaction. Steve probably unconsciously understood this infraction of his need to be an only and preferred object as the breaking of a promise and reacted accordingly. The identified patient, Wanda, not being his therapist but his wife, had no means to understand the dynamic reason for Steve's change in his attitude towards her. Following her failure to understand him, she reacted negatively, perhaps in a way comparable to a therapeutic malfunction (Aviv & Springmann, 1990), thereby making the situation deteriorate further and further.

Only after all the pieces had been put together and a minimal dynamic hypothesis had been formulated could it be spelled out to the identified patient. Having understood it, Wanda could now contain the negative feelings created in her by Steve's behavior and transmit it to him from this new point of empathy, so that he could accept it, regain his confidence of being her preferred object

and the situation was restored to its original harmony.

I feel that two points are in order here. The first one refers to the couple just described. It seems reasonable to assume that a similar negative development in the marital relationship might have occurred if a child were born and also experienced by Steve as a sibling-rival. By the time I lost contact with them this had not yet happened. I surmise, however, that Steve's newly acquired understanding of his particular vulnerability, of his need to be in exclusive possession of his wife-mother-therapist, may have ameliorated, if not completely prevented such a possible future complication. The fact that Wanda was also aware of this danger and had handled it successfully would have helped too.

The second point refers to the unconditional, almost imperative need to be the preferred one in general and in psychotherapy in particular. Ezriel has referred to it as a very common required relationship. I have also met it in many patients that look for signs of being my preferred one, sometimes even openly asking me if they were. They tend to interpret irrelevant issues as signs that indicate that they are my "unique" patients. These issues might be the fact that I do not raise their fees in direct correlation with the rate of inflation. In other cases it might consist of my changing the schedule of their sessions according to their requests, or even of a smile on my face as I greet them at the door of the consulting room.

This required relationship is often intended to avoid a deeper feeling of being unwanted. One patient, a prominent figure in local politics, repeatedly asked me if he were my most interesting patient. When the time came for his fee

to be raised he openly said: "You see! This is another pathetic attempt of yours to get rid of me!" The reason for his fear of being unwanted was discovered several years later. It was connected to deep guilt feelings, connected, in turn, to even deeper rage against his parents who would not recognize him for his potential.

In the case of Xenia, circumstances were as follows. With the help of analysis she had been able to divorce her former husband, whom she hated and who abused her. After her divorce she had found a new boyfriend. Now, for the first time in her life she discovered the delight of sex and could not have enough of it. She used every possible and impossible opportunity to have sex with her new partner, until he suddenly and unexpectedly became impotent. Xenia was still in analysis with her analyst who was familiar with the idea concerning impotence as a possible protest. She now received the advice to tell her boyfriend that he might be afraid that she did not really love and respect him, but only used him as a "sex-machine."

Despite the fact that Xenia's boyfriend, Sam, was in no therapy, he immediately benefited from this message and his potency was promptly restored. He seems to have understood that his impotence was in fact a covert protest: 'If you only use me to satisfy your insatiable sexual appetite and do not really love and respect me, I will not comply.' When this issue had been spelled out and could be openly discussed, impotence became expendable.

I would now like to return to the opening sentences of this chapter, in which three points were temporarily posited.

1. Interpretations are of specific curative value, even when used exclusively.
2. Appreciable curative results can be achieved in psychotherapies that consist of one single interpretation.
3. A theoretical point, pertaining to the necessity of the interpretation to concern the transference and be given only its context.

As to point 1: In each of the cases described above, one variable, an interpretation, was the virtually exclusive ingredient added to a given situation. I can conceive of only one other, non-interpretative factor as being added to the pre-existing situation, a sympathetic attitude on part of the therapist implying: "I understand that you have a problem and I am willing to listen to you and try to help you solve it."

The relief of symptoms achieved after the first session in the case of Robert (the wounded officer) can be understood as an example of the corrective emotional experience as defined by Alexander & French, (1956). As proved by following events, this relief was only temporary, so that it must be surmised that this corrective emotional experience did not contribute decisively to the final result. Only the corrective emotional experience as defined by Ezriel finally resolved the symptom.

The sympathetic listening offered by a "therapist," the referring general practitioner, resulted in no improvement in the cases of Tom and that of Uriah. When offered by Wanda to her husband in the first phases of their "therapeutic" interaction, it proved detrimental. Therefore, it seems that the clinical material presented so far does indeed present strong evidence that interpretations, even

when used exclusively, do have a specific, mutative-curative value in analytic therapy.

As to point 2: A review of the clinical material seems to lead to the conclusion that in each of the cases presented, one interpretation had indeed played a crucial role in the life of the individual or individuals involved. This is, of course, with the exception of Victor. Uriah was no real exception, despite the fact that two interpretations were used in his case. His impotence served two purposes, (it was doubly determined, as Freud would have put it.) Each of the two determinations, the fear of an equivalent of castration and the testing of his wife's loyalty was dealt with by one interpretation.

Robert would probably not have actually died. Ways would have been found to feed him by vein, and somatically he would have eventually recovered. Mentally, however, when compared to other patients suffering from equivalent traumata and not treated analytically, it is fair to assume that unless interpreted, some mental crippling would have resulted. I see no reason to assume a speedy, spontaneous recovery of sexual potency in the cases of Tom, Uriah and Sam. As to Wanda and Steve, it seems fair to assume that marital relationships would have rapidly deteriorated, that vicious circles of mutual hatred, strife and destructiveness would have developed, leading either to constantly increasing frustration and misery or to divorce. The same seems to apply, in a lesser degree of severity Xenia and Sam.

Restoration of the will to live in the case of Robert, restoration of sexual potency in the cases of Tom, Uriah and Sam and the restoration of marital harmony in the case of Wanda and Steve, are definite changes in the direction of mental health, whatever be the criteria we choose to define it.

When I met Dr. Malan during a visit in London, we discussed some of the cases described above, and several others published elsewhere. (Springmann, 1978, 1979a). Dr. Malan asked me half in jest how I had been so lucky to find a collection of patients who were so rapidly analyzable. Despite the fact that the question was asked in jest, I believe that it deserves a serious answer. When I looked for a common denominator for all the cases described above and elsewhere, one common denominator emerged.

All these cases came for analytic therapy shortly after the symptoms had first appeared. In this they resembled the psychoses *in statu nascendi*, referred to in the previous Chapters and to be referred to again in the following ones. Unfortunately this is rarely the case. I have seen many cases that resembled the ones presented here in their basic dynamic structure, who did not yield to brief analysis and the use of similar interpretations for quite some while. This seemed to be the result of the fact that they had looked for psychotherapeutic help only as a last resort, after hormonal therapy in secondary male impotence had, not unexpectedly, failed. This had made them lose hope and the passage of time had allowed for secondary layers of defense and complications to make it difficult to reach the basic dynamics.

I am convinced, (1978), that the longer the time allowed to elapse from the first appearance of symptoms and the initiation of dynamic psychotherapy, the more difficult it is to discover the relative transparency and to rapidly analyze these symptoms.

The answer to Dr. Malan's question would be easier to if it were phrased in negative terms. Such easily analyzable patients are rarely to be found in

primarily mental health oriented clinics. They can be found by the dozens in emergency rooms of general hospitals, in fertility clinics, in departments of endocrinology etc. Patients with symptoms such as secondary impotence prefer to go first to these clinics. If discovered there early enough, most of them can be helped in very short dynamically oriented psychotherapy. I was, indeed, lucky enough to be working at such a clinic as a liaison psychiatrist so that I had direct contact with them and could initiate their therapy as soon as they sought help.

As to point 3, which refers to the role played by the “Here and Now” of the transference in the construction of the interpretations described above.

It is interesting to note that this role seems to have been most outspoken in the cases of Wanda and her husband, and Xenia and her boyfriend. These were the cases in which the person who received the interpretation and benefited from it was not in real therapy at all. When examined at close range, it transpires that the therapeutic interaction took place between “therapist” (wife, girlfriend) and “patient” (husband, boyfriend), related to the relationship that existed between them and directly influenced them, changing them from a pathological into healthier ones. These relationships had become distorted, in the case of Steve definitely, in that of Sam possibly, because of reactivated childhood traumata. These distortions were identified and in the case of Steve traced back to their childhood origin. Then they were corrected by interpretations and related to the relationship between the spouses. As in both cases the interpretations occurred between “therapist” and “patient,” related to and corrected

the relation between them, I can see no alternative but to refer to these interpretations as transference interpretations. In both cases the real therapist, the originator of the interpretations, played the role traditionally attributed to that of a supervisor.

In the other cases described, this was not so. In the case of Robert it can be assumed that an intensive transference/countertransference relationship developed almost instantaneously. Its mutual intensity was felt very clearly, and I postulated it to have been generated by the patient's desperate need to be relieved of his crushing guilt feelings. This desperate need was met by my own, no less intensely felt need to help him, a need that had to do with my feelings of his having risked his life while I was safe behind the lines. I believe the temporary relief achieved after our first session to be attributable, besides my acting as a forgiving superego, to this relationship and therefore to have been a transference cure.

As mentioned above, another possible perspective regarding this first phase of the evolvement of the case would be by making use of the term corrective emotional experience as conceptualized by Alexander & French. The extenuating circumstances I provided the patient with in the first session seem to fit well into their concept: "the consciously assumed role-playing by the therapist to provide the patient with a new experience." This seems to be true except for the fact that in this case there was no role-playing, but a real expiation to counteract a rigid, vindictive superego. The fact that this attitude proved to be of only limited effectiveness, that only the solution of the conflict by an interpretation

clinched the case is in line with the general trend of this chapter.

But the interpretation given in the second session with this patient, although given in the context of this intensely cathected transference/countertransference relationship, did not affect this relationship. It was related to another, extra-transference relationship, that of the patient with his dead friend. The closest correlation I can think of between the interpretation and transference is Freud's dictum that interpretations ought to be withheld until a positive transference has been established.

In the cases of Tom and that of Uriah I see no reason to assume the development of any particularly strong interpersonal relationship between the patients and myself. In any case, even if the transference postulated to pre-exist in any patient who comes for therapy did exist, the interpretations did not relate to this interpersonal relationship. In both cases the interpretations related exclusively to extra-transferential situations, just as had been in the case of Robert and that of Sam. There was no detectable change in any of these patients' relationship with me. Uriah, for instance, showed no sign of attempting to use his temporary weakness to influence my attitude towards him.

In the case of Victor transference seems to have been formed almost instantly, however, it could not be put to any therapeutic use.

There seems to be hardly any doubt that all three patients mentioned last but one benefited from the interpretations given to them despite the fact that they were no transference interpretations. This leaves us with the inescapable conclusion that

interpretations are effective, even lastingly so, when in certain circumstances they relate exclusively to extra-transfereal relationships. Furthermore, they need not even be given in the context of an intensely cathected transference situation. Nevertheless, it cannot be ignored that for patients with more seriously rooted problems than the ones presented here, the transference is the only area that offers a relative unconditional positive outcome of the reality testing of object relationships. This issue will be discussed in greater detail in Chapter Six.

To conclude, four cases have been presented. In each of them it was demonstrable that an interpretation played a decisive role in achieving an important and lasting step in the direction of mental health. One patient needed two interpretations for achieving this goal, and one further patient did not respond at all, because he had too much to lose if he were to give up his symptom. All this seems to be a strong indication for the specific effectiveness of interpretations in analytic psychotherapy, and also towards the possibility of achieving appreciable, lasting results from very brief interpretative interventions, be they "Here and Now" oriented or not.

Three Level Interpretations in Groups

Ezriel acquired most of his reputation in Europe from his contributions to the conceptualization of the practice of group analysis. He used to analyze groups of up to eight patients, preferably of neurotic maturity. In his opinion each individual group-member brought into the group his structure of three-level object relations, so that the collection of “randomly” presented material contributed by group-members was not a mere chance collection of individual contributions. The earlier contributions in each group session he considered to be a kind of probe. These presentations he described as attempts at one level or another of this three-level structure, usually a required one, or at most a disguised hint at the avoided one or the calamity, as close as any particular group-member dared to disclose. These early contributions either coincided or collided with other members’ defensive positions towards these probes, and thus determined their reactions. These reactions could be in line with, indifferent towards or opposed to the original contribution, depending on the amount of anxiety aroused by the initial probes.

Ezriel compared these probes to the patient’s initial reaction to the analyst’s attributes, as perceived by him in individual therapies. These attributes could consist of the therapist’s clothes, his being early or late, his facial expression, his forthcoming going on leave or his returning from it. In other cases, these apparently random contributions could be not necessarily related to the therapist but to other occurrences that were

important to the group. Examples for such occurrences would be the absence of group members or the admittance of new members into the group. In hospitalized patients the discharge or the (re-)hospitalization of patients may constitute the incentive for such, more or less disguised early probes. As mentioned earlier, such early probes would arouse associations that would be in correlation to their distance from the avoided relationship of each responder and to the anxiety aroused by the original contribution. They would arouse contradictions if they were less disguised, regarded as interesting if they corresponded to other individual's defensive position and cause boredom in those responders who could afford to disguise their avoided less than the originator. Ezriel referred to this kind of response as compulsive reactive communications.

In case the therapist does not interfere in this spontaneous "push and pull" other than by interpretations, it will eventually result in what Ezriel referred to as the common group tension. (As will be demonstrated further on, such an entirely passive, merely interpretative attitude on part of the group leader is not always feasible and may, in certain circumstances, endanger the very existence of the group). The common group tension postulated by Ezriel is a generally unconscious common topic, which underlies the ostensibly random contributions of all members. It constitutes the material to be interpreted by explaining to each group member his, or her, contribution to the required relationship, the avoided one or the calamity. Ezriel's favorite example of such an interpretation is that of a woman who, in a group situation, spoke of the smell of roses. From later associations he could divine that this was a reaction formation to her

wish to pronounce the word “fart.” The expression of this word was intended, in turn, to constitute an anal attack on Ezriel, fantasized by the patient to be in sexual contact with another rival female patient. The original patient was afraid to express the word “fart” in this context, for fear of the calamity of Ezriel becoming angry at her, possibly even banishing her from the group. After this had been interpreted to her, reality tested and proved to be safe, she was able to give overt expression to her jealousy and openly say the word “fart.”

It will be explained in greater detail later on that knowledge and especially attribution of significance to the unconscious implications to the group of external events is of major importance as a therapeutic tool. It enables the therapist to understand the underlying common group-tension and interpret it both when these events are directly mentioned by group-members and even more so when they are ostensibly ignored. Such events are, as mentioned, patients being discharged or hospitalized, staff-members going on leave or returning from it, the periodic appearance and disappearance of medical students, who participate in group-meetings as observers in a hospital ward, etc.

Ezriel worked at the Tavistock Center with regular groups of up to eight patients of neurotic maturity. Patients of lower maturity, such as those of borderline or psychotic personality structure were, by definition, excluded from groups and generally from being treated in that Institute.

The institute I worked in before I came to the Tavistock and for several years after I returned from it was an open psychiatric ward in a general hospital. Since 1959, when it had been opened, this ward had instituted ward meetings that

included about thirty patients and as many staff-members as could be persuaded to participate. At first, these meetings were intended for mutual ventilation, with the declared intention of reducing tension between patients and staff-members. This was one of the first open wards in Israel, and staff members, who were mostly veterans of closed institutions, were not yet used to establish cooperation with and compliance of patients without being able to resort to physical coercion. The opportunity for mutual ventilation was intended to reduce the frequency of acting out on part of the patients, as well as on part of staff members. They were intended to create a therapeutic atmosphere and later the very therapeutic atmosphere was defined as an atmosphere that regulated itself by encouraging such ventilating mutual feedback.

The patients included all diagnostic categories, with the only exception of those who could not be prevented from hetero- or auto-destructive acting out without having to resort to physical restraint. The ways in which the patients themselves taught us that besides providing a constantly changing therapeutic atmosphere, non-intimate situation could be used to approach group, or even individual dynamics, has been described elsewhere, (Springmann, 1970, b). It will also be briefly mentioned further on.

In time, I experienced being criticized by doubts, raised time and again on various occasions, such as local or international symposia, for expressing the claim that psychotherapy, resulting in lasting intra-psychic change was feasible in the circumstances just described. It is, therefore, one of the purposes of the present chapter to illustrate the way Ezriel's concepts, applied at first intuitively and after having studied with him

deliberately, can become useful in these circumstances, to show that psychotherapy can, indeed be carried out in ward meetings. These meetings constitute large groups and as will be demonstrated, psychotherapy can be carried out in them both on the level of the individual participant, as well as on the level of the group as a whole.

The achievement of this aim can be accomplished by application of complete interpretations, each one of them being constructed along the lines repeatedly described above. Before delving into discussion of the problems involved in the applications of these concepts in the large group, the following small regular group meeting will serve to initially illustrate the usefulness of such an interpretation. This interpretation was completed in two stages.

The group consisted of six participants, three male and three female, and two therapists, a female co-therapist and me. The fact that according to Ezriel's original conceptualization the use of a co-therapist complicated the feasibility of transference interpretations will be discussed further on in this chapter. The group had reconvened after a break of about three weeks. The break had been announced and discussed and the sessions that preceded it were characterized by associations in which people were forced to depend on themselves without being able to resort to outside assistance. One example was the danger of having to swim in pools in the absence of a lifeguard.

Patient A (female) opened the session that followed the break by saying that everything had to be started all over again. It could be assumed that thereby she came too close to what could

subsequently be defined as the avoided relationship and the common group tension. Patient B., also female, consequently responded with a typical compulsive reactive communication by resorting to denial, claiming she had not felt the three weeks' break at all. Patient A, the initiator, now retreated to displacement. "It was not 'them' that we missed but patient X, (absent at that meeting) because he was so good at filling the void created by periods of silence that developed whenever nobody was in possession of an idea worth serious discussion."

Some silence followed and then patient B remarked that she had a problem for the group to discuss. Why was it that she so frequently felt the urge to abandon whatever social activity she was engaged in? This urge had cost her the loss of quite a number of social opportunities. She was very insistent and became impatient when nobody could come up with a reply. This association of hers seemed to indicate that she was attempting to turn things around. It was not she who was being abandoned but the other way round; she felt compelled to abandon others.

At this point patient C (male) joined in by saying that he had observed a similar phenomenon of people leaving social groups without giving a justifying reason. He had especially noticed this when central figures, on which the correct functioning of that particular society had been dependent, suddenly disappeared and their absence was acutely felt. Incidentally, he added, something very peculiar had happened to him: he had seen a person of whom he was sure was Dr. S. (myself), in army uniform, therefore probably on reserve duty. It had taken him quite some time to realize that he had been mistaken.

He evidently deployed two defense mechanisms. First he displaced the feeling of being deserted outside the group. When he seemed to feel that this was not sufficient he attempted to invent extenuating circumstances for my having deserted the group. If I were on reserve duty, my deserting the group would be out of my control.

For reasons that will be explained further on, I felt compelled to give an interpretation despite the fact that by that time I had no hint at a calamity. I assumed that the common group tension evolved about the idea of being angry for having been deserted. For some reason the group members were unable to express these feelings and had to resort to various tactics to express, or rather not to express them openly. Then I explained to each patient his (or her) contribution towards the required relationship: The use of denial, displacement or the invention of extenuating circumstances, or the avoided one, open admission of feeling deserted, as spelled out above. The immediate response proved that I had spoken too soon.

Patient B said that she had no clue as to what I was talking about (again denial) and patient C added that he had not understood me either. This, he added, was just as was the case with the functioning of a pistol or that of the atomic bomb. Both had been explained to him, but he had never been able to understand these explanations. This mentioning of the atomic bomb has been referred to above, in Chapter Three, as an indication for the existence of unconscious ideas of total destruction. It now provided me with a possible calamity. I resumed the interpretation and said to the group members that I thought that by supplying this further material they had indirectly

told me the reason for their inability to acknowledge the full measure of their fury for having been abandoned. It was because this fury, once openly felt, would be so intense that it might not function precisely, like a pistol, hurting only those aspects of the therapists that had wronged them. Instead, it would indiscriminately destroy everything in sight, the bad, deserting aspects of the group leaders together with their good, nurturing, supporting aspects and even the group members themselves.

Once the calamity had been added to complete the interpretation, the response was less disappointing. Patient C, who had resorted to displacement and the invention of extenuating circumstances, now openly admitted that he often had to hide the satisfaction he experienced whenever he became aware of the death of a distinguished person. Patient D, who had been silent so far, admitted that he had experienced similar feelings at the downfall of important people. Even Patient B, who had denied any feeling of having been abandoned, now realized and conceded that she used to experience the sudden urge to leave social opportunities in those cases in which she felt in danger of being disappointed or abandoned.

Just as has been the case in the individual therapies described in the previous Chapters, the completion of the interpretation by the addition of the calamity enabled the group members to express the avoided relationship, anger at authority figures, more openly. It was still defended against by displacement, but to a lesser degree. The fact that the avoided relationship appeared in this case in a lesser degree of disguise in the post interpretative associations I regard to

constitute empirical proof of Ezriel's assumptions, described in his articles in which he dealt with the psychoanalytic session as an experimental situation (1957, 1965, 1966, 1972).

As mentioned above, this example was taken from a regular therapeutic small group. Several decades of working at various institutes with ward meetings, in open as well as in closed wards and ward meetings which constituted large groups have convinced me that the same principles could be applied in these circumstances too.

This was a conclusion not easily come by. At first no member of the therapeutic staff dared to use this noisy, crowded, constantly changing ambiance for interfering other than by serving as umpires between nursing staff and patients. I have already mentioned that it was the patients who were the first to show that personal dynamics could be addressed.

A particular patient was in hospital because of various somatic complaints for which no organic reason could be found. For weeks on end he refused to be discharged, until one day several inmates in the ward meeting ganged up on him and told him straight out that the real reason for refusing to be discharged was his fear of his wife. This crude, even cruel "interpretation" resulted in his asking to be discharged immediately.

Despite its cruelty, this intervention of the inmates taught us not to shy away from individual or group interpretations in this environment.

The first example for such a group intervention will be a virtual one. No interpretation was given in this particular ward meeting. Nevertheless I have chosen to present it because the dynamics

were very transparent and easily interpretable with an at least theoretically predictable outcome.

While I was still at the Tavistock Center, under Ezriel's direct supervision, I was invited to be present at a ward meeting at another hospital. The group leader briefly introduced me as a visiting psychiatrist and did not refer to me again. The session consisted of about thirty patients and an unknown number of staff-members. It started in a long silence. Then one of the female patients opened with a remark about the doors and windows of the ward. These, she claimed, could never be properly shut. She continued by comparing this situation to the one at home, where her father forbade her to shut the bathroom-door, so that she was constantly in danger of being surprised during her most intimate activities. Another female patient joined in saying that she was reminded of a conflict with her landlord, who was very unpleasant and periodically raised her rent. She was unable, however, to complain about this, because she was afraid to be evicted and it was next to impossible to find alternative accommodations in London at that time. Another male patient joined in, saying that this reminded him of a similar situation concerning his bank manager who was also very unpleasant, even rude towards him, but he dared not confront him because he depended on him for a loan intended for the expansion of his business.

As I was a guest at this meeting, I found it inappropriate to interfere in the proceedings. I think, however, that the group members were covertly protesting against the group leader, disguised as father/landlord/bank manager. They wanted to do so, for his not keeping the doors of the ward properly shut, so that uninvited guests,

such as I, could not be present at and surprise the patients at their intimate group activity. However, they dared not do so directly and had to resort to silence or to complaining about their troubles elsewhere. This was probably because they feared that if they protested directly against the group leader, he would either withhold his benevolence, upon which they depended, just as the bank-manager would withhold the loan. He might even evict them from the ward, where they felt secure and protected just as the landlord would evict the patient from her room if she were to complain against him.

I believe that had such an interpretation been given by the group leader, this would have resulted in the group members being able to express their protest against him more openly and subsequently, by a process of generalization, become more assertive of their rights elsewhere.

It is probably not irrelevant to mention here that many years later I was invited to be a non-participant observer at a group event arranged for group leaders by the Israeli Association for Group Psychotherapy. At this occasion, just as at the one described, the problem of windows and doors not being properly shut was also raised, indicating the presence of the same covert protest.

In the clinical example presented, at which no interpretation was given, it seems reasonable to assume that my preliminarily guessed knowledge of the external circumstances, the presence of an uninvited stranger, (myself) helped me to understand the common group tension and construct the virtual interpretation. Such has been my experience in many ward meetings in which an interpretation was indeed presented to the audience. Whenever my guess about the

relevance to the meeting of an event proved to be correct, I was in better position to correctly interpret and to be rewarded by the avoided relationship becoming more overt.

The following example is intended to substantiate this point. That particular ward meeting took place after I had come back from London and resumed the meetings in the ward I had previously been working at. It was opened by the patients' discussion of the discharge and re-hospitalization of several of them, lamenting their inability to face stressful situations outside and having to seek refuge by being re-hospitalized. Somehow associations then veered towards a discussion of surgery and one patient remarked that she would loath to have to look at the instruments she would have to be operated with.

I was having some personal difficulties at the time and as I lived on the hospital compounds, this was no secret for the patients. By equating myself with the instruments they were to be operated on, i.e. analyzed, I interpreted that their resort to discussion of their difficulties constituted a displacement of discussing my problems openly. Then I suggested a calamity that I presumed to be the reason that had inhibited them from discussing their awareness of my difficulties directly, namely that they were afraid to find out that I might also be found unable to withstand my difficulties and be tempted to look for refuge by fleeing into the ward. This would leave the group with nobody to rely on.

This interpretation resulted in several references to my "poker-face," a first, feeble, indirect admission that authority figures one ought to be able to depend on (such as group leaders) could possibly be perceived to have personal difficulties.

As will be seen, this topic of the group leader's (in) fallibility repeated itself time and again and indeed, this session was followed by quite a few, in which the group's need for the leader's immunity, omnipotence and omniscience were discussed. All these qualities could be regarded as variations on the same theme, the attribution of superhuman qualities to the leader. This attribution was done repeatedly, for instance by patients posing questions such as "why is it that I am afraid to go home?" or "what am I to do about my being depressed?" Without volunteering any further information such questioning did, indeed, require the group leader to be omniscient. The request for the leader to deliver a lecture "on how to behave so that we don't need to come here anymore" constituted another, less disguised, demand that the group leader be in possession of a panacea. A patient who openly said: "You wanted us to present our problems here. All right, we have done so. So now it's up to you to solve them for us," summarized these questions, all of which demanded omniscience on part of the group leader. Such demands were repeatedly interpreted as required relationships. These were supposedly instituted in order to contribute towards the fantasy of the group leader to really be in possession of superhuman qualities. This had to be done for fear that if it were otherwise he could never hold envy and rivalry in check or deal with the endless demands for sympathy and understanding which abounded in such a large group.

Not unexpectedly, these kind of interpretations led to another series of sessions in which I was exposed to strong and furious attacks, unleashed by these very interpretations. These attacks were sometimes voiced in the most direct language and

not infrequently aimed below the belt, literally and figuratively. By emerging from these attacks unscathed and non-retaliating, still in charge of the situation, I provided the group with the reality testing that dispelled the causal relationship between the avoided relationship in form of the relentless attacks (unleashed as a result of previous interpretations) and the calamity, either by my succumbing, in which case the group would be left leaderless or my possible retaliation. When neither calamity ensued, this proved to the group members that they would neither be left leaderless nor be punished by me in one way or another. This was the equivalent of the corrective emotional experience, as postulated by Ezriel, on the level of the group.

Three points are worth mentioning here. One is the very vehemence of the attacks. ("Your group is worthless," "I'll never come here again," [a threat rarely fulfilled], "You are nothing but a boastful egocentric," "Dr. X runs a much better group than yours; he asks us questions," etc.) The presence of the large group with a sufficient number of other patients around to ensure that physical aggression not get out of hand seems to facilitate the expression of such vehement verbal attacks. Interpretations enabled the discharge of anger, and the presence of the crowd allowed it to be expressed much more intensely than in individual or small-group therapy. It is for this reason that I believe that deep-seated rage can be therapeutically reached in the circumstances of the large group faster than in any other therapeutic environment.

The second point is that such all-out verbal attacks were very frequently followed by marked relief of tension in the group and later by deeply

felt reparatory acts. In subsequent sessions the previously most aggressive attacking patients would defend me against attacks by other patients or on ward rounds comment jokingly, "did I give it to you yesterday!" In other cases they would comment, with undisguised reparatory intention, on my "new shoes" or my "beautiful shirt." This often happened with withdrawn, even suicidal schizophrenic patients. Having tested out the vehemence of their internal rage and found it safe from paranoid and depressive calamities, they could now afford to venture a friendly give and take relationship.

The third point, which addressed the large group's demand that its leader be cut of entirely different material than that of the group-members, has been hinted at and will be discussed in greater depth later on in this chapter. (See below the required relationship of segregation).

An external event that made it easy to understand and interpret the current common group tension was the periodic appearance of medical students that used to spend a six week clerkship in the ward. For lack of a better way of enabling them to witness psychotherapy first hand, it was decided to let them participate in the ward meetings. At the end of their clerkship they often said that this participation in the ward meetings had been the most intensive, impressive experience during the whole clerkship. At a much later period a more effective way of letting the students experience psychotherapy as it evolved was instituted. This will be described in Chapter Eleven of the second part of this book.

When the students showed up to the ward meetings, having been announced a considerable time ahead of their arrival, they were frequently

met by a sullen silence or by chaos. I used my knowledge of the open secret that the proceedings of the meetings and their dynamic significance was later to be discussed with the students and interpreted the silence or the chaos as means of depriving me of valuable material for these discussions. I connected this to the jealousy felt by the patients who perceived these discussions as intellectual orgies with my preferred objects. Whenever such an interpretation proved to be correct and was completed by addition of the calamitous results of such aggressive jealousy, chaos or sullen silence would turn into open admission of this very jealousy. This would happen in the form of sentences such as: "Why, all you have to do is compare the amount of time you spend with 'them' with the time you spend with any one of us." A variation of this sort of behavior by the group, or of its interpretation, repeated itself almost every time the students came. This happened both in the ward at which I was working at that time, as well as in the psychiatric hospital where I later became Consultant.

Another topic that repeated itself, in more or less disguised forms in various institutions I happened to be working at, was envy of the staff-members who went home every day to be with their idealized families. This envy was particularly strong around holidays, especially those that had to do with large family gatherings, such as New-Year and Passover.

A further topic, which had to be approached with particular caution, was the avoided protest of elderly patients who had recently emerged from a depressive episode. It concerned their feeling of having been infantilized by the nursing staff during their depression. Unless fundamentally discussed with and understood by the nurses,

such a protest once openly expressed, might lead to covert vindictive acts on part of the nurses that could occasionally even drive the patient back into the depression from which he had just emerged.

The therapeutic significance of being able to openly express anger, jealousy or protest is not immediately evident. At least sullen silence or chaos disappeared and gave place to the open admission of material that had been avoided, to coherent discussions and to the reduction of tension. The reparative acts, which followed the open expressions of rage, as mentioned earlier, seem also to be relevant. Nevertheless the following examples have been chosen in order to present occasions in which therapeutic results could unmistakably be observed and assessed.

It sometimes happens that the group becomes totally dominated by a single patient, who persistently insists on being paid exclusive attention to at the expense of all other group-members. The group might then voluntarily shape itself into a kind of chorus, acting like an enlarging, affirmative, reflecting mirror. On other occasions it simply succumbs to the domineering patient and lets itself be manipulated into a completely passive position.

Sometimes an intervention can be constructed that compares the domination of the single patient over the whole group to the domination of an especially intensively cathected urge in an individual patient at the expense of other internal instances, such as reason. This situation in the individual leads either to acting out or to the deployment of pathological defenses, such as passivity, the attitude assumed in the in the group situations mentioned above. Whenever such an intervention can be introduced and is accepted by

the group, it may shake the group and re-awake it into active participation. When this kind of intervention is either impossible or does not produce the desired effect, the group leader is left with no alternative but to concentrate his therapeutic attention on the domineering patient.

A young neurotic patient created such a situation, in which his insistence on exclusive attention could not be overcome. He persistently insisted on his right to complain about his previous therapists, saying that they had never enabled him to express the full intensity of his aggressive thoughts about them. Further associations of his concerned the untimely death of his father when he was about six years old, leaving him in the hands of his mother. These associations allowed me to assume that he might be speaking about his aggressive thoughts about me, his 'father' in the "Here and Now." I added that he might be angrily envious of my position in the group, especially in the eyes of the female patients. He might, however, be afraid to express these thoughts because I might abdicate my place as group leader just as his father had "abdicated" and left him in sole possession of his mother. He would then also be in position to be looked up to by all the female patients in the group. At the same time, however, he would be exposed to the same aggressive, deadly thoughts, such as his own, now emanating from other male patients.

This interpretation led to a more open confrontation with me, and eventually to an open confrontation with his mother, towards whom he had always assumed a submissive position, his rebellion held in check. This is an example of an unequivocal therapeutic effect achieved in the context of the large group, albeit in respect of an

individual patient. It is also an example of a therapeutic effect in the “Here and Now” of the transference being generalized to an extra-transferencial situation.

The second example is also on the level of an individual. I present it here with some reservation, as the change achieved was on the superficial level, and only influenced that individual’s behavior in the ward. It was also relatively short lived. Nevertheless it did consist of a change to the better achieved in the context of the ward meeting. A young, acutely paranoid soldier was on the verge of having to be transferred to a closed institution because he felt so severely persecuted by staff-members that he alternatively attempted to flee the ward or threatened violent retribution. He was persuaded by other inmates to discuss his grievances in the ward meeting. When his fear that I would retaliate because of his delusional accusations was dispelled by interpretations and reality tested, his behavior changed overnight. He did not give up most of his delusions, nor did he agree to swallow drug treatment, which he claimed would undermine his health. He did, however, lose his fear of being persecuted by staff-members, abandoned his violent defense and became quite friendly and co-operative in other areas. He openly attributed this change in his overt behavior to his therapeutic experience in the ward meeting.

The third example is on the level of the group as a whole. An atmosphere had developed in the ward that demanded that the more regressed patients be transferred to a closed institution, “out of sight.” It soon transpired that the leaders of these demands were patients who had just emerged from such a regressed state, or felt the threat of re-regressing into it. I interpreted as follows: “We

want the more regressed patients to be removed 'out of sight' because they might constitute an example, which we are in danger of being tempted to follow and might not be able to resist. In that case we would also feel in danger of being transferred 'out of sight'." Following this interpretation tolerance towards more regressed patients increased considerably and remained so for several years, despite the constant change in patient population.

So far I have suggested that application of Ezriel's principles to the small, and especially to the large group, could be useful in understanding and interpretation of the dynamics of both types of groups. I also emphasized those characteristics in which the small group and the large one resembled each other both in dynamic structure and in the way this structure might be managed and interpreted. From this point on, more emphasis will be put on the dynamic characteristics that differentiate the two types of groups from each other, and on the technical difference in management implied by and predicated upon these dynamic differences.

After I had summarized the ideas and clinical material presented so far in this chapter in an article (Springmann, 1974), I came across a series of two consecutive dynamically interconnected sessions. These two sessions demonstrated the points made so far regarding the application of Ezriel's principles for the small group and applied to the large one most unequivocally. This might have happened because having summed up and verbalized these principles more clearly in the article made me more acutely aware of these very principles. I stress this point here because it is in line with and anticipates some ideas to be

elaborated later on. These concern the special importance in particularly stressful therapeutic circumstances, such as those of a group leader of a large group, or those of the therapist of borderline or psychotic individual patients of a clear, dependable theoretical framework he can refer to.

At the time these two consecutive ward meetings took place I was still working at the psychiatric ward inside a general hospital. The group met twice a week, consisting of voluntarily participating patients. The number of participants was about thirty, varying from session to session in direct proportion with the relief achieved in previous sessions. The first of the two sessions rumbled along in an emotionally shallow atmosphere. Nobody seemed to be able to come up with a topic worth serious discussion. Whenever anyone did raise a personal problem that might cause a ripple, he was ignored; any attempt to bring up emotionally cathected material was immediately rejected as irrelevant, as belonging to a small group setting, etc. Patients were not unaware of this atmosphere. They complained of painful boredom and anxiety was acutely felt.

Finally, one of the more sophisticated patients remarked that emotions had to be held in check in these circumstances because they were liable to be contagious. My contribution happened to coincide with the conclusion of the session. I said that I believed that the main reason for emotions to be held in check in these circumstances was the fear that they might cause a conflagration, into which I, as group leader, might also be swept. In such a case the group would be left with nobody to depend on.

The following session was opened with a plea for omnipotent help: "What shall we do, Doctor, so as not to be afraid of the future?" This plea was repeated in several variations, until one female patient attempted to offer a semi-magic solution: "We have to hope for things to turn out for the best and try to rely on ourselves, if only for the sake of our children, who have nobody at home to depend on but us." This suggestion temporarily soothed the general anxiety and the clamoring voices quieted down.

Then a male patient, who had been quiet so far, opened an ostensibly unrelated subject. Addressing me directly he asked, "What I would like to know, Doctor, is how you, doctors, relate to us patients? Do you regard us as your equals who happen to be momentarily ill, or do you look down upon us and refer to us among yourselves as the 'crazy ones'?"

My initial internal reaction was panic, "My God! How am going to get out of this one?" Fortunately the patient went on talking and described a young female acquaintance of his who had been hospitalized in a closed institute. He had noticed that after she had been discharged from the hospital, she felt obliged to act in a peculiar way, to dress in peculiar clothes. In this way she made sure that she would always be identified, and the difference between herself and normal people could never be ignored.

While he was talking, I was able to collect my wits. With the help of the information the patient had supplied by invoking his acquaintance, I surmised that the point of his challenge, ostensibly a disguised protest against discrimination, was, in fact a required relationship; that it was a cover for deeper hope requiring that discrimination did

exist, that there exist a fundamental difference between group members and their leader and that this difference never be ignored.

After formulating this for the group, I reminded its members of the previous session and their fear of emotional conflagration. Then I combined both sessions (which I now felt to be an intimately, albeit covertly, connected unit) and formulated an interpretation, the gist of which was: "Emotions in a large group, such as ours, have to be kept at low key because there is too great a danger of an emotional conflagration into which the leader, unless we can be sure that he is a completely different kind of individual than us, group members, is liable to be swept. This would leave us with nobody in control of his rational faculties, i.e. nobody to depend on, just as our children at home have nobody to depend on while we are here, in the hospital. Then we would really have to be worried about what was going to happen to us."

Parenthetically it might be noticed that, just as hinted at in Chapter Three, I made an effort to use the patients' vocabulary as best I could.

Following this interpretation, the tension, boredom and anxiety in the group disappeared completely. Then a male patient who had kept silent so far, came out with a completely unexpected, hitherto carefully avoided relationship: "Isn't it a well known truth, Doctor, that psychiatrists go to learn their profession in order to cover up for their own psychological difficulties?" The group accepted this somewhat bold remark, not unlike the one about my "poker-face," with no sign of anxiety, indicating that another calamity had been vanquished.

Three points, two of which pertain to Ezriel's formulations, have been demonstrated in this

sequence of sessions so far. The first point is that the required relationship, the covert demands for discrimination, masquerading as a disguised protest against this very discrimination was not initially recognized and acknowledged as such. The second point is that here was another example in which a complete, three level interpretation was able to sever the connection between the avoided relationship and its calamity, thus letting the first be openly expressed. In this it resembled the interpretation in which I compared myself to the "tools we have to be operated on." In both cases, the possible fallibility of dependency objects, which hitherto had to be carefully avoided, could now openly be accepted. In my opinion, this was an important signpost on the way to maturation.

The third point is the following: Here was another example that seemed to indicate that the demand that the leader of a large group be superhuman is a required relationship that can be regarded as almost universal. This seems to be especially so when this group is partly composed of psychotic patients.

Incidentally, the fear of the group leader of a large group being swallowed into the group does not seem to be an isolated phenomenon. I was confronted by it in the following circumstances. I had just been appointed Consultant of a ward in a psychiatric hospital, the same ward the patients described in Chapter One were inmates of. It was in the process of being turned from a closed ward into an open one, but many of the patients, most of whom were long-standing schizophrenics, could not be transferred immediately into an appropriate ward.

As soon as I was appointed, I instituted ward meetings. The first of these meetings immediately turned into utter pandemonium. One of the female patients even had to be physically restrained from attacking the therapist who was later to treat Caleb.

One patient then associated about the prophet Jonah, who had been swallowed by the whale. I used a momentary lull in the general commotion to say a few sentences. I said that I felt that the pandemonium to be the result of anxiety, caused by the fear of the removal of the security of the physical boundaries. Then I added that I was probably being exposed to a test instituted in order to find out if I were firm enough to replace the safety of these boundaries; that this test was also intended to find out if I were resilient enough to allow the patients to feel the benefits of the new freedom now that the physical boundaries had been removed. On the other hand, I said, the group was also afraid that if I was to be found out to be too resilient, this might also mean that I was weak. In that case I might not to be able to resist the temptation to join the general confusion, be swallowed into it just as Jonah had been swallowed into the whale. The ward would then be left with neither physical nor symbolic boundaries and anxiety would rise sky-high. This intervention resulted in temporary quiet contemplation, but it took a long time and many ward meetings until real, coherent discussions could be achieved.

I believe this fear of the large group, that the therapist be swallowed by it, to be the equivalent of the individual psychotic patient's fear/wish that his therapist be drawn into his psychosis.

Some theoretical issues that ensue from the clinical material described so far seem to be in

order. My turning in the previously described sequence of session, first to an external, symbolic authority (Oh, my God!) and later to a theoretical, internalized concept (Ezriel's theory of object relations), can be regarded as attempts to find a reliable frame of reference in order to keep me from being swept off my feet, so that I keep my own ego functions intact and not lose my capacity for secondary process thinking. In such stressful circumstances, such as those of the large group, this faculty is endangered. As the group leader's acutely felt need for external supervisory support cannot immediately be met in real time, the only authority he may turn to is such an internalized, firm, and yet resilient, dependable theoretical framework. Such a framework then fulfills the supportive, reassuring role, traditionally attributed to the positive, supportive aspects of the superego. (Lederer, 1964.)

The vital importance to the integrity of the therapist's ego of having a sound theoretical framework he may rely on as an internal frame of reference is especially important when the therapist is supposed to be working in stressful circumstances. This was poignantly demonstrated in the treatment of psychiatric casualties in the early chaotic days of the October war in 1973. By that time I had passed the age of serving in the field. Other, younger therapists were, however, supposed to function in extremely stressful situations, topographically and psychologically not really different from those that had victimized their patients. Needless to say, they had no access to any external supervisory support. Several of them later told me that thinking of theoretical concepts was the only means at their disposal to help them function more effectively than the casualties they were supposed to treat. In an entirely different

context, the importance of a firm yet flexible theoretical foundation has been emphasized by Kohut, (1979).

In the first part of this chapter I implied that incoherence and inconsistencies in the large group were to be regarded as technical difficulties. In the two consecutive sessions described in the previous paragraphs, it was possible to discern them as defenses. The first of these sessions turned out to be one of a series of similar sessions, which indicated fear of unity and cohesion in the large group to be a prevalent phenomenon. Subsequently, I began to notice that people, and especially psychiatric patients in large group situations, unless these are structured, spontaneously tend to avoid by various means any attempt to find a common denominator. In such circumstances it can frequently be observed that attempts to raise an issue that might serve as a starting point for a general discussion, unless encouraged by the leader of that particular event, will be vehemently resisted. It will often be replaced by open demands for structured, leader-centered activities. When these demands for assertion of leadership are not met, group members tend to isolate themselves from each other's stimuli. Subjects are raised from various corners only to be dropped as soon as they are raised. In other words, the group succumbs to fragmentation.

Looking back on other large group events, I was struck by the frequency of this kind of phenomenon. In small group situations, especially when these are composed of patients of neurotic maturity, patients tend to respond and associate to each other's contributions, either by compulsive reactive communications, or in any other way. The

situation in the large group, unless it is authoritatively led, is usually entirely different. Patients will hardly ever respond directly to each other's comments and this unwillingness to respond to each other can be understood as an expression of fear of potential unity and coherence.

The dynamics behind this phenomenon of disunity, or fragmentation, seem to be as follows. In small groups, especially when these contain no psychotic patients, there is a fair chance of group members to come to recognize each other and differentiate them as not-me. The large group, especially when composed mostly of psychotic patients, offers no such chance. A large proportion of the members of a large group will be destined to remain anonymous, even more so when the group contains a constantly changing population of patients. The anonymous, especially when defined *a priori* as mentally ill, is a perfect opportunity for projection³ to run wild. Each individual in this situation tends to see his feelings, especially the ones he would like to avoid, such as aggression aimed at the group leader, infinitely magnified by the multitude, which in these moments appears to him to be endless. In order to avoid the excessive depressive anxiety aroused by his projected and magnified feelings, each individual does his best to isolate himself. The final result is that the group undergoes fragmentation.

This fragmentation can easily be obviated and cohesion can be (re-)achieved by any act of active assertion of leadership on part of the group leader,

³ For the reason to use the term projection rather than that of projective identification in the context presented here, C.F. Chapter Five, Part Two of this volume.

even by as simple an act as picking one of the various suggestions brought up from any corner as the one to be discussed. The same effect can be achieved by identification by the group of an external adversary. (In the psychiatric ward inside a general hospital there is no difficulty in finding such an adversary: "They {patients of other, non psychiatric wards and their personnel} look upon us as if we were garbage"). Both acts, the assertion of leadership and the identification of an external adversary seem to make it safe for the group to unite. The first by fulfilling dependency needs and thus abating aggression, the second by diverting this aggression, originally aimed at the group leader, elsewhere. Both facts tend to support the theory presented here, namely that fragmentation is an active group-defense that emerges when depressive anxiety threatens to become unbearable.

The way in which the large group deals with its excessive depressive anxiety resembles the way this problem is dealt with by the developing individual. When faced with excessive depressive anxiety, unassisted by a "good enough" mother, the individual tends not to emerge from, or else retreat to the schizoid-paranoid position. This resemblance between the two processes, that of fragmentation of the group and that of either not emerging from or regressing into the schizoid-paranoid position is even clearer when we consider the identification of an external adversity as a unifying factor onto whom the aggressive feelings can be displaced. This resembles the splitting of ambivalent feelings on part of the infant between both parental figures, so that mother can be unequivocally loved, as described in the earliest stages of the Oedipal conflict by Melanie Klein.

Nevertheless, it must not be forgotten that the processes in the individual occur on a quite different level of integration than those in the large group. I find it, therefore, advisable to regard this resemblance to be more of an analogy than a homology. Even as an analogy it can, however, be carried further. Winnicott (1945) has described the pain felt by the individual when forced back into the schizoid-paranoid position. It may be compared to the pain of boredom, discomfort, forced isolation and anxiety felt in the group when fragmentation is implemented as described above and also by Hayne, (1974).

Jacobs (1974), as well as Bion (1961), have referred to fragmentation. Bion recognized it when interpreting the story of the Tower of Babylon. To the best of my knowledge he has, however, not pursued the idea or related it systematically as a group phenomenon to one of his three basic assumptions.

So far I have hinted at the possible relationship between fragmentation and two of Bion's basic assumptions. It can be obviated by granting the group dependency by the assertion of active leadership on part of the leader. It can also be obviated by fight-flight, by the identification of an external adversity. Bion's third basic assumption is that of pairing. This basic assumption can also be related to fragmentation: Fragmentation can be achieved by several, bilateral discussions being carried out in the group simultaneously, making any coherent discussion by the group as a whole impossible. It seems, then, that a direct relationship exists between fragmentation and all three basic assumptions of Bion's. Bion himself had described basic assumption behavior as "defenses, intended to avoid dealing with painful

material" (Bion, 1955). From this point of view we may ask whether we are entitled to regard dependency, fight-flight and pairing as defensive phenomena of more fundamental importance than fragmentation. The evidence presented here seems to indicate that this is not the case, and that at least in the context of the large group fragmentation is of no less fundamental importance than any other basic defense. Should we then postulate fragmentation as a fourth basic assumption?

I do not believe that would prove to be fruitful, even if it were agreed upon that fragmentation was a fundamental phenomenon in the large group. There is no certainty that further fundamental defensive phenomena will not be discovered in the future. One such phenomenon would be segregation, the insistence of large group members in various degrees of consciousness and disguise, to have a fundamental difference between group members and their leader. As demonstrated above, this constitutes another regressive, required defense of dependency. In fact, it is when this defense is endangered that fragmentation is liable to become most pronounced. I have in mind one of the particularly disorderly sessions, mentioned at the beginning of this chapter. In that session chaos turned out to be a means to avoid coherent expression of the patients' covert jealousy of my intellectual relationship with my students. I believe that de-segregation is a prerequisite for jealousy, because only those who aspire equality can feel themselves to be entitled to afford being jealous rather than envious.

This line of thought, fragmentation coming into being when attempts at desegregation endanger dependency, can now help us in the interpretation

of the story of the Tower of Babylon in Ezriel's terminology. A previous attempt at de-segregation, the eating of the Apple of Knowledge, had been an act that endangered God's hitherto unquestioned supremacy, and had resulted in the calamity of being banished from the Garden of Eden. Any renewed attempt to question this supremacy, such as the building of the Tower of Babylon, which was deliberately intended to do just that, had now to be avoided for fear of an equivalent calamity. The required relationship deployed for prevention of such a calamity was that of fragmentation. (Genesis 3:22). The resemblance to the phenomena in the large group is almost unmistakable.

It seems, then, that the main advantage of Ezriel's formulation over Bion's is that Ezriel postulated the relationship between psychological phenomena without rigidly attempting to predict the phenomena themselves. A theoretical framework that does not rigidly predefine but rather attempts to systematize the relationship and interdependence between constantly varying observable phenomena seems to be more practical than one that predefines the phenomena themselves. Regarded from this perspective, fragmentation and perhaps segregation can be seen, just as Bion's basic assumptions, as special cases of required relationships, avoided relationships or calamities, according to circumstances existing at any given time. Ezriel's formulation appears to have more internal consistency, depending, as it does, not on one, two, or any given number of rigidly predefined group situation, but rather upon the relationship between these situations. It is therefore more resilient and adaptable.

If we now come back to the importance to the maintenance of the therapist's ego functions of a sound, dependable, consistent theoretical framework, the intensity of stress involved in the leadership of a large group seems to make this point of preferring one theoretical framework over another of more than merely academic importance.

As mentioned above I attempted in the first part of this chapter to highlight the similarities between the characteristic dynamics of the small, traditional group with that of the large one. In the second part I attempted to do the same regarding the characteristics that make them different from each other. The existence in the large group of a spontaneous tendency for fragmentation seems to be one of these latter characteristics. It may even constitute a danger to the large group's very existence, at least in its initial phase. This danger of the group being disrupted by centrifugal defenses calls for a different technique of leadership.

The leader of a regular small therapeutic group may assume a passive, merely interpretative attitude from the very beginning of the group's existence. In the large group, as well as in other situations in which projective mechanisms tend to flourish and defenses tend to be centrifugal, this is not so. In these circumstances, such a passive, merely interpretative attitude is liable to result in the disruption of the group. Here the leader ought to assume a more active, assertive technique of leadership, even if only in the symbolic fashion of choosing one particular subject as the one to be discussed, as mentioned above. This has to be done at least until a kernel of "trained" patients, who have worked through and overcome their

initial depressive anxiety has formed. Only then can the leader safely retreat into the background and assume the passive, merely interpretative attitude, just as in the traditional therapeutic small group, composed of patients of neurotic maturity.

The large group I was leading stopped functioning for some time when I was called up for military reserve duty for two consecutive periods of three months each. First I was called to serve as supervisor at a field hospital to be described further on in Chapter Eight of the second part of this book. The countertransferecial implications of this first period will be discussed in that chapter. Later I was called up for other military psychiatric duties at the hospital in which Wanda worked as a nurse (Chapter Four). The devastating results for an individual patient, member of a regular group I was conducting at that time will be reported in the case of Mary in Chapter Eight of Part One.

At the same time, most of the more mature patients of the psychiatric ward in the general hospital I was working at during this period were evacuated and replaced by a new population of patients. Therapists, who had seen me adopt the passive, interpretative attitude, albeit with "trained" patients, formed a new series of large group meetings. These therapists attempted to assume a passive, merely interpretative attitude from the very first session. This caused the depressive anxiety in the group to reach such levels, that the group became completely chaotic and unmanageable resulting in serious replications on the running of the ward in general. Discontinuation of the group sessions had to be seriously considered.

When on leave, I discussed the situation with the new group leaders and suggested to relinquish their passive, merely interpretative attitude and replace it by more assertive leadership. Following this change in leadership style, things calmed down quite perceptively. Later, the passive, merely interpretative attitude could gradually be re-assumed by the new leaders.

Hopper (1977) commented on an article I had written about fragmentation (Springmann, 1976). He expressed views similar to the ones expressed here. He had also independently observed the occurrence of fragmentation not only in large groups, but also in small, regular therapeutic groups when these were composed of borderline or psychotic patients. Thereby he supported the theoretic assumption that fragmentation might be the ultimate result of the projection of aggression. He also stated the usefulness of the comparison, in therapeutic interventions of fragmentation, or that of any other defense mechanism operating on the level of the group, to intra-psychic processes that might be taking place in any individual patients.

In the first part of this chapter I commented on the relative ease and speed in which deep-seated rage could be therapeutically reached and dealt with in the context of the large group. I claimed that this speed exceeded the speed this could be achieved in small groups and in individual psychotherapies. One of the reasons I suggested the existence of this relative speed was the feeling attributed to the latently aggressive patient that it was safe to express rage in these surroundings. The presence of enough people around would prevent him from carrying out his rage into action. In the second part of this chapter I commented on

the depressive anxiety in the large group, caused by this same aggression, now felt to be dangerous, even endangering the very existence of the group.

At first glance it would seem that I was making two, mutually contradictory expressions concerning aggression in the large group. I described it as a place in which the expression of rage was exceptionally safe in one part and as particularly dangerous and depressive anxiety arousing in another part of the same chapter. This apparent paradox may be explained in the following way. In the first part of the chapter I described a relatively early stage of my experience. I still held the reins of the group transactions rather firmly in hand, unaware of doing so. Consequently the group's dependency needs were unintentionally constantly being fulfilled and the group felt safe to unite, thus providing the protection from his own aggression any individual patient might be in need of.

The second part of this chapter deals with a later period, during which I became a much more passive, interpretative figure. At this stage deep-seated rage could still be reached relatively quickly. This could, however, be achieved only after relevant interpretations had made it safe for the group to give up defensive fragmentation and unite, so that the individual patient could again feel safe to be in touch with his internal rage. I feel the jealousy situation referred to twice above to be illustrative of this point. An interpretation had turned a chaotic session into an orderly one and once this had been accomplished, the anger associated with jealousy of my relationship with the medical students could now be safely and coherently expressed.

One last remark concerns ward meetings. If nothing else, experience has convinced me that in all wards in which ward meetings were instituted, friction between patients and staff members and acting out inside the ward in general were reduced quite considerably. This seems to concern even wards populated by the most disturbed patients and also seems to be in direct proportion to the willingness of nursing staff-members to participate in these meetings.

To conclude, I hope to have been successful in demonstrating the usefulness of the application of Ezriel's theoretical formulations in various group situations. This could be done in small groups as well as in large ones. I also hope to have been able to demonstrate the dynamic similarities of these types of groups to each other, as well as their differences. Furthermore, I hope to have been able to describe the technical implications concerning the style of leadership that are to be drawn from these differences.

As of about ten years ago a discussion has been going on about the advantage vs. disadvantages of single leadership of groups as compared to co-therapy. The Tavistock group is, or rather was when I was a WHO fellow there, unequivocally against co-therapy. Their main argument was that co-therapy confused the handling of transference. It also minimized the possibility of rivalry and envy between co-therapists (Lermann 2002).

From my own experience I learned that the question is not easily answered. As will be explained in the case of Mary it may be seen that co-therapy, despite confusing the transference, would have ensured the continuity of the group and perhaps avoided the patient's psychotic breakdown. This, however, seems to be specific to

our country, in which any young male therapist might be called up for reserve service without giving the group any warning.

My experience with co-therapy is not unequivocal. In the small group described above, I had a female co-therapist. When I gave an interpretation that I thought was more to the point than hers, and which indeed produced a better result, I must confess that there was a small part in me that silently said: 'I'll show her what an interpretation ought to be.'

From conversations we had, it emerged that the co-therapist's personality was unusually rigid. Thus she told me that one of her patients could communicate with her only via letters he had written at home. She refused to read these letters and demanded that he exclusively communicate with her only verbally during the sessions. The therapy broke down.

She may have intuitively felt my competitiveness and not being devoid of competitiveness, the final result was that at one of the following sessions I had to announce to the group that she had committed suicide. Despite the fact that my contribution to the co-therapist committing suicide was probably minor, the very thought that I had contributed towards it at all keeps nagging me to this day.

There were several periods in which I led a large group. Two of these are relevant here. In the first period, soon after I returned from the Tavistock, I led the ward meetings in the open ward left. My superior, a woman of mid-European education, wanted to participate. I welcomed her but asked her to be consistent in her participation. For some reason she was unable to do so and came

irregularly, frequently in the middle of a session. This behavior confused the issue of transference to such a degree that I felt compelled to disassemble the group. In the second period I was already Consultant in the ward that consisted mostly of psychotic inmates. My competitiveness had probably declined. In these circumstances I found myself frequently clamoring within myself, "Why don't any of the co-therapists open his mouth to save the situation?"

After several staff meetings it was decided that junior therapist deal with individual problems, leaving me the task of group interpretation. This arrangement functioned quite well for several years.

Comparison of the Analysis of Two Delusions

The main purpose of the present chapter is to highlight the paramount importance of the introduction of the “Here and Now” into the analysis of severe psychopathology. To demonstrate that failure of its inclusion in an interpretation in these circumstances, such as the analysis of delusions, may at best lead to disappointing results.

Increased psychoanalytic interest in the psychoses has resulted in intensified work in this field. Among the many articles published in this field, Arlow & Brenner’s (1969) critical review of Freud’s concepts regarding the psychoses and their formulation of a revised theory of their psychopathology seems to be of special interest. This new formulation stipulated that psychotic and neurotic symptom formations resembled each other in following the economic principle of primary gain. Arlow & Brenner further added that some of the differences between these entities could be found in the quantitatively more severe involvement and regression of major ego functions and more extensive use of primitive defense mechanisms in the psychoses. Put in Ezriel’s formulation, psychoses differ from non-psychotic psychopathology in the fact that the former deploy more regressive, pathological required relationships because their avoided relationships are connected with fear of calamities of a more severe nature. It might be added here that in the description of Olivia, in Chapter Three, it has already been pointed out that Freud’s claim that

psychotic patients were incapable of forming transference was also misconceived.

Another main point of this chapter is to present and discuss two cases in which some of the points made by Arlow & Brenner in their new formulation, translated into Ezriel's terms, were clearly demonstrable. In one of them, Jane, mentioned briefly in Chapter Two as an example of an initial spontaneous negative therapeutic reaction, the disruption of a major ego function, that of reality testing, could temporarily be restored by a non-interpretative intervention. This enabled the patient to re-integrate parts of herself that she had eliminated by projection, but left her in an intolerably painful situation. Her case may also serve as another example for the claim that a negative therapeutic reaction will result when a required relationship is disqualified and the avoided relationship and its calamity are not properly dealt with in the "Here and Now" of the transference. In the second of these two cases, that of Arnold, the interpretation was completed, and the result was a net resolution of his delusion.

A further purpose of this chapter, conjoined with the following one, is to discuss some theoretical implications of non-interpretative psychotherapeutic interventions and their relationship with intra-psychic growth.

Jane was eighteen years old when first admitted in a paranoid-catatonic state into the open psychiatric ward of the general hospital I was working at then. During the year prior to her admission, since she had participated in a short excursion with her class to a kibbutz near the frontier, she had become more and more withdrawn and uncommunicative, without apparent reason. When admitted, she was mute,

rigid and negativistic. A remotely possible differential diagnosis of a hysteric stupor was ruled out by her subsequent admission of having had delusions and auditory hallucinations. Diagnosed as a case of acute catatonic schizophrenia she was treated according to the protocol in use at that time by electro-convulsive therapy and massive doses of anti-psychotic drugs. After several weeks she became communicative, was discharged and sent to ambulatory follow-up.

When I met her in the lobby of the outpatient-clinic, she told me that there was a secret connected to her illness she had never told anybody, and hesitated to tell it to me. In an attempt to persuade her to co-operate, I replied that I could think of no harm that could befall her from sharing her secret with me. This was the first of a series of non-interpretative psychotherapeutic interventions to be discussed later on, especially in Chapter Seven. As a result of this intervention Jane agreed to enter my room to discuss the matter. Upon entering the room, she noticed a ceramic ashtray on my desk, a product of occupational therapy. Now she immediately told me that there really was no need for her to tell me her secret, as the ceramic ashtray indicated that I already knew it. I reassured her again, saying that there was no way of my knowing her secret unless she told it to me. Finally she reluctantly agreed to confide in me.

The secret was that while she was on the excursion near the frontier, all members of her class had been warned never to leave their quarters at night in any circumstances. As usual, these were dangerous times, there could be enemy infiltrators about, and the guards had been given

instructions to shoot anyone who ventured out. One night Jane felt an irresistible urge to defecate, and being afraid to leave her room for the outdoor lavatory, she messed her bed. This made her feel unbearably dirty and untouchable, a feeling that gradually became more and more intense, until it finally developed into the full-blown catatonic state she was hospitalized in.

I then made a clarification. I explained to her the psychological association between ceramics and feces, telling her that this might have been the reason for her assumption that I had pre-knowledge of her anal secret without her having to tell me about it. Despite the fact that this was by no means an interpretation, it did temporarily disperse her fear that I had magic power to unveil her secrets and seemed to create a foundation for a preliminary basic trust between us. This trust helped us work through guilt feelings connected to further secret anal fantasies and sometimes re-integrate parts of her personality that she had eliminated by projection. (Incidentally, the topic of secrets was prevalent in her later stories, and this was the basis of my interpretation of her initial spontaneous negative therapeutic reaction, mentioned in Chapter Two.)

The incident that made the points mentioned above clear, occurred about eighteen months after psychotherapy had been instituted. During this time Jane enjoyed a fairly normal life. Although occasionally tormented by delusions, one of which constituted the initial spontaneous negative therapeutic reaction mentioned above, she went out to parties, held temporary jobs, related to people and acquired a boyfriend whom she steadily dated.

One morning she came storming into the ward, furiously accusing her father and the Consultant of the ward of having conspired against her and having published derogatory facts about her mental illness in the press. She also related in the stream of her accusations that an old man she had never met before had shouted at her on her way to the ward "Illusion, illusion," a word, she claimed, she did not even understand. Attempts to calm her down by invoking projections that had previously been dealt with only increased her fury. She kept shouting and accused me of colluding with her persecutors. I was definitely on the verge of losing her trust and our therapeutic relationship.

Reacting intuitively, I made an intervention, which looking back retrospectively might have been a very dangerous one because it disqualified her delusion without attempting to find out immediately the reason she needed it for. (C.F. Professor Hugo & Igor in Chapter Eight). I asked her what she would have thought of me, if I had told her that my father and the Consultant had conspired against me, in the same way she claimed her father and the Consultant had done to her. Without thinking twice she answered: "I would have thought that you had lost your mind." Then she smiled and agreed to tell me what had happened.

On the night before the delusion appeared, she had been to an engagement party of a cousin of hers, also a previous patient of our ward. She became envious of her cousin and started contemplating making her relationship with her boyfriend a permanent one, too. Then, however, she was struck by the terrible idea that if she were to propose to her boyfriend, she would feel obliged

to tell him the truth about her mental illness, in which case he would probably leave her. After a restless, almost sleepless night she awoke with the delusion just described. By now the structure of this delusion was clear to both of us. I interpreted that in order not to have to accuse herself for having made her boyfriend leave her, she had projected this need for unconditional honesty into her father and the Consultant. The fact that her father was a judge, an ostensible symbol of unconditional honesty, may have contributed towards choosing him to be the container of this projection, and the Consultant was added as an additional father figure.

She now knew that her delusion was a fantasy, also understood the word "illusion," shouted at her on her way to the ward. In Hebrew this word also has the connotation of deceit, possibly containing her hidden wish to deceive her boyfriend and not reveal her illness. It could also be related to the fact that her wish for a permanent relationship was just an "illusion." The complicated maneuver of producing the illusion was enabled at the expense of the sacrifice of reality testing, a major ego function. Only after my lending her my own ego had momentarily restored this ego function could the true meaning of the delusion be understood. When, however, asked for her feelings about having found that her delusion was mere fantasy, she answered, "Terrible, because I know that there is no way I can avoid telling my boyfriend the truth and he will consequently leave me." Unfortunately, this turned out to be the case, and a few weeks later Jane was deluded again. No effort on my part could now reach her in her omnipotent delusions. On one occasion she illustrated the primary gain of her delusional world, saying: "Why should I

leave this wonderfully beautiful and gratifying world of fantasy, (thereby denying some of her more frightening delusions). Don't I know that the real world has nothing to offer me in exchange but pain, misery and disappointment?"

In retrospect, it can be said that the interpretation given to Jane virtually forced her to reality test the inescapable bond between the avoided relationship and its calamity on an extra-transferecial ground. This ground proved to be disappointing, and instead of severing the ostensibly inescapable causal relationship between the avoided relationship and its calamity, it re-enforced it. A negative therapeutic reaction was now to be expected. One of the definitions of this phenomenon of negative therapeutic reaction in Chapter Two was the (re-)appearance of painful feelings after an incomplete interpretation. The delusion had been interpreted and understood and the appearance of Jane's despair has to be regarded as such a negative therapeutic reaction. The same holds true for the deeper psychotic regression that was soon to follow this incomplete interpretation.

In an article published later, (Springmann, 1976) in which I reviewed my experience with psychotic patients, I deplored this omission of the inclusion of the transferecial "Here and Now" into the interpretation. I claimed that what I should have said was something like: "I don't know about your boy friend. You might tell him the truth and you might not. This is up to you. Neither do I know if knowledge of the truth will indeed make him leave you. I do believe, however, that what you really are afraid of is that if **I** knew all the secret aggressive, dirty, lecherous fantasies you might not even be conscious of yet in yourself, **I** would also desert

you. All these unconscious fantasies you still conveniently conceal, even from yourself, under the headlines of 'mental illness.'" This is, again, only a schematic formulation of what I should have said. I would, of course, never use these very words. I would put them in much gentler terms, using no derogative language and would spell out the various fantasies in more positive terms. Nevertheless, I believe that had I used such an interpretation, the outcome of reality testing would not be as catastrophic as it turned out to be when performed with an extra-transference object that proved to be a disappointing one. This is the reason for which the interpretation of deep psychopathology should always be done in the context of the "Here and Now" of the transference. This is the only environment which promises that there hardly ever be a negative and almost always a positive outcome of reality testing.

Another point worth mentioning here is that I was able to witness a psychotic episode being created, *in statu nascendi* as I already referred to it. This situation, in which a psychotic episode develops in sight of the therapist, or in sight of the supervisor, is usually relatively easy to analyze. This situation frequently leads both to the disappearance of the psychosis itself and to a deeper understanding of the patient's dynamic structure. Even in the case of Jane, in whom the final outcome was unfavorable for the reasons just stated, the fact that the psychosis developed while she was in therapy, virtually under my eyes, enabled me to help her temporarily abandon her delusion, and, had I known better, would probably have eventually resulted less unfavorably.

Arnold was a patient who presented this very situation. I treated him after I had become

acquainted with Ezriel's formulations, especially with the paramount importance in such a case of the "Here and Now" implications of the transference being included in the interpretation.

Arnold was a thirty year old junior accountant with a childlike face. Before he was referred to me for dynamic psychotherapy, he had been in the hospital three times. Each of these periods lasted for approximately two months and each episode was caused by Arnold hearing derogatory remarks being made against him behind his back while riding on the bus and other, similar psychotic symptoms. Each time he was treated by anti-psychotic drugs, and when the symptoms subsided, he was discharged, the therapy to be continued by long-term injections once a month. The reason for his being elected from among all other schizophrenics to seek psychotherapeutic help has remained an enigma for me to this very day.

From material to be presented further down it can be assumed that he had serious trouble with intimacy. Nevertheless, he did not develop the initial spontaneous negative therapeutic reaction typical for this kind of patients. This fact constituted another enigma. I surmised that it might be related to the fact that he was still being treated with a rather massive dose of drugs.

When I first interviewed him he told me that the appearance of the voices and the other psychotic phenomena was usually connected with a relationship with some woman. He was, however, unable to go into any details concerning these facts and their significance.

When he showed up for his first therapeutic session, he was free of hallucinations and

delusions, but utterly passive and apathetic. Nevertheless, at his second session, while I was about to write his receipt, I discovered to my dismay that I had forgotten his name. I attempted to look as discreetly as I could through the copies of my previous receipts to be reminded of it. He observed me carefully, and after a few seconds said: "Don't worry, Doctor. My name is so and so." All I could do was compliment him on the acuity of his capacity to observe and interpret what he had observed. Later, when we had come to know each other better, I became familiar with the traumatic, chaotic, ambiguous and unpredictable atmosphere in which he had been raised. Then I explained to him that I surmised that in order to survive somehow in this atmosphere he must have developed extremely sensitive antennas. He had to do this in order to predict and understand the true meaning of what was being said or even more so of what had been left unsaid.

In his youth, these extraordinarily sensitive antennas were of vital importance, helping him to achieve some degree of internal coherence, to forestall disasters and to survive. In the present, however, I kept explaining, these very acutely sensitive antennas were sometimes detrimental. I told him that most people usually had some ambivalent feelings about each other, especially when closely acquainted. I added that his super-sensitive antennas apparently made him perceive the negative aspects of these ambivalent feelings before the people who harbored them became conscious of them and especially before they had conceptualized them into thoughts, words or actions. His ability to spot my predicament when I was unable to remember his name I used as an example, on this occasion an example which had no negative results.

He listened carefully and agreed. Later, when he already had a steady job, he occasionally developed passing paranoid ideas and suspected one or another of his fellow workers or superiors of having bad thoughts about him. On these occasions he used to remind me and especially himself of his antennas and say: "My antennas are acting up again." In this way quite a few paranoid upsurges aborted before they got out of hand.

This constellation, Arnold's unusual sensitivity to other people's conscious and unconscious ideas, seems to be a clinical example akin to Searles's (1958) ideas about the schizophrenic's vulnerability to other peoples' unconscious. They also seem to fit ideas expressed by Winnicott so many times that I feel myself free to use Winnicott's ploy and not quote any specific reference in his work. Bunim (1979) has also expressed ideas concerning the dynamic background of various types of delusions that seem to be relevant in this context. Ethan, who has been mentioned in Chapter Two in connection with negative therapeutic reactions, will be referred to in a similar context to the one discussed here in the following chapter. In these last sentences I feel that I have encroached upon the boundaries of the psychological etiology of schizophrenia, and this is beyond the scope of this book.

About eighteen months after therapy had been initiated Arnold was already steadily employed in his profession at a large building company. As he knew his way about money, he told me that he had made a modest investment at the stock market. His mother, with whom he still lived and who still supported him partly by paying for his sessions, scolded him severely about this. "Not

only will you lose your investment. If you do lose it, I will stop supporting you and the whole town will know you for the fool you are.” Later in the session he told me that he had been reading about the drug therapy he was still receiving in form of one injection a month. He knew that on the one hand these injections decreased the danger for him to be re-hospitalized. (Being in hospital was a euphemism he generally used instead of being psychotic). On the other hand, however, he also knew that the drug treatment he was receiving was not innocuous; that it might cause side effects, some of which, like tardive dyskinesia , could be irreversible. “What shall I do, Doctor? Shall I continue drug treatment and risk dyskinesia, or discontinue it and risk being in hospital again?” Instead of answering directly I interpreted. I told him that he was asking me to make a decision in a situation in which he knew all the ingredients involved. That he wanted me to take the responsibility for his decision because he was afraid that if he made the wrong one, he would have to carry the consequences. This he was ready to do, just as he had been willing to risk his money on the stock market. In both cases, I said, he was ready for being at risk. What he was really afraid of, I added, was that if he made the wrong decision, not only would he be responsible for the consequences, but because he had made the decision without consulting me, I would deprive him of my moral support and furthermore ridicule him for being such a fool, making medical decisions he was ostensibly not entitled to make, perhaps withdraw my help altogether, just as his mother had threatened to do. I then added that if he ever needed further hospitalization I would do my best to see him there too.

By making this interpretation I believe to have disabled two calamities, each on a separate developmental axis. By helping him to make his own decision, independent of my opinion, I helped him on the way of separation individuation, forestalling the calamity the content of which was that any step in the direction of independence would inevitably be followed by utter desertion on part of the object. This was a correction of a common parental mistake on the Mahlerian developmental axis, a mistake in which the parent warns the child that if he insists on his own opinion, he would lose the parent's support entirely.

In this context I remember being called to supervise the case of a young girl of low-level borderline personality organization, who was repeatedly discharged with the admonition never to come back again. Of course she showed up time and again with complaints that could not be ignored, such as suicide threats and was hospitalized repeatedly. I advised that the next time she was to be discharged she would be told the following: "You are better now and can be discharged. But never forget that whenever you feel that you need us again, we will be waiting for you, ready to accept you with open arms." She never needed to be hospitalized again. Among other things, this is one of the examples in which the immediate availability of a theoretical concept, in this case the Mahlerian concept of healthy separation-individuation was of crucial importance (Mahler, 1989). This point, of the immediate availability of a sound theoretical basis for interventions, will be referred to repeatedly in this book in various clinical situations.

By indirectly making Arnold sure he would not be ridiculed, I ensured him against a calamity on the Kohutian developmental axis, ensuring him that his mistake would be regarded as just that, an honest mistake and not a cause for losing the object's respect. This constituted the correction of another common parental mistake, in which the child is not only made responsible of the consequences of his mistakes, but made fun of, thus losing self-respect. This seems to be an adequate example of the influence of one developmental axis on others, hinted at in Chapter Three.

Following this interpretation, Arnold decided to discontinue his drug treatment and leave it aside for emergencies. Such emergencies did arise, but most often when he felt misunderstood by me, or when I intervened in a way I later found out to have been a mistake.

The occasion that made me choose the case of Arnold to be compared to that of Jane occurred several months later than the one described just now. Arnold was seeing several girlfriends in succession, but none of them proved to be of any real significance for him and being a religious man, he had no sexual contact with any of them. Then one day he announced that he had found the woman of his life and that he intended to marry her and spend the rest of his life with her.

Soon thereafter strange things began to happen at his workplace in form of colored paper clips being put among his papers, his notes being displaced, etc. He was certain that these things were being done to him on purpose in order to annoy him. His tension gradually increased until finally he was unable to bear it any longer and he told me that he had decided to quit his job. But alas, if he had

no job, how could he afford to support a family? Quitting his job would mean that he would have to give up his hope for marrying his new girlfriend. I said that I thought that he had put the cart before the horses; that he had learned from his traumatic experience of living with his mother that living with a woman was not easy and that any permanent, intimate commitment to a relationship with a woman unconsciously frightened him. Then I added that I believed that quitting his job was an elegant excuse to avoid this commitment. On his next session the annoying occurrences at his workplace had disappeared.

Then he told me, "Now, Doctor, that I no longer have an excuse to dodge the marriage, I am in real trouble. Now I know that I have no choice but to tell my future wife about my illness and then it will not be I who does not want her but the other way around. She would not want to marry me."

Despite the difference in the outer appearance of their delusions, the dynamic resemblance between Jane's delusion and Arnold's was now apparent. Both had to resort to psychotic required relationships, and both had to do so in order for their illness, and especially what it stood for, not to be disclosed. By now I had learned better and spelled out a complete interpretation, including myself as the main object he was afraid to be abandoned by, if all his inner secrets, still disguised under the general headlines of being mentally ill were known to me.

At this point it must be confessed that fate intervened and spoiled my "experiment." Following my interpretation Arnold discovered a refined way of telling his bride about his "nerves," and she stayed with him. They eventually married and had at least one son, so that the necessity of the

inclusion of the transference in the interpretation could not unequivocally be proved in this particular case. Nevertheless, it does not seem too far-fetched to assume that the inclusion of the transference in the interpretation did prove to Arnold that he was not unconditionally unacceptable. Consequently, this might have enabled him to phrase his words in such a way that he was finally accepted.

In any case, he developed no further delusions in the next years, that is, until I made a further mistake. Arnold confronted me with a dilemma. When riding the bus, he felt attracted to the young women there, wanted to lean against them and enjoy their touch. But this would prove to be immoral, even punishable. What should he do? For reasons that have to do with my therapist-induced-countertransference⁴, I did not pursue the issue of his attempt to appoint me umpire between his superego and his id, but sided with his id. He did not show up for any further sessions. When I met him accidentally on the street, he explained to me that he had perceived my response as a temptation to betray his religion. This was something he could not afford. Several months later he was deluded again, threatened to commit suicide by jumping from a high balcony and had to be re-hospitalized.

In lectures given at the school of psychotherapy of Tel-Aviv University, I frequently use the comparison of the cases of Jane and Arnold for the purpose they have been presented here, especially for highlighting the importance of including the

⁴ For explanation of the term "therapist-induced-countertransference," C.F. Chapter Four, in the second part of this book.

transference in interpretations given to deeply disturbed patients. Someone in the audience composed mostly of psychologists and psychiatric social workers nearly regularly asks: "How can we assume the responsibility of undertaking psychotherapy with such deeply disturbed patients? Their sanity and insanity, and sometimes even their very life and death, either by murder or by suicide, depend on our choice of words." I have learned with time to expect these questions and have a standard answer up my sleeve. I make use of Freud's comparison of therapists to surgeons, albeit in a somewhat different way. I compare the therapist's word to a surgeon's knife. When used carefully, guided by experienced teachers and in secure hands, both can heal. When used carelessly, both can cost the patient his health, mental or physical or even his life. Like surgeons, all psychotherapists (and I include myself, having made sufficient mistakes to fill another book,) are liable to make mistakes, but both have to begin somewhere and gradually learn to make less and less mistakes. Only thus can they ensure their patients, sometimes at the expense of their previous ones, to expect to have better results with their future patients.

Some Theoretical Remarks on Non-Interpretative Psychotherapeutic Interventions and their Relationship to Interpretations and Growth

Interpretative interventions have been extensively studied. They are based on essentially conscious elaboration on part of the therapist of material, unconsciously selected for presentation by the patient. They can be rationally planned in terms of content (Strachey, 1934), and according to Ezriel, they can be consciously timed and certain conditions being given, their outcome can be predicted fairly precisely.

This is not the case concerning non-interpretative psychotherapeutic interventions. All the ones described in the case of Jane, as well as some of those to be described further down, were spontaneous and unplanned, based on intuitive guesses of and reflex-like responses to the patients' immediate needs or fears. The results, although sometimes temporarily beneficial, were surprising and unpredictable. This was so at least at the earlier period of my maturation as a therapist. When both partners, patient and therapist alike, had to rely on unconsciously selected material, the degree of uncertainty of the results was greatly increased. The results were frequently erratic, inconsistent and as mentioned above, unpredictable. As will be shown further down, they might even be dangerous. Their beneficial effect, when not re-enforced by interpretations, was liable to relapse and the targets achieved usually disappeared.

While dealing with another problem, Ezriel (1956) made a passing remark about the necessity of further investigating non-interpretative psychotherapeutic interventions. At least two such interventions seem to have played a significant role in the evolvment of the therapy of Jane, described in the previous chapter. Consequently, it seems to be appropriate to explore this issue further here. I intend to do so in the light of Jane's therapy and that of some further clinical cases. One of them, that of April, has been described elsewhere, in conjunction with a detailed description of Herbert, mentioned in Chapter Two. (Springmann, 1970).

April was in analysis because of severe panic attacks and agoraphobia, which prevented her from leaving home unless accompanied by one of her parents. She entered analysis with a highly critical attitude, expressing a very low estimate of my willingness and ability to help her. Most of this negative transferential feeling was subsequently traced back to her belief that I was trying to subjugate her. In doing so I was no better in her eyes than her father, whom she described as an intelligent but highly possessive, domineering man, who criticized all her boyfriends in comparison to himself. Recently he was beginning to show signs of being intensively jealous of April's confidence in me, meager as it was. This jealousy led to recurrent conflicts, at the height of which April's father threatened to banish her from home. At the time she was by no means capable of living on her own and was very frightened by these threats. I suggested that she try to soothe her father by explaining to him the nature of the therapy and the necessity of her confiding in me. Then I added that if the tension at home became intolerable, temporary discontinuation of the

analysis could possibly be considered. The therapy could then be continued at another more suitable time, when her father had calmed down.

To my surprise, at the next session her attitude towards me had undergone a complete change. Subsequent analysis proved that this was not because she was frightened to be banished from therapy, just as she had been frightened to be banished from home by her father. On the contrary, it was because she had understood my conditionally releasing her from the analysis to constitute proof that I was not the tyrannical, jealous, possessive father figure she had turned me into in her transference. This change in her attitude enabled her not to see me as an enemy, whose every word had to be rejected, but as a potential ally, whose words could at least be considered and given the benefit of the doubt. Several interpretations that had previously been immediately rejected, including those relating her negative attitude towards me to her feelings about her father, were now given a second chance and the outcome of the analysis was favorable. It goes without saying that conditionally releasing April from analysis constituted a non-interpretative intervention.

Another example of a non-interpretative intervention is taken from the case of Ivanhoe, a catatonic schizophrenic patient.

Ivanhoe had been lying on his bed for several days in a rigid position without moving. He refused to communicate and had to be fed intravenously. Only his hand was stretched out, not unlike a Nazi salute, ending in a fiercely clenched fist. On ward rounds I playfully met his fist with mine, and then changed the gesture into a handshake. The grim expression on his face disappeared instantly,

changed into a smile and he indicated that he was ready for interaction.

Although no words were exchanged, the constitution of this intervention can, at least hypothetically, be put into the framework of Ezriel's formulation. It could be surmised that the rigid position was a required relationship, a cover for Ivanhoe's avoided aggression, which found its expression only symbolically via his clenched fist. Two sorts of calamity could also be surmised. One would be that he was afraid that his aggression, once freed, might destroy "us" and leave him alone (Depressive calamity.) The other could be that "we" would retaliate in a terrible way and destroy him (Paranoid calamity.) By meeting his fist with mine and by then turning the gesture into a handshake, I probably symbolically forestalled both calamities. The fist would mean that "we" were not easily destructible; the handshake, that "we" would not retaliate.

Despite this being a hypothetical interpretation of the situation, it may lead to a generalization, namely that one kind of non-interpretative intervention promises, without spelling out the required relationship or the avoided one that no calamity will ensue. My first non-interpretative intervention in the case of Jane, my reassurance that no harm would befall her if she told me her secret, would be of the same kind, a groundless promise that no calamity would ensue.

Generalizing again, it can be said that one of the characteristics of non-interpretative psychotherapeutic intervention is that without paying tribute to defensive (required) behavior or to avoided fantasies, they implicitly forestall unspecified calamities. In other words, this kind of

non-interpretative intervention takes place exclusively at the level of the calamity.

There are at least two theoretical reasons to assume that unless re-enforced or followed up by an interpretation, interventions of this kind, in which an as yet unidentified calamity is reassured against, will be of only temporary usefulness.

The first reason is that with the continued unconscious existence and potential activation of the avoided fantasies, there is no reason for the fear of their disastrous results not to reappear. The temporarily relieved anxiety is therefore liable to reappear too.

The second reason is that unless the therapist familiarizes his patient with the logical steps he follows in his deliberations, the patient is inevitably led to one of the following, mostly unconscious, conclusions. (It ought to be remembered in this context that this is indeed the case in the intuitive construction of non-interpretative interventions):

1. Either the therapist's omniscient and omnipotent reassurances are only boasted and therefore he is not trustworthy, or
2. The therapist is indeed omniscient and omnipotent and he does indeed possess magic access to the patient's deepest and most fearsome fantasies. "How else could he be so sure that no calamity is imminent?"

Unless dispelled by subsequent interpretations, assumption (1) will lead to secret, possibly unconscious, derision of the therapist, and assumption (2) to an awestruck, compliant attitude, with all the snags and pitfalls inherent in

such an attitude. Jane's endowing me with magic knowledge of her anal fantasies, her associative reaction to the presence of the ceramic ashtray that followed my first reassurance, which implied that no harm would befall her, is relevant in this context. It might either imply real trust in my magic omniscience, or, more likely, it could be understood as very subtly expressed irony of this pseudo omniscience and omnipotence.

The just mentioned contemplations have led me to discourage giving projective tests, such as the Roarschach inkblot test to patients who will later be treated by dynamic psychotherapy. Such tests imply that the therapist has pre-knowledge of the patients' unconscious before the patients are ready to acknowledge such contents.

In this context I remember a further patient who developed delusions soon after he had been discharged from a closed mental institute. He showed up in the emergency room, and I offered him to be hospitalized. He refused, saying that he would be executed as soon as he entered the ward. Without thinking twice I retorted that we were not in the habit of executing our patients. He agreed to come in, but fled two days later. The non-interpretative intervention had, as could be expected, produced only a temporary result.

My second intervention in the case of Jane, in which I temporarily allowed her to use my ego functions, and my conditional discharge of April from the analysis, contained no implied or forestalled calamities. Nor was there any reference to any avoided fantasies. By elimination we are left with the assumption that in these cases a manipulation occurred at the level of the required relationship.

In the case of Jane, it must be assumed that she was taken by surprise by the spontaneity of my offering myself for comparison and therefore found no way to defend her delusion at face value. Consequently she felt her required relationship blocked by a cognitive dissonance, and had to temporarily abandon it. How could I understand her refusal to accept this ploy when offered to her on subsequent occasions unless I was to attribute the short-lived therapeutic effect of this intervention to the element of surprise and spontaneity? Deluded patients usually show astonishing resilience in eluding such cognitive dissonances that may arise between reality and their delusions and in dealing with them when they do arise. This will be described in detail in Chapter Eight, where it will be shown that otherwise, the results may sometimes be catastrophic.

As stated above, operating from my present standpoint I would never attempt such a blunt challenge of a psychotic required relationship. All the same, this particular challenge of the delusion, especially as it was followed by an incomplete interpretation, did no immediate harm and turned out to be at least temporarily helpful.

In any case, projection and loss of reality testing played an important part in the formation of this required relationship. Elimination leads us to the same conclusion, so that it may be concluded that the maneuver that temporarily restored reality testing and the temporary re-absorption of the projected intra-psychic material, was executed at the level of the required relationship.

The dynamics of the non-interpretative psychotherapeutic intervention in the case of April is more easily discernable. In this case, later

analysis revealed that the patient's fanatically maintained rebellion against me, as a father substitute, was required in order to avoid the manifest statement of her desire to be dominated and possessed by him/me. The reasons for this desire not to be manifestly stated was not yet known, or not yet understood at that time. The conditional release from the analysis took the sting of immediacy out of this required need to rebel and reject. Once the new required relationship was accepted and the immediacy removed, valuable time was gained in which interpretations could be assimilated, insight gained and feelings metabolized and mitigated.

As pointed out in the original article about this young woman, the change of her required behavior towards me in the transference resulted in no immediate change in her basic dynamics, such as her relationship towards other objects. This can now also be generalized. Providing the patient with a new, more convenient required relationship within the transference cannot by itself lead to a change towards extra-transferential objects. When the avoided relationship and its calamity are not dealt with within the context of the new, more convenient intra-transferential situation, reality testing cannot sever the link between the latter two entities. No generalization can be accomplished, and the patients are not provided with the ability to change relationships to other prominent figures in their lives.

From the above material it seems deducible that the second type of non-interpretative psychotherapeutic interventions consists of offering the patient convenient required relationships within the framework of the therapeutic relationship. This is done without

paying tribute to the avoided relationships and their concomitant calamities.

These more convenient required relationships can be defined as such which enable the patients to function in the therapist's presence in such a way that they feel free to reveal enough hints of their avoided fantasies and their feared calamitous results so that meaningful interpretations can be formed and accepted. This would be in line with French and Alexander's (1956) original definition of the corrective emotional experience, i.e. providing the patient with an object, the therapist, who differs from the original parent, as referred to in Chapter Two.

Another school of thought, the Short Term Anxiety Provoking Psychotherapy, (STAPP), founded by Sifneos (1979) operates, as I seem to understand it, on an almost diametrically opposed principle. Here the emphasis is put on more or less forcing the patients to face what Ezriel would have referred to as the avoided relationship, without at the same time spelling out and dispelling the calamity. This method even resorts to the use of words or phrases associated with the postulated calamity, such "cutting off" the session, or "abandoning" the subject, thereby deliberately creating anxiety, just like in an incomplete interpretation *a la* Ezriel. The idea behind this method is that the patients selected for STAPP are psychologically strong enough to face their anxiety and work it through, either by themselves, or with the help of their therapists. Such a method is definitely not recommended for the less maturely integrated patients described in these pages.

The more convenient required relationships within the therapeutic environment are liable to relapse into their former state, unless constantly repeated,

or re-enforced by complete interpretations. The argument here is virtually the same as the one given in the discussion of the first type of non-interpretative psychotherapeutic interventions, the one done at the level of the calamity. As the avoided relationship continues to exert pressure for expression, the fear of the calamity, unless dispelled, is liable to cause the patient to fall back on previous required relationships. Otherwise the patient is liable to re-experience the negative feelings for the avoidance of which the required relationship had been constructed in the first place.

Just as the non-interpretative interventions described hitherto happened to contribute positively, even if only temporarily so on the therapies involved, so they may be harmful in others.

The damage liable to be caused by such non-interpretative interventions was painfully brought home to me on at least two occasions. De Bernard was a paranoid patient just discharged from hospital. I was seeing him privately. At that period I had no access to professional supervision and was blindly following arbitrary hospital rules, as I understood them. Nevertheless, de Bernard was doing fairly well in therapy. In due course he informed me that he had found the perfect bride: beautiful, intelligent, warm, rich, and, what was most important for him, being a “de,” originating from a respectable family which accepted, welcomed and thought highly of him. I congratulated him and then, following what I had learned, asked him how he intended to tell his future wife about his having been in the hospital. He answered that he intended to keep this a secret for the rest of his life. I expressed some doubt

about a marriage permanently based on a lie, with this ominous secret constantly lurking between him and his wife, although, once more, not in these harsh words. Shortly following this exchange, de Bernard started to find faults in his previously ideal bride, found excuses to break off the engagement, and soon thereafter found pretexts to break off his therapy.

About twenty-five years later he looked me up again, this time because he had been suffering for some time from panic attacks and agoraphobia. He told me that until recently he had felt well. Shortly after leaving his first therapy he had formed a relationship with another woman, neither as beautiful nor as intelligent as his first choice and what was more important to him, of plebeian origin. He had married her, fathered several children and was moderately happy with her. As he had said in his original therapy, he kept the secret of his mental illness all these years, and never felt it to be an obstacle between himself and his wife. I could not help feeling that had I kept silent, he would have found greater happiness with his first bride and that my intervention had cost him twenty-five years of living with a second best. Later I could not refrain from the thought that he had not sought me out from among the many therapists available by now just by chance. He had possibly, unconsciously done so in order to admonish me and to teach me a lesson: "Do not interfere in issues you have no business to interfere in."

The second example of the damage possibly done by interfering, other than by an interpretation, is a more ominous albeit hypothetical one, never to be proved because the patient committed suicide. Carmen, of borderline personality configuration

constantly felt, among other things, that she was never sufficiently appreciated. I was the psychiatrist in charge of her treatment and again had no access to professional supervision. On one occasion, I went on leave for three days. Carmen offered me some cushions she had produced in occupational therapy as a parting gift. Blindly following hospital rules, which forbade accepting gifts from patients in any circumstances, I politely refused, and explained my reasons for doing so. Upon my return from my leave, I was informed that Carmen had committed suicide in my absence. This time the non-interpretative intervention consisted of not doing something. I cannot differentiate it from other such interventions, in which doing or saying something was involved. Like other interventions, or non-interventions, it was not based on real, deep, dynamic understanding of the patient's motives, (in this case the need of herself or her gifts to be appreciated), but on the thoughtless following of rules. Without being able to prove it, I believe that not accepting her gift was perceived by Carmen as another proof of non-appreciation, and may have finally motivated her to commit suicide.

As I matured as a therapist, my non-interpretative interventions became less reflex-like or blind obeying of arbitrary hospital rules. They became more deliberate and goal oriented. Nevertheless, they still lacked a theoretical basis. Here are two examples.

The first example is another case in which I refused to accept a gift from a patient. I was seeing Lily, a teenager student, of whom I felt, without her saying so overtly, that she was about to commit suicide. For some reasons she could not be hospitalized despite the severity of her illness,

probably impending schizophrenia and had to be seen on an ambulatory basis, spending the rest of her time in students' residence. Because of the severity of the illness and the feeling that she was constantly contemplating suicide, I saw her almost every day.

On the eve of a weekend break, she offered me some valuables, asking me to keep them for her. I intuited (a term borrowed from Kohut) that she was willing them to me, and that she intended to commit suicide over the weekend. Consequently I declined the acceptance of the gift, and told her to keep the valuables for me over the weekend. Ostensibly, this was the same situation as that in the previous case. The underlying dynamics, and even more so, my intuitive understanding of the situation, however, were entirely different. Returning from the weekend, I was relieved to find out that she had not even attempted suicide and in fact, she later thanked me for having saved her life by not accepting her "inheritance."

The second example is that of Nancy, briefly mentioned in Chapter Three as a typical example of a common required relationship. She had participated in a group I had run, and when the group came to its predestined end, she decided to continue her therapy with me as an individual patient. She was in her mid forties, unmarried, of a high-level borderline personality organization. Whereas in her fantasy she was afraid of being impregnated by me, in real life there was nothing she wanted more than the experience of motherhood. She conceived at the age of forty-five from a man of no particular importance and was happy about it. She was even happier when ultrasound discovered the fetus to be a boy. She gave her unborn son a name, the connotation of

which was something like “hope” or “looking forward to a better future.”

Then, at the end of the seventh month of her pregnancy the fetus died *in utero*. She was devastated. Not only was her only hope of being a mother destroyed forever but doctors’ orders forbade her to abort the dead weight and forced her to carry it for another two months, up to the very end of the natural period of her pregnancy. During these two terrible months I did my best to support her by lending an empathic ear, by giving her extra sessions whenever she required them, even on weekends and from time to time by an appropriate interpretation.

Two weeks after the dead child was finally born, she resumed her therapy. It was mid-winter, one of the coldest in our country, heavy rain was falling, no alternative transportation was available, and she knew that she was my last patient for that day. At the end of the session she asked me to take her home in my car. I could not find it in my heart to refuse her. After the cruelty fate had meted her, I felt that refusal in these circumstances would be perceived as further cruelty and I feared that it might drive her over the edge in one way or another. So I took her to her home in my car despite my knowledge that from the point of view of analytic theory and practice, the fulfillment of a desire instead of its use as a building stone for an interpretation was a grave mistake. This time I felt that I had no alternative. The result was that the therapy dragged on endlessly and threatened to become an “analysis interminable.”

This situation continued for about two years, until I had to go abroad for a long period. I did not want to leave her unsupported and referred her to a

female colleague. What happened there I can only describe as analytically mutual falling in love at first sight. When I returned, Nancy opted to stay with her new therapist, the therapy was finished in a satisfactory way, and even the damage caused by my deliberate, unavoidable mistake, could be mended.

One more example seems to me to deserve being mentioned here. It left a strong impression on me, supported the hypothesis that non-interpretative interventions may improve the intra-therapeutic relationship, make the patient more comfortable in the presence of the therapist and easier for him to reveal his secrets, but have no real impact on extra-transference relationships and lead to no generalization. At the end of Norbert's therapy, when the improvement in his extra-transference life mentioned in Chapter Three had already been achieved, I asked him what had helped him most in his therapy. To my surprise he answered, "You remember that at the beginning of our relationship, before you offered me my coffee, I was still smoking. On one occasion you said, 'why don't you take the ashtray closer to you. You will be more comfortable.' Although this simple kindness of yours made no difference in my life, it made me feel so at ease in your presence that I thought: This is someone I can tell everything to"

Sometimes ostensibly insignificant, almost negligible non-interpretative interventions may change the atmosphere of a whole ward. Brian was about sixty-three years old when I became Consultant of the ward he was hospitalized in. The reason for his hospitalization against his will, which had happened several decades before, could only be dug out from ancient files, deeply buried in hospital archives. By now he was completely

rational, but whenever his discharge from the hospital, or his relocation in a chronic ward was mentioned, he threatened suicide. When he reached the age of sixty-five, he declared that he had now reached the age of retirement and was, therefore, entitled to spend the rest of his life peacefully in the ward. Nobody could come up with a reasonable reply to this argument.

After some time he began to demand a glass of milk whenever he woke up from his afternoon nap, which usually happened around 16.00. As this did not coincide with the ward routine, a quarrel broke out each time he made his demand. This quarrel increased beyond all proportions and gradually began to cause a great commotion in the ward. The matter was brought up by the nurses in a staff meeting in form of a complaint against Brian and his "irrational" demanding behavior. Against obstinate resistance on part of the nurses, it was suggested that each day, at 15.45, a nurse would wake him up gently and ask him: "Brian, how would you like your milk today? Would you like it warm, cold, with sugar or without it, etc.?" Three days later Brian had forgotten all about his milk and an impending crisis had been overcome.

Another non-interpretative intervention, which was very meticulously prefabricated, can be mentioned in this context. The patient was a schizophrenic psychiatric social worker. She had been in the hospital previously, but no details about this hospitalization were available. When she was elected for psychotherapy the only psychotherapist who had a vacancy was a highly intelligent psychiatric social worker, just like the patient, even a few years younger than her. No wonder the patient was indignant about this arrangement. She continually attempted to dispirit

her therapist and the most immediate target of her ridicule was her therapist's optimism.

I can still remember how we sat, the therapist (the same one who also treated Caleb) and I, racking our brains to find an appropriate way to overcome the wall the patient had erected. Finally, we hammered out the following words, to be said to the patient as if this was what she wanted to say. We hoped that although this was not an interpretation, it might make the patient feel that the therapist could empathize with her indignity. "Who are you, you young, inexperienced, pissed social worker to tell me that I will recover?" This, in these very same words, was said to the patient during the next session. Fortunately it worked. The patient became more compliant, the therapy could be carried on and when I last heard of her, (about thirteen years ago) she was doing her job as a psychiatric social worker, albeit with a lighter caseload and with reduced responsibility.

Bearing in mind the shortcomings of non-interpretative interventions, it still seems fair to point out the positive, if temporary and partial results achieved by the interventions described in the cases presented above. It can be argued that April might have achieved similar positive results by interpretations only, provided her tension and hostility towards me would not have mounted to such intensity that she would have fled the therapy. In the cases of Jane and Ivanhoe, however, the interventions seem to have been decisive and vital in situations in which interpretations were neither acceptable nor practical. In the second intervention in the case of Jane, in which I offered her my ego for comparison, the discontinuation of the therapy was prevented. In the case of Ivanhoe, the very

basis for the existence of a therapy was laid down. Even in the case of April, valuable time was gained and the possible breakdown of the analysis was prevented.

I have hitherto described two common types of non-interpretative psychotherapeutic interventions, one at the level of the calamity, the other at the level of the required relationship. I would now like to go one step further and maintain that if we fully follow Eziel's concepts, any psychotherapeutic intervention that does not sever the imaginary obligatory connection between the avoided relationship and its concomitant calamity is to be defined as a non-interpretative intervention. In any case, it differs in practice and in principle from an intervention that does fulfill these conditions.

Balint (1969), paid tribute to two different kinds of analytic interventions when quoting his "Basic Fault" he distinguished between interpretations and the creation of a therapeutic relationship. In continuation of the previous paragraph I would maintain that Balint's therapeutic relationship corresponds to the larger scope of non-interpretative interventions, as described above. Their therapeutic effectiveness, like Alexander & French's corrective emotional experience, seem to depend on the introduction into the internal dynamic structure of a new, benevolently neutral object, the task of which is to outweigh the effect of previous unsatisfactory or traumatic relationships.

This is generally, although not exclusively, accomplished by processes of internalization and identification. When successful, the new benevolent internal object may become emancipated from the immediate physical

proximity and availability of the external, now successfully internalized therapist. Whether it also acquires immunity against later disappointment in the therapist's personality, is a question that has, as far as I know, never been investigated. (C.F. Mary, who will be described in Chapter Eight. Early in her therapy this schizophrenic girl was disappointed in me twice and reacted each time by developing a full-blown delusional psychosis, thereby undoing a great deal of therapeutic achievement that had been accomplished previously. Several years later, she was disappointed in me again. This time she did not regress into psychosis, but simply refused to see me anymore. This seems to indicate that if sufficient intra-psychic repair has been accomplished, at least some patients do become immune to being disappointed by their therapists.)

In cases in which the internalization is less successful, the continued existence of the internalized object remains dependent on the physical proximity and availability of a faultless therapist. This seems to be the case in severe cases of chronic schizophrenics. These patients can maintain their conditional sanity and functionality only when in constant, ongoing physical contact with a "holding," "containing," "sustaining," "life-giving" object, i.e. their therapist, sometimes for the rest of their lives. In even less favorable cases internalization does not occur at all.

Complete interpretations, as conceptualized by Stachey and adopted by Ezriel operate on a different principle. Theoretically, they postulate no addition to internal dynamics, but rather a subtraction, a dispelling of unsatisfactory, fearful calamitous object relations by reality testing them

in the transference or in any other suitable environment. When done correctly and sufficiently, this is virtually by definition a permanent achievement, which can be generalized, opening the option for the creation of more satisfactory relations with other objects, beside the therapist (internalized or otherwise).

Ezriel put little emphasis on interventions other than interpretations and as mentioned above, referred to them only in passing. This view is probably reflected in the lines presented here, first written under the direct impact of his influence in the late sixties. In this context, it ought to be borne in mind that the question of the specific therapeutic role of interpretations versus the role the therapist's very proximity over a long time is not new, especially when the therapist's personal and professional attributes are taken into account. Nacht (1962) seems to have been among the first and most prominent spokesman for this opinion, while Bibring (1962) and Eissler (1958) continued to maintain that interpretations were the very core of psychoanalytic therapeutic activity.

Then the terms of "Holding," (Winicott, 1971), "containing," (Bion, 1967), "sustaining," (McDougall, 1986), "mirroring," (Kohut, 1971), "life-giving" (Symington, 1993,) etc. were gradually introduced into the psychoanalytic arsenal. All these terms refer to non-interpretative therapeutic attitudes and according to the concepts maintained here, all of them are played out at the level of the required relationship, at least as far as I understand them. The introduction of these terms seems to have added impact and specificity to the importance of non-interpretative interventions, laying down foundations for rationally planning and applying them.

All the authors mentioned above identify the psychoanalytic process with one of growth and maturation. They bring forward overwhelming evidence that indicates that intra-psychic growth does occur in the presence of a “holding,” “containing,” “sustaining,” “mirroring” or “life-giving” environment, respectively, supplied by the analyst. I have seen many “burned out” schizophrenic patients begin to grow and unfurl cognitive and emotional aspects that had seemingly vanished into the post psychotic defect in the mere constant presence of a benevolently neutral object. Consequently, I cannot refrain from referring, as do the authors mentioned just now, to the analytic process as one of growth even in the presence of a merely non-interpretative environment.

Katherine, mentioned in Chapter Two in the context of the spontaneous initial negative therapeutic reaction, stopped being a “thing” (“Barbara,” 1975) and showed signs of a budding feminine self while still vehemently fighting off her therapist’s attempts to approach her.

Ethan, mentioned in Chapter Two as an example of a temporary negative therapeutic reaction that followed an interpretation that could only subsequently be completed, also showed signs of growth after the incident described there. From having constantly to produce silly jokes, he now gradually developed a finely honed, gentle sense of humor. In his childhood, his mother and his elder sister used to sit in the kitchen, sharing secrets about him that he was not supposed to know that he knew. Later he developed the delusion that people were talking about him behind his back. [Once more Shengold’s (1998) “Soul murder” comes to mind]. After he had understood the

connection between the content of his delusion and his mother and sister's sharing secrets about him in the kitchen, he turned to me with a smile and said, "Would it not be fair, Doctor, to say that my paranoia, (as he referred to his illness) was really cooked up in the kitchen?"

Nevertheless, and in spite of Kohut's quote of his patient not to interfere with her analysis by his interpretations, all the authors mentioned also use interpretation, albeit these are not always necessarily "three level" or "mutative" ones. At least they do not overtly define them as such. Each of these authors constructs these interpretations along the developmental axis he favors.

What, then, might be the relationship between growth and interpretations? Perhaps the answer to this question lies in a somewhat unorthodox definition of transference, "transference in the restricted sense," to paraphrase Sandler's (1973) "countertransference in the restricted sense."

The original supposition about transference was that the patient, who came to analysis because of some troublesome symptom, gradually developed feelings towards his therapist. These feelings were recognized not to be based on reality but to constitute the patient's feelings towards significant objects in his formative years transferred on the therapist and were consequently named transference. Ezriel claimed that the very formation of a symptom necessitating analysis was created when a hitherto satisfactory required relationship, experienced in real life, could no longer, for one reason or another, be maintained. He furthermore claimed that the unconscious reason for coming into analysis was to be understood as an attempt on the part of the

patient to form the same required relationship, now impossible in the real world, with the analyst. Transference, according to Ezriel, was consequently not a result of analysis but the very reason for its being instigated by the patient in the first place.

In case we presume that analysis is to be identified with growth, we might also assume that another unconscious motivation for coming into analysis is the wish to resume the growth that had been abandoned in the formative years for fear of one calamity or another. We can agree with the original view that maintained that transference developed during the analysis, or we can agree with Ezriel, that the formation of transference had been the unconscious reason for coming into analysis in the first place. In both cases we can assume that the patient soon discovers that the analysis is an optimal environment in which to resume the growth he had missed in his childhood. This might be the reason for the frequently observed phenomenon that some patients leave their presenting symptom unresolved until the very end of the analysis. The cause of this phenomenon might be the patients' unconscious, (and in some more sophisticated patients, conscious) fear that the resolution of the presenting symptom might bring about the end of the analysis before the accomplishment of the need to complete intra-psychoic maturation has been achieved.

Herbert, whom I mentioned in Chapter Three as an example of intelligence that had been liberated by a series of interpretations, turned out, after this had been accomplished, to be an extraordinarily sophisticated person. After about ten months of analysis, when he had already understood the

roots of his homosexuality and lost his sexual attraction to men, he said, "By understanding the origin of my homosexual tendency, it has dissolved. But in spite of the fact that this was a primary objective in my treatment, I have a feeling that I have only started on my way and that this constitutes only a part of the problem. My feeling is that in everything that connects my mother with the formation of my personality, my ancient love for her, my disappointment in and my identification with her, I have not been completely liberated. I am still far from standing on my own two legs and have not yet achieved complete maturity. If you were to tell me now that the analysis is finished, I would regard this as a disaster."

The analysis continued for another eighteen months and then it got "stuck." My supervisor, who was also my analyst, said that I had reached the end of the analysis and instructed me to discontinue it. I obeyed him and told Herbert that in a few weeks we would have to finish his analysis. He immediately punished me by attempting to resume his homosexual activity, but, alas, he was unable to do so. He had forever lost his attraction to men. (The fact that the analyst was at the same time also the supervisor was by a mistake in itself, but at that time I was too inexperienced to raise my voice against this mistake.)

In the case of Herbert no real harm was done by this premature discontinuation of his analysis. I saw him two years later in a follow up session, and he assured me that he was well and was no more attracted to men. Further and probably more reliable evidence that this analysis had not failed could be deduced from the fact that his wife, who

knew nothing about his homosexuality, came to me about a year after the analysis had been terminated, complaining that I had corrupted him. Whereas prior to the analysis he had been a docile person, now he had become assertive, had a mind of his own and stopped listening to her.

In this he resembled Leonard, (to be described in detail in Chapter Eight) for the brief period before he became psychotic for the third time. He also became assertive, without becoming aggressive. In that case, a symptom, a delusional system, was removed by the completion of an interpretation. The underlying psychotic personality disorder was, however, psychotherapeutically neglected, and the ultimate result was tragic.

If I now come back to the topic of this chapter, I might maintain the following: Despite the more comfortable environment provided by the therapist and for lack of evidence to the opposite, the patient develops an automatic assumption. The meaning of “transference in the restricted sense” is that the patient automatically assumes that as soon as he dismantles his required relationships and attempts to deploy his newly discovered innate faculties, these will be stifled by some derivative in the “Here and Now” of some disasters, equivalent to those that had forced him to relinquish his growth in the first round. He has no reason to believe that the “Here and Now” will be anything but a repetition, in somewhat more convenient circumstances, of his childhood experiences.

He might fear, as McDougall (1986) has pointed out, that his voracity might destroy his therapist. In other cases, he might fear that his developing sexuality might be punished by an equivalent of castration. In still others, that being assertive

might offend the therapist or that steps in the direction of independence might lead to total and immediate desertion and/or humiliation by the therapist. Transference interpretations given in these circumstances are intended to obviate these fears. The interpretation given to Arnold, described in the previous chapter, in which he was assured that deciding about his own drug treatment without consulting me would not lead to my deserting him, is an example of such an interpretation. Another example could be the interpretation given to Caleb, in Chapter One, concerning his inability to maintain eye contact with his therapist. This interpretation dispelled the fear that was based on his traumatic experience that used to take place when he sought eye contact with his mother from being repeated.

In other words, the task of interpretations is to undo the "because clause" mentioned in Chapter Three. In the case of Adam it would be: "You may let me approach you, and **no harm** will befall you." In the case of Caleb: "you may look into my eyes, and you will **not be met** by the cold, rejecting, smiting look you used to meet in your mother's eyes." In the case of Ethan it would be: "You may deploy your intelligence, and you will **not suffer** the consequences of having exposed your mother's craziness." Herbert might deploy his intelligence and **not intimidate** me so that I sabotage his analysis, Gilbert might express his disappointment with his objects, such as the therapist, and they will **not be tempted** to give up their investment in him, etc.

A similar situation concerned Yolanda, highly placed in the diplomatic service, who, like Arnold grew up in the presence of an intrusive and abusive mother. She began her growth in my

presence to a certain degree, but it was via a three level interpretation that she discovered that she was not unconditionally obliged to share all her secrets with me, but had a new responsibility. This new responsibility consisted of having to distinguish between the secrets she wanted to hide from me because they were none of my business and those she wanted to hide because she was ashamed or afraid of my reaction. She was surprised to learn that I did not possess the power, attributed by her in hers childhood to her mother, to know hers secrets anyway. She was even more surprised to learn that even if I did find out about her undisclosed secrets by chance, by guesswork or by logical deduction, I would not hold her hiding them from me against her.

This interpretation, I guess, will be found to be somewhat un-orthodox, an ostensible infraction of one of Freud's basic rules. It has, however to be remembered that the uncovering of secrets is no longer a therapeutic goal *per se*, the very core of psychoanalysis. The present tools and techniques of psychoanalysis, at least as far as I understand them, consist of creating circumstances in which the patient's withholding information from his therapist is no longer necessary because of the fear of imaginary calamities. The goal of our endeavors is the creation of the option to tell the truth or to withhold it at will, in accordance with external realities, not the disclosure itself.

In any case, the interpretation given to Yolanda constituted a turning point in the creation of a secure and emancipated self. She no longer felt the need to resort to all kinds of avoidance of commitments and human closeness. (She used to refer to his overt behavior as sitting on the fence). This had been her previous way of

preserving the boundaries of her identity. Now she felt these boundaries to be secure and was able to approach other human beings. This was something she had previously been unable to do, in her opinion because she had felt transparent to them. She even stated that she could now feel what she defined as empathy towards other peoples' internal feelings, something that had previously been possible for her only at an intellectual level.

Summing up, it might be concluded that the therapeutic atmosphere, which consists of the sum-total of non-interpretative benevolently neutral behavior, encourages a process of growth. Interpretations play a crucial part by removing the fear of imaginary calamities that threaten this growth. In this way they prevent the new growth of turning into a sterile, more or less stereotyped repetition of the first round in a somewhat more comfortable environment.

The Relationship between Reality, Reality-Testing and Delusions

Statement (1): Delusions are mental formations, resistant by definition to reason and to reality testing.

Statement (2): Reality testing and reason are means for resolving delusions.

The purpose of this chapter is to demonstrate that when viewed from the proper perspective, these two statements are not contradictory but complementary.

I would like to start by stating my meaning of the term “resolving delusions.” It is relatively easy to suppress delusions by various biologic means and we are not even in the position to criticize the exclusive choice of these means as long as we are obliged to perform psychiatry on an industrial scale, given the manpower we are allotted for this purpose.

Unfortunately, this exclusive approach leaves the patients in the same intra-psychic constellation that had necessitated the formation of their delusions in the first place. Hence the need exists for sometimes life-long, by no means innocuous, maintenance drug treatment with the frequent occurrence of relapses. Furthermore, as will be demonstrated in the cases of Danielle and Emily, this exclusive use of drug treatment or any other biologic approach, such as electro-convulsive-therapy, does not even result in the complete eradication of the delusions. The meaning of statement 2 is not forgetting the delusion, an act

accompanied by suppression of important components of the patient's personality. It means, instead, the transformation of the delusional content into mentally useful material, remembered and integrated into the normal or neurotic psychic apparatus, perhaps with the value of a fantasy.

Danielle was in her late teens. She had been hospitalized because of psychomotor hyperactivity of such intensity that she had to be put in a closed ward. She was treated by massive doses of haloperidol (butyrophenone). When she calmed down she was transferred to the open ward I was Consultant of. The first sentence she uttered when I met her was, "Now that I am cured, Doctor, would you please perform the operation and remove the transistor from inside my head that incessantly keeps transmitting orders about what I should do or think and what I should not."

A delusion, probably accompanied by auditory hallucinations, had evidently survived several weeks of intensive anti-psychotic drug therapy.

It should perhaps be added here that Danielle did indeed have an internal transistor that was finally removed. In subsequent family sessions Danielle's mother proudly spoke about a special way she had invented to prevent her children from mischief. She used to hold them by the hand and whenever she felt that they were about to do something she did not like, she would press their hand. This would mean: "Stop what you are about to do and do the opposite." As an example for the effectiveness of this way of transmission she chose an incident that involved Danielle's brother.

On a particular occasion the house the family lived in was to be re-decorated. Mother wanted to go shopping and told the boy, at that time barely

four years old, to keep an eye on the decorators so that nothing would be stolen. When mother had left, the boy approached the foreman of the decorators and asked him, "Excuse me, sir. Are you thieves?" "Of course not," was the answer. "It's all right then," said the boy, "I can go out and play." When mother returned, the foreman confronted mother and asked her if she had told the boy to watch that nothing would be stolen. Mother felt a scandal approaching, transmitted her signal and the boy immediately understood it and said, "Oh no. It was my idea."

This way of transmitting orders had evidently been internalized and now acted as an internal "transistor." Following this particular family session, the transistor was not mentioned again.

Emily was in her sixties when she entered the hospital because of the acute development of a depressive-paranoid episode. Its content was that twenty-five years previously an enemy agent had abducted her and injected the germs of a highly infective and deadly venereal disease into her vagina. These germs had been dormant all these years. Now they had become active and were intended to constitute the biological aspect of a total war, intended for the destruction of the country. We, the attending physicians were stupid enough to approach her without taking appropriate precautions and would be the first to succumb to this deadly disease. Emily used her inability to think clearly and her constipation as proof that the germs had already destroyed some of her internal organs.

Two aspects of her illness she could not understand. One was the question why she, of all people, had been chosen to be the starting point of the epidemic. The other was the question why, if

all this had been done to her against her will, did she feel such excruciating guilt feelings?

A full description of this woman's dynamics would lead us too far a-field. It is, however, noteworthy that her husband, with whom she was in constant latent strife, dominated her and at the same time was dependent of her. He had chauvinistic character traits and had forced her to immigrate to this country from her western homeland against her will. She had passively rebelled against this by obstinately refusing to learn the language for several decades. This, in turn, revenged itself by her inability to communicate with her grandchildren.

Emily's husband was a journalist and one of his favorite topics was to write in journals in his original language rather pessimistically about the country's chances in case of biological warfare. Emily's duty, as his "assistant," was to type these articles for him. All the years they had lived together he cheated on her, leaving their home time after time to join a new love. As long as she was young, she had balanced these narcissistic insults by having affairs of her own. Now, in her sixties, this option was no longer at her disposal. Shortly before the outbreak of her psychosis, the husband left home again to join another newly found love, only to return a few days later, dejected and seeking his wife's forgiveness and support. She reacted by becoming depressed and he tried to comfort her by buying her solemn records such as Mozart' requiem and Beethoven's Missa Solemnis. Shortly thereafter the full-blown psychosis broke out.

Emily was treated by anti-depressive and anti-psychotic drugs and had to admit that her condition had improved and in fact that she was

now cured. When asked, however, how this cure had come about, she said that we had included strong antibiotic drugs in our drug treatments, and these had killed the fatal germs. In other words, she would not give up the central kernel of her delusion, of having been an instrument for the destruction of what her husband cherished. She had found an elegant compromise that allowed her to preserve her need to be a tool for the expression of her latent revenge. These deliberations also helped to clarify both of her questions. She had been chosen because the destruction of her husband's loves had been her unconscious intention in the first place. She felt guilty because of her aggressive feelings.

Unfortunately, at that time I was not yet aware that information like the one just described could be used psychotherapeutically. Consequently, this case can only be used as an example for the elegant ways psychotic patients defend their delusions against ostensibly impossible odds.

A further example would be that of Fawn. Ezriel told me her story and I never found out if it was real or an invention of his, intended to demonstrate a point. Fawn argued that she was really dead. In an effort to prove her wrong, her psychiatrist asked her if dead people could bleed. "Of course not" was her answer. Thereupon he pricked her finger with a pin. When a drop of blood appeared she was surprised, but surprised her physician even more by saying, "What do you know! Dead people do bleed." When confronted by reality, she preferred to look at it from a new perspective, abandon statistically proven reality in order to preserve her delusion.

Another example, to which I testified in court, was that of Gordon, an elderly man who accused his

uncle of bewitching him. On one occasion he could no longer tolerate this situation, seized a heavy tool and killed his uncle by clubbing him to death. At first glance it would appear that “no uncle, no delusion.” It was, however, not long before Gordon started accusing his uncle’s children of having inherited their father’s witchcraft, and it was now they who were bewitching him. He had found a way of preserving his delusion by resorting to displacement.

As mentioned above, I have chosen these examples to illustrate the ways deluded patients resort to in order to keep their delusions in spite of ostensibly impossible odds. One highly intelligent schizophrenic patient said while in remission: “It’s amazing, Doctor, how, while I was schizophrenic, everything that happened in reality used to adapt itself to my madness.” He spontaneously used the words “schizophrenic” and “madness.”

I would now like to describe two patients who were unable to upkeep their delusions against the onslaught of reason or reality.

Professor Hugo was a prominent mathematician and nuclear physicist who was in the hospital because he felt to be under surveillance because of having allegedly betrayed vital security secrets. He felt himself constantly being watched and followed and used his extraordinarily developed dexterity in statistics to prove that remarks that he felt to be referring to him were far more in number than warranted by chance. Much later it could be discovered that both he and his superior had secret love affairs, and each of them feared the other one to betray the secret. This situation might have triggered the delusion in the first place, or at least contributed to its content.

After he had been hospitalized, he relinquished the idea that he was being persecuted because of alleged treason. Now he was being followed in order for his entire biography to be recorded for a comprehensive scientific psychological study. He claimed that the conspiracy, which despite having changed its overt content was still very bothersome, had now become universal. Everybody, including myself, his psychiatrist, was involved. The pen I was using to write down his history was nothing but a converted microphone, etc. He still made ample use of his highly developed intellectual faculties to prove his delusions statistically, he was completely lucid, his arguments made sense, there were no disturbances to be discovered in his thought processes and the only pathology to be detected was the existence of delusion.

In an attempt to re-establish reality testing I addressed him and said: "You are an experienced mathematician and nuclear physicist. You know how difficult it is to secure grants for pure scientific research. How can you explain the way such a cosmic network of detection and recording, in which, as you claim, virtually everybody you come in contact with, including myself, is involved, could be financed?" This question was such that his intellect could not provide him with an immediate rational answer. The result of this unfortunate intervention was an acute schizophrenic breakdown, complete with bizarre associations, blocking, suicidal attempts etc.

He was treated with anti-psychotic drugs and could finally be discharged, but he never regained his intellectual sharpness, or his scientific enthusiasm. In other words, he became a chronic schizophrenic with a post-psychotic defect. I met

him again several years later in court, where I was summoned to testify in divorce proceedings that his wife had instigated. He looked dull, his face expressionless, his thought process disturbed; he could not be differentiated from a “burnt out” schizophrenic. I, however, had learned an important lesson. All this had happened before I had real understanding of the dynamic significance of delusions and also before my experience with Jane, in which I also directly challenged a delusion.

The fact that Jane did not immediately develop a full-blown schizophrenic breakdown I will have to attribute to beginner’s luck, also to the fact that the challenge was almost immediately followed by an interpretation, incomplete as it was. In any case, the lesson I learned was never again to openly challenge a delusion. The result might either be a refutation in one way or another of the attempt, as exemplified by Fawn, or an attempt by the patient to upkeep his delusion in secret. In the worst case, like that of Professor Hugo, the result might be a schizophrenic breakdown with all its ingredients, sometimes even suicide.

If I needed further proof that the destruction of a delusion, unless it was done by a complete interpretation, might result in a schizophrenic breakdown, Igor provided such proof. In his case it was not the delusion itself that was directly destroyed. It was indirectly destroyed by the destruction of the means of up-keeping it. The results, however, were the same as those in the case of Professor Hugo. In this case, the result was a gradual development of a schizophrenic breakdown, finally leading to suicide attempts and a typical post-psychotic defect.

Igor was a thirty-five year old private detective who incessantly accused his wife of having an affair with another man. Like Professor Hugo he also made use of his faculties, used his training as a detective to observe and interpreted small gestures of his wife's, such as sneezes, scratching of an ear etc. as invitations for assignations with her imaginary lover. Beside the existence of this delusion, which he made no effort to hide, he was completely lucid. From evidence gathered later from neighbors and acquaintances he appeared to be a reasonably decent, honest and intelligent man, who showed no sign of any manifest psychological disturbance, always spoke coherently and to the point.

He constantly pestered his wife for the fifteen years of their stormy life together to finally admit her disloyalty and when she could not stand his insistence any longer she said, "OK. If you insist, and if this will finally shut you up, I will admit that I did have a relationship with X." This false confession of hers proved to be a fatal mistake. Igor developed a fit of rage, grabbed a knife and stabbed her to death.

I saw Igor in prison in order to give an expert opinion in court. When I examined him, he was no longer entirely lucid. His sentences were already blurred, his associations bizarre, blockings could be discerned in his thought process and he seemed to be listening to voices emanating from no-where.

Nevertheless, the following details could be gathered. He had no guilt feelings about having killed his wife, at least as far as I could determine. He said, on the contrary, that she was a slut and had it coming. At first sight, this seemed to be a classic "Othello Syndrome" (Todd & Bewhurst,

1955). Other admissions of his, however, almost blatantly pointed out that he was unconsciously in love with his wife's imaginary lover. He said, for instance, that at the peaks of his jealousy he could achieve an orgasm with his wife only when he could fantasize that it was her lover who was making love to her. This seemed to lead to the conclusion that in these situations he probably unconsciously identified with his wife and used her as a bridge between himself and his loved one.

Furthermore, he claimed to be sterile, that he had even had his semen examined to prove so. (No records of such an examination could be unearthed). Consequently, he said his son was not really his but his wife's lover's. He added that this "fact" made him love his son even more. This admission seemed to strengthen the assumption that he was really, unconsciously, homosexually in love with his wife's imaginary lover.

A similar, albeit not identical situation is described in Coleman's analysis of Tolstoy's *Kreutzer Sonata*. (Coleman, 1937). The protagonist in Tolstoy's novel, Pozdnishchikoff, is unconsciously in love with a violinist. He sets up a situation in which Pozdnishchikoff's wife and the violinist are left alone and upon coming back home from a train-ride in which he imagines his wife and the violinist in an intimate relationship, he is overcome with such extreme jealousy and rage that he stabs his wife to death. Coleman does not describe deterioration into psychosis nor suicide.

The situation in which a pathologically jealous spouse kills either himself or his spouse when he, or she, admit to having committed adultery is not a rare one. The admission by the faultlessly

accused spouse seems to overthrow a delicate balance in the ostensibly betrayed one, a balance that had existed between masculine and feminine identities and the disturbance of this delicate balance often results in violence.

A dynamic explanation of this constellation might be that as long as his wife's "infidelity" was only delusional, a delicate balance existed between Igor's masculine and feminine identities. As soon as his wife confessed the balance was tipped in favor of one aspect or the other. In this situation the person in question, being unable to tolerate his now unbalanced sexual identity, attempts to physically kill the aspect he cannot tolerate. He cannot, however, do so without at the same time physically killing the other aspect too. In other words, he is driven to suicide. His other option is to "kill the messenger," the one who had unbalanced the situation. Besides later attempting suicide, this is what happened in the case of Igor. In any case, Winnicott has already pointed out that murder is usually an externalized suicide.

Be that as it may, by killing his wife, by burning the bridge that had helped him to be unconsciously in sexual contact with his homosexual beloved, Igor made his delusion impossible.

The result was that the hitherto lucid, coherent, intelligent man now showed the first signs of a developing schizophrenia. When I heard of him several years later, he had committed several suicide attempts and could no longer be distinguished from a chronic schizophrenic. In this development of a full-blown schizophrenia after a delusion had become impossible to uphold, he resembled Professor Hugo.

Statement (1) at the beginning of this chapter can now tentatively be changed into the following: delusions are mental formations the duty of which is to withstand the onslaught of reason and reality testing. They have to fulfill this duty because if they fail, the result may be an intrapsychic catastrophe. Fortunately, most deluded patients are very agile in defending their delusions against frontal attacks by reality testing and by logic, at least to a reasonable degree. This results in the fact that internal catastrophes are much fewer than they would be if attempts to destroy delusions by mere confrontation with reality and logic were more frequently successful.

If we put this sentence into the framework of Ezriel's conceptualization, it will be found that delusions are a required relationship, the overthrow of which, unless accompanied by a complete interpretation, might lead to calamities such as psychotic disintegration or suicide that take the place of the invalidated delusional required relationships.

Despite the fact that my unfortunate intervention in the case of Professor Hugo cannot be regarded as an incomplete interpretation, it does serve to illustrate this point. An intervention that invalidated a required relationship, in this case a psychotic one, probably constructed by massive projection and loss of reality testing, resulted in the patient's need to fall back on more primitive, (more pathological) required relationships, based on fragmentation of the personality. In falling back on more primitive (more pathologic) required relationships the individual patient resembles the large group. When the latter is deprived of a more mature required relationship, such as dependency or, as described in Chapter Five, segregation, it

gives up coherence and also undergoes fragmentation, a required relationship equivalent to psychotic disintegration. This analogy can be carried further. Unless properly treated, as exemplified there, the large group might disintegrate entirely, a situation not far removed from being equivalent to an individual's suicide.

Kaplan, (1971) has demonstrated a dynamic relationship between depression and paranoia. In his case, a direct challenge of a depressive state unveiled definite paranoid traits. The evidence presented above seems to point in another direction. Direct challenge of a delusion, unless warded off, is liable to result in the development of intra-psychic fragmentation. Furthermore, as has been demonstrated in the cases of Professor Hugo and Igor, and will again be demonstrated in the case of Leonard below, this constellation constitutes serious danger of suicide.

I would now like to get to statement (2) at the head of this chapter, to the constructive role logic and reality testing can play in the resolution of a delusion. It seems most fruitful to start with the case of Jack.

Jack was a senior VIP. He was in the hospital for what at first glance seemed like a reactive depression following the death of one of his sons and a serious loss of prestige in his position. Because of his being a VIP, he was in a ward for internal diseases. His first delusion, which could be termed mood congruent, was that his wife, a very beautiful woman, would leave him because of his illness. All attempts to convince him of the opposite were in vain, including the question of whether he would leave her if she were the one to be sick. This was not quite a naive question as it might sound, because the thought of X leaving

oneself is frequently the projected opposite of the desire to leave X. Jack was quite open about this first delusion.

The second one was found out almost by accident. I was, at that time, working part-time, and an arrangement was set up in which I was to see Jack twice a week in the ward he was in and once a week in my private clinic. The first time he was expected in my clinic he did not show up and when I saw him next in the ward, he made some flimsy excuse. This cycle repeated itself several times. Finally, he did show up in my clinic. He opened the session by saying that had someone, especially his wife, annoyed him, he would not have been able to have come this time either. By this brief statement he already hinted that there existed a quantitative correlation between his coming (and not coming) to my private clinic on one hand and the intensity of his aggression on the other. Then he added, "I will now tell you the real reason for my not coming to your clinic. I suspected from the beginning that you were trying to lure me out of the general hospital in order to incarcerate me in a closed institute. This would mean the end of my career. I am so glad that I have been proved wrong by your behavior, so glad, in fact, that I might as well give up the silly idea of my wife wanting to leave me because of my illness."

Ostensibly, by giving up his delusion, he seemed to prove wrong everything said in the previous paragraphs about relinquishing a delusion. Reality proved a delusion to be wrong, and the patient did not develop a negative therapeutic reaction, but actually benefited from his delusion being proved unfounded. It constituted the turning point of his

recovery. He regained his energy, his joy of life, and no further delusions were detectable.

There were, however, three points in which Jack proving his delusion mistaken differed from the case of Professor Hugo and that of Igor.

The first point would be that Jack reality tested his delusion within the context of an already intensely established transference — countertransference relationship.

The second point would be that Jack reality tested his delusion voluntarily. This fact seemed to signify that some of his aggression that had been fueling his delusion had already been inadvertently metabolized in previous sessions.

The third and most important point would be that Jack reality testing of his delusion was immediately followed by a complete interpretation that integrated it into the framework of his object relations. I told him, not in these exact words, that he could not tolerate himself as an aggressive person. In order not to recognize his aggression in himself, he had resorted to projecting it into his objects, in the present context into me, thereby transforming me into a potential persecuting object. He had to do so for fear that if his aggression were recognized, everybody would forsake him forever. The fear of his wife leaving him because of his illness could now be recognized not as a separate, mood congruent delusion, but as one of the components of the calamity of the same complex. In order not to miss the introduction of the “Here and Now” into the interpretations, I put myself among the objects that would forsake him.

This interpretation did not come out of the blue, nor was it based merely on his brief remark at the

beginning of the session just presented, although I did use the latter in constructing the interpretation. During the preceding sessions I had already realized that he had stored a great deal of aggression inside himself, and that the loss of prestige in his position had merely intensified this aggression. Description of the roots of this aggression at this point would be unnecessary and lead us, as in the case of Emily, too far afield.

By his indication that a correlation might exist between the intensity of his aggression and his delusion, Jack presented me an opportunity to interpret his delusion at the level of his object relations. Thereby he more or less instigated the interpretation and put himself somewhere between statement (1) and statement (2) at the beginning of this chapter. In the following cases I intend to show that the real (and at the same time imaginary) fearful ideas hidden behind delusions can and should actively be divined by the therapist from the patient's ostensibly random material. Reality testing of these imaginary fearful ideas should then be carried out not at the level of the overt delusion but at the level of object relations, in the "Here and Now" of the transference, and the fearful calamitous ideas should be refuted at that level. Jane and Arnold have already been described in detail in Chapter Six. I mention them briefly again here, especially Jane, in order to highlight again the relatively disappointing results even a "correct" and ostensibly complete interpretation can achieve in deluded patients, when reality testing does not take place in the "Here and Now" of the transference.

I briefly mentioned Kid in Chapter Two as an example of an initial spontaneous negative

therapeutic reaction. Here are some of the details of his therapy, which lasted for about fifteen years.

Kid had just finished his medical studies and was working in rotating internship. In one of the wards he started hearing the nurses making mocking remarks about his masculinity behind his back. He also felt, and this made him even angrier, that the chief resident of the ward he was working in had “shown him his back.” I was never, during his whole therapy, able to find out the exact meaning of the phrase “to show one’s back.” Evidently it had a very derogatory meaning in the language of the country he had immigrated from, something like “not taking one seriously” or “forsaking one.”

Upon being hospitalized he was treated with anti-psychotics until his symptoms subsided. Then I decided to take him on for dynamic psychotherapy. At first I took him on *pro bono* as a fellow physician. Later he insisted on paying me because he felt that I would not take such a therapy seriously. I also remember that while he was still in hospital, I fought for him in staff meetings, in which it was suggested that he sell his car, at that time a status symbol, in order for him to be able to support his family. I did so because I knew from my own experience that in the circumstances the country was in at those times, he would never be able to afford another car, and this would further lower his self esteem. I also provided him with a temporary job as an assistant male nurse in a medical ward.

When I saw him for the third time privately, after he had been discharged from the hospital, he was still heavily sedated. Nevertheless, he told me that his delusions had flared up again. He expressed this in the following words, “I lie in bed as if I were all alone, unable to sleep, tossing from side to

side, constantly thinking of that chief resident who had shown me his back. I feel my anger towards him growing more and more and can hardly check my impulse to go up to him and murder him." I interpreted that he was probably furious with me for forsaking between our sessions. That he had to separate his feelings of loneliness and his anger from each other and displace the latter onto the chief resident. I added that he had to do so because he was probably afraid that if I found out about the intensity of this murderous rage at me for forsaking him, even temporarily, I would "show him my back." For the sake of the interpretation I translated this phrase to mean that I would forsake him forever. His response was one of the most valuable compliments I ever received from a patient and I cherish it to this day. He said one sentence, "You are the only person in the world who welcomes my aggression." The issue of his chief resident was never mentioned again, nor was Kid ever deluded again.

The technique of the interpretations I used in this case as well as in that of Jack was a three level one. In the case of Kid, or as I prefer to call him, Dr. Kid, it contained the following three relationships, (1) Required relationship: "I hate him," (2) Avoided relationship: "I feel temporarily forsaken by you and harbor murderous fantasies about you," (3) Calamity: "I am afraid to acknowledge these murderous fantasies **because** if you found out about them, you would forsake me forever."

Dr. Kid gradually (and fearfully) reduced his drug treatment, and for the last twelve or so years we were in therapeutic contact, he no longer needed it. As mentioned, this therapy lasted for close to fifteen years. It had its ups and downs. One

interpretation I remember to have missed was the following: Dr. Kid told me that he was afraid to give injections for fear of carelessly piercing the skin. Retrospectively I believe that I ought to have interpreted that this fear of his was a transformation of his fear that I might carelessly pierce his defenses.

Sometimes his sessions were so boring that I felt like shortening them. He reacted by becoming tense, and I had both to interpret his tension to be a result of this attitude of mine and return to giving him full sessions. At a certain point he acquired a paramour and cheated on his wife. By that time he had moved out of the city into a peripheral town, and could not wait for our sessions to end because he would meet his lover in the city after the sessions. This behavior of his also increased his tension. I had to interpret that he was afraid that I might be offended by the fact that he had found an object more important for him than me, even if only temporarily so. At another point he bought a new house, but could tell me about it only much later, for fear that I might envy him and sabotage his therapy.

The extra-marital affair, which lasted for about two years, deserves to be mentioned in some detail, primarily because it did wonders to his belief in his masculinity and improved his potency to a degree I never could achieve. He used to mock me about my relative inability to help him in that area and say that by the time I cured his potency, he would be too old to benefit from it.

Two further points concerning his infidelity are worth mentioning. One point would be that he used to sleep with his lover on those occasions they did not meet after our sessions in a very peculiar way. He did so in such a way that his

wife, as well as his neighbors, was almost bound to find out about it. This had at least two implications. The first one was very close to being conscious. He had to proclaim his masculinity for the whole world to see, so that there would be no more doubt about it, thereby undoing once and for all his own doubts, as they had appeared in his delusion.

The other point was that he behaved towards his wife in conducting his extramarital affair in this peculiar way, leaving semi-obvious signs, sleeping with his paramour, in a manner of speaking, under his wife's very nose. I found this to be theoretically significant, because he acted in a way exactly parallel to the way we are used to hear pathologically jealous spouses to speak about their ostensibly unfaithful spouses: "She/he does it under my very nose, the moment I turn my back. He/she does so in order to spite me." Dr. Kid did just that. Freud at his time defined a neurosis as the negative of a perversion. Dr. Kid acted out his "perversion" as a negative of a delusional jealousy.

In the fifteen years we kept in contact he fathered two children and was a devoted, but not overprotective father. He accomplished two specialties, passed two board examinations, each time at his first attempt (a rather rare occurrence in Israeli board examinations) and is now Consultant of a ward of his own.

It is perhaps also significant that during our acquaintanceship I learned very little about his childhood. The only facts I knew for sure were that his father was "no good" and that his mother had sabotaged his masculinity by not allowing him to date girls according to his choice.

Two last points concerning this case. One would be to mention again that he developed a typical initial spontaneous negative therapeutic reaction. In his case it was based on the certainty that any object he tried to approach would eventually leave him forever, because it could not tolerate his rage when left alone even momentarily. The second point is that I was able to watch a delusion being formed under my very eyes, *in statu nascendi*, and therefore relatively easy to decipher.

I now feel entitled to change statement (2), stated at the beginning of this chapter. Reality testing in the “Here and Now” of the transference of the causal relationship between the avoided relationship and the calamity, even when the avoided relationship is defended against by delusional required relationships, can bring about the resolution of these delusional required relationships.

In other words, I have attempted to demonstrate that when certain particularly dangerous avoided relationships have to be avoided at all cost, patients have to resort to delusional required relationships. This was demonstrated in the case of Jane, and in the cases of Arnold, Igor, Jack and Dr. Kid. If, however, the avoided relationships can be divined and liberated from their concomitant calamities, patients can abandon their delusions.

I have elected the next case, that of Leonard in order to reiterate the mortal danger inherent in an incomplete interpretation in a psychotic patient, unless there is an opportunity to complete the interpretation at the first opportunity. I mentioned Leonard briefly in Chapter Two as an example for a negative therapeutic reaction. Here are the details.

Leonard had immigrated from behind the Iron Curtain several years before. The episode to be described in the following paragraphs occurred during his second stay in the hospital. The first one had been because he felt he was stared at, spoken about behind his back and a general feeling of being persecuted. He was treated by drug treatment and was discharged as "partly improved." During his second stay in the hospital, several months after his first discharge, he was in a similar state. He gradually became more and more agitated, included staff-members among his persecutors, accused them of staring at him, aping his movements in order to mock him, etc.

Beside his anger, which became quite apparent, he also expressed suicidal ideation. All this time he was fully lucid, coherent, in control of his activities, attempting to hold his aggression against his surrounding persecutors and against himself in check.

One day he suddenly attacked and severely beat up a young, pretty, provocative female hebephrenic patient, who used to interfere in everybody else's activities. Acting as chief resident, I was sent to investigate. As this was also supposed to be a teaching experience, I was accompanied by a young female resident, who happened to be wearing a black scarf. When I attempted to explore the reason Leonard had beaten up this particular girl, he immediately, emphatically and convincingly ruled out sexual provocation as a motivation for his attack. All he could come up with was that she had been "just too much," without being able to define his meaning. Then he became suspicious of me and accused me of having brought the young intern on purpose, in order to remind him of his mother,

who, like the intern, used to wear a black scarf. I made use of his bringing his mother into the session in this roundabout way and further explored his relationship with her. This exploration revealed that he had lived most of his life in the shadow of a highly overprotective mother, who constantly interfered in all his decisions and stifled all his attempts to assert himself.

At this point I suggested that perhaps his mother, especially her internalized figure was “too much.” I added that I thought that his attack on the girl was really aimed at his mother, and that his suicidal ideation was linked to an attempt to get rid of this figure and destroy it inside.

Now Leonard covered his face, which expressed very intense emotions. I understood this to mean that my interpretation had been “too much” for him and suggested a break in order to continue the session on the following day. Leonard seemed somewhat relieved, but after several hours he experienced what he later described as a terrible blow inside his head, a blow he attributed to some poison I had instructed my agents to introduce into his lunch. He felt a sudden increase in his suicidal ideas, he could hardly control them now, and accused me of having induced these ideas in him on purpose in order to make him kill himself and thus rid myself of him. His accusations were very furious indeed and into this flow of accusations, which took place in a meeting which I set up on the following day, he also added that he could not help but wish me to feel the suicidal feelings he had felt all that afternoon, “even for a few moments.”

I suggested that it might perhaps not been the poison I had instructed my agents to introduce in

his lunch that had made him feel the internal blow and increased his suicidal thinking to an almost unbearable intensity. Then I asked him if it might have been the deeper sinking in of the real meaning of what we had discussed the previous day, i.e. the link I had established between his attack on the girl and an attack on his mother. To this he answered that his mother had always been sacred to him, that even the thought of an attack against her was punishable by death.

Now I was finally in a position to clarify the link between my (incomplete) interpretation that had uncovered some of the denied aggression against his mother and the increase of the intensity of his suicidal urges. I was also able to make him understand the reason for his accusation, that it had been I who had induced the increase of the intensity of these ideas in him. After all, it had been I who had put his sacred mother within the range of his aggression and thus exposed him to the danger of being executed by his superego. The omission in the previous session of spelling out and thereby dispelling the causal relation between "aggression against mother" and "death by execution by the superego" had nearly cost Leonard his life.

When I had finished speaking his expression revealed that he could hardly believe his ears. "All this is entirely new to me," he said, adding, "Is there then nothing sacred in the world?" I said that I did not know about that, but I did know that even the most pious sometimes gravely protested against the Lord when they felt He had done them an injustice. Now Leonard burst into tears, the first time, he confessed, he had done so in years, then he raised a smiling face and his delusions were gone. The only explanation he could offer was

that he now found it possible to believe again in people and especially in me.

I was, however, not yet satisfied as I still missed the “Here and Now” of the transference. The material supplied so far was sufficient for the construction of such an interpretation, but the patient offered me a perfect opportunity for formulating it. After he had finished talking, he turned to me again and asked me if I were angry with him. I resisted the first thought that came to my mind to say that I was not, that I had no reason for being angry with him. I said instead: “A few minutes ago you were so angry with me that you implied that you wished me dead, preferably by suicide. As you see, nothing has happened to me. So why should you be afraid of me even if I were angry with you?” Thereby I finally cut the imaginary causal connection between murderous anger with object, including death wishes, death of object as a result of death wishes and execution of subject by superego. Or so I thought.

The next day he was a changed man. Smiling, joking, trusting, communicative to a degree he was suspected to have become hypomanic. This, however, was not the case. He simply felt immensely relieved, “reborn” as he later described it.

In this reaction he resembled Jack who could also be described as euphoric following the relief that had been given to him by reality testing of his delusion, followed by a complete interpretation. But in neither of these two cases could signs of their becoming hypomanic be detected. There was no loss of judgment, no extreme expense of money, no sexual extravagance, merely an immense joy at being alive and free of the feeling of being persecuted. Not only did Leonard not

become hypomanic, nor undergo any other type of deterioration of his personality, at least not immediately. In contrast to patients who receive drug treatment exclusively, he was now able to use some positive aspects of his personality, including his now detoxified aggression. Without losing his tactfulness, he now became more assertive towards his wife, a copy of his mother, lost a great deal of his general suspiciousness, developed new friendships and began fostering long forgotten dreams of an academic career.

Leonard was not alone in his feeling of exhilaration. I remember clearly telling my colleagues that I felt as though I had performed a miracle. I feel obliged to mention this feeling of having performed a miracle here, because it contributed towards a mistake that later almost cost this patient his life, and definitely contributed to his later becoming a chronic schizophrenic.

As he was now pronounced cured, he was discharged from the hospital to an ambulatory clinic in his hometown, where no psychotherapy was available. At first he requested that I treat him further as an outpatient, but the Consultant would not agree. I did not put up too much of a fight in support of Leonard's request, although retrospectively I think that I could and ought to have done so. At first I thought that my hesitation resulted from the fear of having to perform "miracle" after "miracle," something I felt I was not up to. Further introspection revealed, however, that at that time I was still under the influence of my analyst, who was an ardent Freudian and ridiculed any attempt to make sense of a schizophrenic patient's communication, referring to it as "gibberish." I now feel that I did not yet

have the courage to prove him wrong other than by dreaming of him clothed in medieval clothes.

In this way it came about that despite knowing that by having removed a delusion I had not cured a schizophrenic process, I did not persist in Leonard's therapy. The final result of my hesitation was that six months later he had to be hospitalized again, this time in a closed institute, after seriously having slashed his throat. Twelve years later I gave a series of lectures at that institute. I discovered that he was still there, a chronic schizophrenic in a chronic ward. I find it impossible to escape the thought that if I had stood my ground, exploited my initial success and made use of the trust he had in me, the result might have been different.

In later experience as a supervisor, I have met with this fear of being responsible for the restitution of a psychotic patient in many young therapists. (C.F. Example Eighteen, Chapter Nine, second part of this book, also Chapter Three, above). They are frequently the last to attribute any progress in their patients to their therapeutic contributions and have to be encouraged repeatedly to keep up their good work. Besides the fear of surpassing their own therapists, mentioned above, the feeling they seem to be transmitting, to paraphrase Searles, is: "Who, little me, is to rescue the damsel patient from the claws of the dragon schizophrenia?" This feeling is attributed to the impotence of words against the omnipotence of schizophrenia or to its opposite, the fear of the omnipotence of the therapist's own words. It can be exemplified by the fear that by saying the wrong word, the therapist might cause a negative therapeutic reaction, sometimes even to cause the patient to commit suicide. In both instances this

fear has to be fought against again and again by laying down the basic rules of human relations, of object relations and of psycho-dynamics. The therapist has to be reminded that nobody is infallible, that even the best-analyzed analysts sometimes lose their patients to psychosis or to suicide.

Be that as it may, I make it a rule, already mentioned, that no member of my staff undertakes the therapy of a seriously mentally ill patient unless he makes a long time commitment, as long as the patient needs the therapy, sometimes for decades and that no seriously mentally ill patient be treated unless the therapist undergoes continuous professional supervisory support. My therapy with Dr. Kid took place after those of Leonard and that of Mary, to be presented below, and fulfilled both conditions. I believe that the fulfillment of both conditions in that case contributed considerably to its final favorable outcome.

Notwithstanding the reservations mentioned above, I still feel entitled to combine statement (1) and statement (2), made at the opening of this chapter into a single meaningful one: "Delusions are mental formations intended to be resistant to reality testing and to logic and defended against them, because they serve as defenses against ostensibly intolerable imaginary dangerous object relations. These object relations that underlie the delusions, and not the delusions, as was so inappropriately done in the case of Professor Hugo, can be reality tested in the transference. This can and ought to be done actively by the therapist in order for the imaginary causal relationship the avoided relationships possess in the patients' minds with calamities to be

disqualified. If this can be achieved correctly, the delusions become expendable, they can be abandoned and replaced by the option of deploying the hitherto avoided relationships in accordance with external reality.”

Fried and Agassi (1976, and also personal communication by Fried, 1988), reviewed paranoid conditions and made several attempts to classify their thinking processes into logical systems *en vogue* in contemporary philosophy. The final conclusion they arrived at was that we still lack the mathematical tools that would enable us to translate delusions into common sense, logical statements. I believe that the clinical material presented hitherto above constitutes rather solid evidence that object relations theory constitute the very mathematical tools that enable us to translate delusions into logical statements, the tools that Fried and Agassi were looking for.

I would like to conclude this chapter with another clinical example. This case, that of Mary illustrates the one to one correlation that exists between object relations, as expressed in the transference on one hand and the formation, resolution and flare-up of delusions on the other hand. In order to do so convincingly I will have to describe this case in detail, despite the fact that it casts some shadow on my capacity to handle countertransference at that point of my development as a therapist.

Mary has been briefly mentioned in the previous chapter as an example for the gradual emancipation of the patient from his internalized therapist. She will be mentioned again briefly in Chapter Four of the second part of this book as a further example of the devastating effect that can be caused by the unexpected and unprepared-for

desertion of a patient by his/her therapist (in this case, my absence). This devastating effect appeared in her case even though my absence was beyond my control and she probably was not unaware of this, as it coincided with a national emergency.

Mary was a twenty year old member of a group I was running on an outpatient basis. Meetings took place once a week and the therapy was traditional group analysis. She had joined the group some time after it had been formed and from the start showed signs of being the weakest link, sometimes resorting to defenses that seemed to be on the border of psychosis. I was contemplating ways to remove her from the group and send her to individual therapy, but had not yet come around to this.

During a particular session, Mary misunderstood an interpretation that was meant to liberate a libidinal avoided relationship from its calamity and cheered up and encouraged by other group members stood up from her chair and sat in my lap. All I could do was to lift her gently and send her back to her chair. This happened to coincide with the end of that session. Despite the fact that the other group members had actually incited her to act, they used the following session to viciously attack her for what they called incest. I did my best to interpret the situation, to show the other group members that they had put their own incestuous conflicts into her, that they attacked her because they were afraid to attack me, an authority figure, to no avail; she still felt unprotected and only weakly accused me of having tempted and then forsaken her.

This session happened to be the last one before the sudden outbreak of the October war of 1973.

Without being given an opportunity to inform the group of the cancellation of the following meetings, I was called up and served for three months. When I was discharged I tried to re-assemble the group, all other members by telephone, Mary, whose phone number was unknown, by mail. On the very day the group was to re-assemble I was called up for another three months, again without being given the opportunity to inform the group of my absence and of the further cancellation of the group meetings.

When I returned, I was informed that Mary had desperately and repeatedly tried to contact me. She failed to establish contact and had been hospitalized in an acutely deluded state. When we finally met she told me that in my absence she had worked in a certain office. There she received several phone calls from a woman who would not identify herself and only said that she was calling from a firm called "Ampa." Such a firm does exist, and the phone calls were probably genuine. In Mary's mind, however, "Ampa" was translated to "Mafia" (the letters P and F are, in certain circumstances, interchangeable in Hebrew).

Now Mary was convinced that the office she worked in was a branch of the Mafia. The Mafia was trying to enlist her as a prostitute through the services of one of her co-workers who knew her address. Her punishment in case she refused to co-operate would sometimes be that she be killed, other times that everybody would abandon her and refuse her any aid. It soon transpired that she regarded me as the arch criminal, head of the Mafia. The mysterious woman who had called she identified with my wife and accomplice. At the same time she had become promiscuous, seducing

men at random without deriving any sexual satisfaction from having intercourse with them.

Looking back for a moment to what was said about her in the previous chapter about a patient being disappointed with his/her therapist, this was the first time Mary was disappointed in me, and she did indeed react by the development of a full blown psychosis.

It took three or four sessions to show her the associative dynamic connection between the content of her delusion and what had happened between us. I told her that by forsaking her in the specific circumstances described, I must have made her extremely furious with me. So much so that she must have had terribly aggressive ideas against me for having tempted her time and again, only to frustrate her repeatedly. I added that the letter in which I invited her to re-join the group, a letter that led to yet another frustration must have been the last straw. I associated this letter with her idea that the Mafia knew her address, the Mafia's attempts to enlist her services as a prostitute to her ambivalent sexual feelings towards me, etc. I mainly concentrated on her murderous rage against me. She was probably afraid to acknowledge this rage due to her fear that it would either kill the helping aspect of me together with the frustrating one, or that I would forsake her forever if I knew about it. I associated this with her delusional fear that the Mafia would either kill or forsake her. In order not to acknowledge this extreme fury in her she had to resort to projecting it into me, thereby turning me into the arch criminal.

To my surprise, Mary accepted these interpretations. She even admitted that before she had become overtly psychotic, while she was still a

group member, she used to think of me as a criminal whenever I said, did, or omitted something that frustrated and infuriated her more than she could tolerate. The interpretative work was much more detailed than can be told here, but the result was that she could abandon her delusion. She did this, however, not by suppressing it, but by attributing to it its proper delusional sense. Several months later, after she had heard a lecture about mental illness, this unsophisticated girl could say, "I know that I am still a very disturbed human being. I also know that I have been psychotic." (This was the very term she used) "But I know now the difference between fantasy and reality."

The nullification of her fear of the calamities via the reality testing the interpretations offered to her now enabled her to expose her extremely aggressive fantasies about my personality, my potency, my intelligence and my sexual partners. Her promiscuity could be understood as an attempt of hers to even the score between us: I, in my private life, and especially in the group, handed out my love indiscriminately, like a prostitute. She had to behave in the same way to assuage her anger. Some of the more prominent fantasies this young, innocent looking, pretty and constantly smiling girl gradually disclosed were the following: Killing me, either by poisoning me directly or by hiring Mafia members to do the job for her. Several variations on the theme of emasculating me and of homosexual seduction of my spouse, either in order for me to come begging on my knees for her return or for appropriation of her genitals for her own use.

Another fantasy, at that time probably still with the attributes of a delusion, was that her vagina

was full with a corrosive acid. At the same time she used to come to our sessions dressed very provocatively, wearing semi-transparent T-shirts, which hardly hid her breasts. I interpreted that she was attempting to confuse my cognitive processes, distract my attention by showing me her breasts, so that I would not be concentrated enough to formulate interpretations. If these interpretations that constituted some aspects of me were not nullified by my being distracted, they would penetrate her through her vagina, where they were to be destroyed by the corrosive acid because they were still perceived as potentially hurtful. Consequently, the corrosive acid disappeared from her vagina. Until these fantasies were rendered safe by appropriate interpretations that ensured her that the very fact that she was harboring them did not make her unacceptable, the only way she could defend herself against them was by disavowing and projecting them. Descriptions of the origins of these fantasies in her deprived childhood will lead us again too far afield.

This phase of her therapy lasted for over a year, the last months of it on an outpatient basis. She still had to contend with extremely intense aggressive and sexual fantasies, but was no more deluded. In fact, when some corruption was discovered at the office she was working in, she could joke and say, "Who knows? Maybe I was right about the existence of the Mafia there."

During this period I took several vacations, but none of them had any serious effect on Mary's condition beyond that to be expected in any patient whose therapist goes on vacation.

After about one year I took a further vacation. At that time I was rather irritated for reasons that had nothing to do with Mary. Like any patient with

paranoid traits, she knew everything there was to know about me, including my private phone number. When, however, she called me concerning some minor complaint while I was in that specific mood, I was impatient with her and summarily referred her to the doctor on duty in the ward.

When I returned to work a fortnight later, I found Mary in hospital again. The Mafia was after her once more, it had infiltrated the ward and I had become the arch criminal once more. All the insight that had been gained in a whole year's work had evaporated. This time she was much more adamant in her psychotic defenses and it took many weeks of hard interpretative work before things started to clear up again. Much later it transpired that she had to be so obstinate in her defenses for fear of being tempted to trust me, only to be disappointed yet again. This occasion constituted the second time she was disappointed in me, and as it occurred fairly early in her therapy, she reacted again by developing another full-blown psychosis.

But even while she was still deluded she stated openly, "It was you, with your behavior on the telephone, who put the Mafia back into my head." The issue of partial insight is beside the point here, but the correlation between our mutual relationship and the flare-up of the delusion seems to have been established in this statement of hers beyond reasonable doubt.

At this point I have to call Searles as witness for my defense. Searles (1965) stated that in the therapy, especially of deeply disturbed patients, therapists find it easier to deal countertransferenceally with their patient's hate than with their love. I mention this here as a partial excuse for the unfortunate mistake of mine

that finally put an end to the therapy of Mary that up to that particular point seemed to be a rather promising therapy of a schizophrenic patient.

This incident was again connected with my coming back from a vacation. The vacation passed uneventfully, but upon my return from it Mary greeted me with an affectionate kiss on my cheek. Looking at it retrospectively, this kiss had no sexual overtones, expressed sheer happiness of meeting me again and an appropriate response would have been: "I am glad to see you, too" or something to that effect. I was, however, so taken by surprise, so threatened by her open admission of her affection, that I automatically made use of the interpretation I had used previously. I said that she was probably using her sexuality again in order to confuse me.

This blunt rejection of Mary's love was more she than could take. Without becoming deluded again, she refused all further contact with me, and my efforts to re-establish the therapeutic relationship were in vain. It does seem that in order to acknowledge the love of a schizophrenic patient without rejecting it in such a traumatic manner, more professional maturity was needed than I had at my command at that time. (Springmann, 1986). Mary, however, had by now acquired sufficient maturity not to need to resort to psychotic required relationships. It seems that the interpretations she had received so far had done sufficient intra-psychic repair that she could now tolerate her therapist not to be faultless, and yet retain her sanity, at least for the foreseeable future. To come back to what has been said about her in the previous chapter, she was now emancipated from the physical proximity and availability of an unblemished therapist.

Despite this unhappy ending, I still feel justified in presenting this case. I do so in order for it to serve as an example for the direct, one to one correlation between the development and the regression of object relations in the transference and the development of delusions and their resolution. This situation can be equivalent to the condition in the theory of heat. Thermodynamics enables us to translate the measurement of heat from degrees into units of wavelength and frequency. Psychodynamics enables us to translate delusion, and for that matter dreams, into logic statements that “make sense.”

On the Affinity between Schizophrenia and Violent Death

In some cases a thorough history can turn the initial interviews of a schizophrenic patient into dynamic diagnostic interviews that have the same beneficial qualities ascribed to this type of interview in Chapter Four.

Paula was in the hospital in an acute paranoid state in the United States, where she had been studying for her Ph.D. In certain circumstances she began suspecting her superior of constantly watching her with an erotic purpose: "He put my instruments in such a place that he could constantly watch me. It was like a spider spinning its web." She kept on telling how she had talked to her superior about music, saying that Mozart was her favorite composer and that Don Giovanni was the best opera ever written. She had innocently meant the beautiful music, he, however, understood the erotic connotation of Don Giovanni's personality. When the superior invited her husband and herself to go swimming in his private pool, she became indignant: "If he had invited me straight forward to go to bed with him; of course I would have refused, but to do it in such an insidious way! This was simply ugly."

When she was transferred home, she could admit that the superior's wife had attracted her prior to the inceptions of her delusions, and it seemed that she had been using at least two defense mechanisms: displacement and projection. As mentioned previously, the reason for my using the term projection rather than projective identification will become clearer in the chapter on

therapist-induced-countertransference, in Part Two. She was treated with chloramphenicol, and her thought process, which had been disrupted, became coherent.

At this point, about a week after she had been hospitalized, a full history could be obtained. She related that she was a second child, born after a boy who had died when he was four years old and she was two. After the boy's death she was constantly compared to him to her disadvantage, and began hating the fact that she had been born a girl. Furthermore, she thought that it would have been preferable if she had died in his stead.

Despite her parents' objections, she insisted on wearing her brother's clothes and assumed a male, protective attitude towards a younger sister who was born after her. She continued her story saying that her father used to tell her she should live her life as if she were constantly being observed, "You must live your life as if you were in an aquarium and behave accordingly." She was left-handed, but her father made her write with her right hand, "I am a bad girl, I am ugly and stupid," etc.

As she was telling this she said: "I always knew these were bad things to do to a girl, but it was only cognitive knowledge. Now I can feel the wrong he did to me. It is extremely painful for me to tell you all this, but at the same time it is like a self analysis, and I can feel the relief." She also said that she could now understand the connection between "living in an aquarium" and that part of her delusion in which she was constantly being observed.

A few days later she could be discharged. The last words she said before being discharged were, "All

my life I was compared to my elder brother to my disadvantage, both when he was alive and even more so after he died. This left me no choice but to attempt to be him.”

When looked at closely, it may be observed that she had practically constructed her own three level interpretation except for the causal relationship between the avoided relationship and the calamity, even though the latter could already be surmised. In an order somewhat different than stated above, this interpretation could be reconstructed thus:

Avoided relationship: "I want to be myself, a girl"

Required relationship: "I must be my brother because otherwise..."

Calamity (surmised): "I will feel excruciating guilt feelings for having killed him by my envy. I might even contemplate suicide." This surmise was later verified in her second stay in the hospital.

She was re-hospitalized a second time after about two years. During these two years she had functioned well as a teacher in her profession, had become pregnant, lost her child and reacted normally with grief

When hospitalized this time she told that she had started to feel extremely tense, that everything had become different and that she had a general feeling of being persecuted without being able to identify a specific persecutor.

Then she continued saying that it had been a holiday, like Halloween, in which all disguise themselves. She was very concerned with the children's happiness, and for herself she chose a particularly "funny" disguise: She disguised herself as a witch riding on a broom, and in order

to be even funnier, she put a death mask on her face.

She did not immediately recognize the significance of her behavior, when, however, it was explained to her she understood that she had once more disguised herself as her dead brother and identified with him: The broom was a phallic symbol and the death-mask a symbol of death. She understood immediately and the symptoms subsided. She could be discharged again, cured once more for the time being.

Besides having this curing effect, this sequence of events also constituted the verification of the calamity, which, in her previous hospitalization could only be surmised. As can be seen in the next paragraph, this calamity consisted of the fantasy that in order to be appreciated, she had to be her dead brother, i.e. to die.

At the end of this hospitalization she said, "I do perfectly innocent ordinary normal everyday deeds, and then the past grabs me, everything turns upside down and I want to kill myself."

Unfortunately I met Paula very early in my career as a psychiatrist. The structure of the (complete) interpretation could only be reconstructed retrospectively, and no real therapeutic action was undertaken.

About two years later she was hospitalized for a third time. I do not know the exact circumstances of her third hospitalization, as by then I was working elsewhere. I was told that in the emergency room a psychiatrist who happened to have the same surname as her own examined her. When he introduced himself, she thought that he was mocking her, and slapped him. As a result she was sent to a closed hospital without the

examiner attempting to find the reason for her behavior. Her fate later on is unknown to me, but it can be surmised that the prognosis in these circumstances was gloomy.

Nevertheless, as stated at the beginning of this chapter, it seems that in certain cases the opportunity of receiving a good history can have at least a temporary curing effect even in schizophrenic patients.

Freud has convinced the world that neuroses are a substitute for perversions. Contemplating all that has been written in the pages of the present work, I cannot help but wonder if at least in some cases schizophrenia is not a substitute for death, albeit not always an effective one. Sometimes death might be spiritual. In this context drug treatment, especially of the new generation is indispensable. In others, it might be physical, either by suicide or by murder. It has, however, already been mentioned that it was Winnicott who claimed that these latter entities were but two faces of the same coin.

The notion about an affinity between schizophrenia and violent death in its various forms is not based on the case of Paula alone. Several patients come to mind in this context.

Adam had committed several suicide attempts prior to, as well as during the stay in the hospital described in Chapter One. His "Deadly force" is another manifestation of the affinity between schizophrenia and death and his saying, "You have given me back the will to live," is in concordance with his death wish and with his guilt feelings, which probably existed from early childhood.

Moses: "What is it with you, Doctor, do you want me to commit suicide?" points in the same direction (Chapter Two).

Arnold committed a serious suicide attempt some time after his therapy had to be terminated in the circumstances described in Chapter Six.

Gordon murdered his uncle under the influence of his delusions (Chapter Eight).

Professor Hugo attempted suicide when he was unable to defend his delusions against the onslaught of reason (Chapter Eight).

Igor murdered his wife and later attempted suicide when reality no longer allowed the up keeping of his delusion (Chapter Eight).

Dr. Kids spontaneous negative therapeutic reaction concerned murderous intentions, an expression of his rage (Chapter Eight).

Leonard cut his throat about six months after his therapy was terminated in the circumstances described there (Chapter Eight).

Mary contemplated various versions of murdering me, her therapist (Chapter Eight).

All this seems to point towards a close relation between schizophrenia and violent death.

In six of these patients the origin of the tendency towards violent death in its various forms could be recognized.

Adam felt guilty because he thought that his premonitions were the cause of disastrous consequences.

In the case of Gordon, it can be surmised that the feeling of being bewitched by his uncle was a

transmutation, probably based on projection of intense aggression.

Igor, if we are to follow the theoretical assumption presented in Chapter Eight, wanted to get rid of an aspect of his personality, male or female. Killing his wife and his later suicide attempts were ways to achieve this result.

Dr. Kid had to revert to a psychotic required relationship that concerned murder because he could not tolerate the notion of being deserted by his object.

Leonard instigated his suicide attempt in order to get rid of a persecuting internal mother.

Mary harbored murderous fantasies against me for reasons similar to those of Dr. Kid, namely of being abandoned.

Paula wanted to die so that her beloved and envied brother would live. Envy and guilt feelings must have played an important role in this case like those of Adam.

The remaining two cases were not submitted to deeper examination and the reason for their affinity to death is unknown.

These are but the immediate reasons for these patients committing their acts, be they murder or suicide. The deeper reasons are beyond the scope of this book.

PART TWO

“EX-PARTE”

Reflections on Countertransference
and Supervision

Introduction

The amount of literature written about countertransference in recent decades is virtually insurmountable. Prominent authors have concentrated their efforts on illumination of its vicissitudes in various personality configurations. Winnicott (1947, 1960, 1969), Searles (1965, 1979), Sandler et.al, (1973), Racker (1974), Kernberg (1975, 1984), Blank & Blank (1974), Bollas, (1987) and more recently Giovacchini (1989), and McDougall, (1990). These are but a few of the leading theorists and practitioners who have dedicated important portions of their writings to furthering the understanding of countertransferential processes. They explored their diagnostic significance and possible applicability in various psychoanalytically oriented treatment modalities. Langs (1976), Epstein & Feiner (1979) Wollstein (1988), and again, more recently, Young, (1994) and Michels et al (2002) have attempted to assemble comprehensive and/or representative collections of articles on the topic.

If I dare believe to be justified in adding yet another work to those mentioned, this is because my experience as a therapist, and especially as a supervisor, has convinced me that a certain unclarity regarding countertransference still exists despite all the efforts invested by the authors just mentioned. This unclarity becomes apparent whenever psychoanalysis, or for that matter psychoanalytically oriented psychotherapy, is to be practiced, taught or supervised in the field. When countertransferential processes have to be analyzed in these circumstances in order to be

properly applied, exact definitions become elusive. The boundaries between those aspects of countertransference that are to be legitimately admitted into the therapeutic interaction and those that ought to be dealt with by the therapist outside, become blurred.

The purpose of Chapter One in the second part of this book is to attempt to identify the nature of this confusing ambiguity by tracing it to its sources. In Chapter Two I will attempt to demonstrate a possible connection with victimology. Chapter Three through Chapter Seven will utilize the information gained in Chapter Two in order to clarify the ambiguity and suggest a possible way of circumventing it. Chapter Eight onwards will be dedicated to the examination of the position of the supervisor from the point of view of the hopefully gained unambiguity.

Countertransference vs. Countertransference

Freud was aware of “countertransference” (Gegenuebertragung) since Breuer's analysis of Anna O. but officially announced it in his “Lectures on the future of psychoanalytic therapy” (1910). In this article Freud very precisely and unambiguously defined countertransference as “an emotional reaction induced in the analyst by the influence of the patient's transference.” He regarded it as an unequivocally undesirable phenomenon: “We are not far from the point in which we will have the right to demand that each physician (analyst) will recognize this countertransference in himself and will be obliged to overcome it.”

The term was explicitly mentioned again in Freud's “Observation on transference love.” (1915). Here Freud specifically warned against responding to the (female) patient falling in love with the (male) analyst. He wrote of the “battle the analyst had to wage” against internal forces that would seduce him to succumb to his patient's temptation and “tear him down from the analytic *niveau*.” At the same time he strongly advocated, as he had done previously, that analysts undergo thorough analysis in order to minimize, preferably eliminate, their non-resolved conflicts. Those he regarded as the shortcomings that would make the analyst vulnerable to their patients' transference influence, i.e. to their countertransference, as defined by him in 1910.

Freud published “Recommendations to the physician practicing psychoanalysis” in 1912. In

this article Freud dealt extensively with the analyst's internal processes and their possible (deleterious) effect on his therapeutic capacity. Quoting Stekel, he wrote of "therapeutic blind-spots" that prevented the analyst from consciously recognizing the correct significance of the material presented by the patient in his free associations, whenever this significance coincided with the analyst's own unresolved conflicts. Certain issues, he argued, would in this constellation be distorted and others would be missed entirely. His comparison of the ideal analysts to surgeons or projection-screens was intended to underline the need for the analysts to be entirely objective in their evaluation of the presented material. He demanded of them to be able to reflect it back to their patients free of distortions, with cool rational precision. Above all else, the analysts were to be emotionally immune to the patients' transferred feelings. Freud attributed deviation from this clear, non-involved objectivity to the analysts' unresolved, unconscious conflicts that should be eradicated as far as possible by the analyst being thoroughly analyzed. He dealt in this article extensively with the (deleterious) effect of the analysts' internal processes on their therapeutic capacities, just as he had done in the two previously mentioned articles. Nevertheless, the term countertransference was not mentioned in "Recommendations" despite the fact that it had been used previously in 1910 and would be used again in a similar context in 1915.

Freud regarded countertransference as "nothing but a source of trouble." The issue I would like to emphasize here is that in "Future prospects" and in "Observations on transference love," in both of which Freud explicitly mentioned the term countertransference, he attributed it to the

influence of the patient's transference on a possibly "not well enough analyzed analyst." In "Recommendations," on the other hand, in which countertransference was not mentioned as an entity, the analyst's shortcomings were attributed almost exclusively to his internal, non-resolved conflicts and the patients were hardly mentioned as a source of these distortions.

It seems then that Freud, without stating so explicitly, may have differentiated between two, in his opinion, undesirable processes that took place in the analyst during analytic treatment. One was a spontaneous process (or rather state) prompted by the analyst's own, unconscious unresolved conflicts. The other, also going on inside the analyst where it might be met by and interact with these same, unresolved conflicts was primarily the result of the impact of the patient's transference. Only the latter process was termed by Freud "countertransference." In this context one might speculate that the fact that Freud did not rigidly adhere to his admonition concerning the non-use of what he termed "countertransference" might have been a result of his intuitive distinction between these two processes. (Wollstein, 1988, p.2) Most of his students with the outstanding, controversial and short-lived exception of Ferenczi and Rank (1923) did adhere to this admonition to the letter, at least to the best of their ability.

Rank and Ferenczi overstepped the boundaries set by Freud because they believed that they were doing the right thing. According to Fiebert (1992) Jung succumbed to temptation and had an affair with Sabina Spielrein. At first Freud accepted Jung's version when the latter wrote to him that Spielrein's letter to Freud of 1909 was the product of a disturbed mind. When, however, Spielrein

visited Freud in 1912, Freud tended to believe her and this might have contributed to the rift that developed between Freud and Jung. It might also have prompted Freud to write his "Recommendations" and later his article on transference love.

Winnicott (1947), Berman (1949) and especially Heimann (1950) were among the first to openly, consistently and systematically challenge Freud's entirely negative view of countertransference. Winnicott's contributions in this field being, at least ostensibly, self-contradictory, will be discussed separately in Chapter Seven. Heimann's contribution, although also not free of ambiguities, I find easier to start this discussion with. Heimann stated that countertransference was more than "transference on part of the analyst" (The fact that this already constituted a deviation from Freud's original definition of the phenomenon, as discussed above, will be put aside for the time being).

Heimann's important contribution was made by her putting emphasis of the fact that psychoanalysis was, among other things, very much a relationship between two persons. It was to be distinguished from other relationships not by the assumption that one of the participants had feelings about the other, while the other one ought not to have them. The difference between this relationship and other ones was rather to what use these, in her opinion legitimately mutual feelings, were to be put. Elaborating on Freud's statement that the unconscious of the analyst understood that of the patient, she argued that this was possible only by the analyst paying close attention to the emotional and intellectual responses caused in him by the patient.

Here is an example of my own. Nancy, who has been described in greater detail in Part One, opened one of her earlier sessions saying, ostensibly out of context, that there was a semantic inconsistency in her life. Of course I did not understand what she meant and probably neither did she. Later on in the session she described how she had always felt unloved by her mother. Whether this was justified in reality or not seems to be irrelevant, as the main issue was her subjective feeling. Then I heard an internal voice, not unlike an auditory hallucination, calling to me "Beloved, beloved." The first thing that came to my mind was: This is the beginning of my schizophrenia, and not for the first time in my life. I had had such experiences of hearing, or mishearing internal voices before, especially after I had finished my clerkship in psychiatry.

After some deliberation it occurred to me that "Beloved," with a slightly different intonation was the verbatim translation of Nancy's name, something like the French Aime'e. Only then did it become clear that the semantic inconsistency in Nancy's life was the discrepancy between the literal meaning of her name and her subjective feeling of not being loved.

Heimann experienced repeatedly that her emotional responses were not always in accord with the manifest significance of the material presented to her. Whenever this happened, she maintained that it was to be regarded as an indication that important latent issues had not been properly dealt with. Far from regarding countertransference (implicitly defined by her in this particular context in accordance with Freud's original definition of the term) as a mere nuisance, she saw in it an important tool, to be used as a

valuable source of information, helpful in understanding deeper meanings in the communicated material. Heimann did not use the term “projective identification,” introduced at about the same time by Melanie Klein and her students. Nevertheless, she argued that certain countertransferecial manifestations were created in the analyst by the patient and as such constituted parts of the patient’s personality that had found expression in this particular way via the analyst’s feelings. Consequently, she advocated these aspects of countertransference to be included in the analysis.

Berman’s, and especially Heimann’s contribution to the understanding and technical analyzability of deeper personality disorders can hardly be overestimated. In the present context it cannot, however, be ignored that on the one hand Heimann commended countertransference as a valuable, indispensable tool, while on the other hand, she did not refrain from referring to countertransference as a possibly negative manifestation and kept warning against oversimplification of matters, such as ignoring Freud’s admonitions concerning its negative influence.

The important issue in the present context is to point out that Heimann explicitly used the same term, countertransference, to cover all the feelings an analyst might harbor about his patient, regardless of the origin of these feelings. All the analyst’s feelings towards his patient having been subsumed and referred to indiscriminately as countertransference, an ambiguity was created. “**Countertransference**,” the undesirable, obstructive residuum of the analyst’s non-resolved feelings, (“transference on part of the analyst”),

with which the patient was not to be burdened, now co-existed in the analyst as an intra-psychic phenomenon side by side with “**countertransference**,” the useful, important message, unconsciously transmitted by the patient, to be included in the analysis. This constituted a perplexing situation indeed, definitely conducive to confusion.

It has already been mentioned that Winnicott also used the term in an at least ostensibly self-contradictory manner, albeit he did so on two different occasions, separated by almost two decades. He referred to it as a useful source of information in one article (Winnicott 1947) and warned of its spoiling influence on the analyst’s professional attitude in another. (Winnicott, 1960). As mentioned, I will attempt to fit this contradictory attitude of Winnicott’s towards countertransference with the ideas to be presented here later on, hoping to show the contradiction to be merely apparent. At this point it seems appropriate to suggest that it would not be implausible to assume that by exclusively reserving the term “countertransference” for those of the analyst’s emotions that were aroused by the influence of the patient’s transference, Freud may have intended to prevent such a confusing ambiguity.

This ambiguity has by no means remained unnoticed. Kernberg, for instance (1984), writes: “Much apparent controversy regarding the management of countertransference derives from the different ways in which countertransference has been defined.” He suggested to describe and to define the various components of countertransference with the help of a model he had introduced previously, consisting of a

concentric configuration. In the center of this concentric model were the analyst's unconscious reactions to the patient's transference. This central area was in line with the original definition of the term by Freud, as mentioned above. At the same time, however, it allowed for the "blind-spots" in understanding the patient's material derived from the analyst's non-resolved conflicts, thereby overstepping Freud's original definition of the term. Two further external areas surrounded this central one. These consisted, respectively, of the analyst's total conscious and unconscious reactions to the patient, and the habitual specific reaction of any particular analyst to various types of patients.

It may be surmised that Kernberg was not entirely satisfied with the operative applicability of this model, as he writes several pages later on: "The analyst must also continuously separate out such projected material from his own **countertransference disposition (in the restricted sense)**" etc. (Highlighting mine, R.S). (For the significance of Kernberg's use of the term **Countertransference in the restricted sense** in this context C.F. Sandler et al, 1973, below). Kernberg seems to have implied by this statement that he felt that a clear-cut, discriminative, applicable terminology that might indicate a sharp demarcation between those aspects of countertransference that should be allowed into the treatment and those that should be excluded from it had not been achieved. The ambiguity that had followed Heimann's subsuming of all the analyst's feelings towards his patient under the one term, countertransference, was still to be found at the root of a great deal of un-clarity and confusion. It had apparently survived subsequent contributions to the concept.

This situation was perceived as rather awkward. Therefore it does not seem surprising that steps were taken to resolve it. This was attempted by declaring one or another aspect of the phenomenon under discussion to be termed countertransference “proper” and coining other terms for other aspects of the phenomenon. Winnicott, for one, explicitly moved to revert to the original formulation: “Would it not be better at this point to let the term counter-transference revert to its meaning of that which we hope to eliminate by selection and analysis and the training of analysts?” (Winnicott 1960). Parenthetically it should be remarked that “be restricted” would have been a more accurate choice of words than “revert.” This would be because if my assessment of Freud’s original meaning of the term “countertransference” is correct, i.e. “the feelings aroused in the analyst as a result of the impact of the patient’s transference” then Winnicott’s definition of the term as “what should be eliminated by selection and analysis and training” etc. was not identical with Freud’s definition of the term. In any case, this suggestion of Winnicott’s has evidently not been adopted, and if we are to judge by his later expressions in the same year, he seems to have abandoned his previous positive attitude towards the phenomenon. Tower (1956) expressed views that coincided with Winnicott’s ones in 1960, referring, like him to countertransference as “transference of the therapist - in the treatment situation - and nothing else.” Thereby she also diverted from Freud’s original definition of the term in the same way Winnicott was to do later. Racker, whose contribution to the usefulness of countertransference in analysis can hardly be over-valued, also equated Freud’s definition of

countertransference with transference on part of the therapist. Thereby he also diverted from the original definition of the term by Freud, just as did Tower and Winnicott. (Racker, 1953, p. 163.)

As recently as 1995 the Comprehensive Textbook of Psychiatry (Karasu, 1995) still adopted a similar, negative, one-sided view of countertransference, a view also not in line with Freud's original definition of the term. The new edition of this Textbook does recognize countertransference as a complex phenomenon that contains many aspects, contributed by both patient and analyst and maintains that these may be used therapeutically. Countertransference is put into the context of inter-subjectivity and Melanie Klein, projective identification and the more recent authors such as Ogden are mentioned as contributors to the understanding, analyzability and application of countertransference. The Textbook mentions neither Winnicott nor Heimann as the real pioneers in this new conceptualization of countertransference and does not provide the clinician with a clear-cut distinction between the useful and the deleterious aspects of the phenomenon, (Gabbard, 2000).

Attempts were made to differentiate between the two major components of countertransference in ways that would make them operationally applicable, without abandoning the term countertransference in either component. Sandler et al (1973), who are mentioned in the above mentioned Textbook, summarized the historical development of the analysts' attitude towards countertransference, and made such an attempt. They suggested the term "*countertransference in the restricted sense*" to refer to the specific emotional responses aroused in the analyst by the

specific qualities in his patient. This term was in line with Freud's original definition. It was the same one used by Kernberg in the context mentioned above, implying that it had not really solved the problem of the dilemma of correct differential applicability. Annie Reich's attempt to differentiate between "healthy" and "pathological" countertransference seems not to have been accepted into the vocabulary of psycho-dynamics as it is practiced and has consequently not solved the problem (1951). Winnicott's attempt (1947) to differentiate between "objective" and "subjective" countertransference was later to be abandoned by him. This becomes evident from his re-adoption, in 1960, of Freud's entirely negative attitude towards the phenomenon, without at the same time being exactly in line with Freud's definition of it, as just mentioned. Giovacchini's (1989) suggestion to differentiate between "idiosyncratic" and "homogenous" countertransference has not yet withstood the test of time. It seems, then, that an effective, comprehensive, differentially operational definition of countertransference is still lacking.

My own experience derives from having been confronted repeatedly by students and supervisees who presented me with difficulties in handling various treatment situations, sometimes in acute distress, in need of what could, perhaps, be called supervisory first aid. These difficulties frequently resulted from erroneous understanding and manipulation of transference — countertransference interactions that could be traced back, time and again, to the ambiguity and confusion concerning the various aspects of countertransference. This ambiguity impeded, in turn, the correct choice between those aspects of countertransference that should be used in the construction of therapeutic interactions and those

that ought to be avoided. Despite their apparent severity, (sometimes students – supervisees declared themselves unable or unwilling to carry on their therapeutic undertakings), these therapeutic crises could not infrequently be resolved with relative expediency. More often than not this could be achieved in one or two supervisory sessions, provided the countertransference entanglements could be dissected precisely into their contributing components. I will attempt to substantiate this point, among others, in the clinical examples presented in the following Chapters.

It is by now well established that Freud's hope that future analysts be immune to the complicating influence of their patients' transference was not to be fulfilled. When dealing, as most analysts are forced by present circumstances to do, with patients whose personality structure is of less than neurotic maturity, countertransference entanglements are virtually inevitable even in analysts who had had the best of analyses. (Searles 1979, Kernberg 1975). This is especially true when working with schizophrenic patients in hospitals and even more complicated in therapists who have been trained to be dynamically oriented therapists without having being able to afford the benefit of undergoing an analysis. Therapists of this category lack the extensive introspective experience that might facilitate the spontaneous analysis of their countertransference well enough for them to be able to discriminate effectively between its various components. Most of the students – supervisees presented in the following pages belong to this category. Consequently they are less well equipped to extricate themselves from such transference – countertransference

entanglements, and more acutely in need of an internal, immediately accessible, sound, dependable theoretical set of concepts, to act as an internal supervisor. (Casement 1985).

The importance, as an aid in contending with complex dynamic situations of a clear set of concepts has been called attention to repeatedly. As was also emphasized in the first part of this book, (Chapter Five) Kohut, (1979) writes about it from a cognitive perspective when he describes how he was helped by a clear conceptual framework he had developed: "I was beginning to test a new frame of reference — a new viewpoint, which, to state it briefly, allowed me to perceive meanings, or the significance of meanings I had formerly not consciously perceived...The change in my theoretical outlook that had taken place during that time influenced decisively the focus of my perception of Mr. Z's psychopathology and enabled me, to the great benefit of the patient, to access to certain sectors of his personality that had not been reached in the first part of his treatment." In Chapter Five, in the first part of this book I also referred to a firm, immediately accessible theoretical framework as an important internal supportive supervisor, mainly on the emotional level. (C.F. Lederer, 1964 and Jacobson, 1964). The preference of one theoretical framework over another seems, therefore, to have implications as far as implementation is concerned.

One young therapist poignantly illustrated this point in a supervisory session. He had been interviewing the parents of a young schizophrenic patient and became aware of the patient's failed struggle for independence. While contemplating this during the interview, he suddenly felt inundated by memories of his ostensibly long

forgotten struggle for separation-individuation. "Only the possession of an internalized set of co-ordinates made it possible for me to collect my wits, to clear up the blur of confused feelings and to continue the session in a professional way." When speaking of the "set of co-ordinates" he was referring to the theoretical concepts concerning countertransference to be presented in the following Chapters that had been discussed repeatedly in this supervisory constellation. It goes without saying that such a conceptual framework can be benefited from only on condition that it operates as an internal set of guidelines, not as an internalized straightjacket.

One might speculate that one of the reasons for the fact that none of the attempts undertaken by the above-mentioned authors to differentiate between the various aspects of countertransference is to be found in the fact that none of the terms suggested by them was immediately self explanatory. A therapist in a stressful countertransferecial entanglement, who is in need of an immediately available conceptual tool to refer to, who finds himself having to struggle with a question such as "'idiosyncratic', or 'homogenous'?" "'is my feeling Objective countertransferece' or 'subjective countertransferece'?" "On whose side, mine or the patient's?" or "Which is 'healthy' and which is 'pathological' countertransference"? Which one is the one to be included in the therapy and which is not? Such a therapist will probably not be in position to gain the support he so desperately and immediately needs from such a term, unless its self-explanatory nature is in-built and, therefore, immediately available.

Prompted by these deliberations, I considered the plight of the students – supervisees. I gradually realized that in order to help them disentangle, to minimize as much as possible future complications and to partly compensate for their lack of personal analytic experience, these students – supervisees had to be provided with clearly defined, immediately available conceptual tools. Besides enabling them to differentiate the two major components of countertransference from each other on a cognitive intellectual level, such a conceptual framework would also serve as an internalized supervisory support. These aims should be achieved by officially separating the two components of countertransference from each other by giving them separate names. These names, or terms, would enable them to be distinguished from one another, while at the same time preserving, in order to prevent further complications and confusion, the term “countertransference.”

Countertransference, as Visualized in Victimology

A reasonable solution presented itself at that time in the field of victimology. This science is constantly handicapped by the fact that the very act of victimization, one of its central phenomena, can virtually never be directly, deliberately be witnessed by independent observers. (Schneider, 1982). Even when an act of victimization does happen to occur in the presence of witnesses, these witnesses have no access to underlying psychological processes and can, at best, give a more or less accurate description of external events. Furthermore, as both offenders and victims have overt and covert vested interests in representing the facts in forms that are distorted by personal bias, retrospective reconstruction by both parties can hardly be regarded as objective, scientifically useful data.

One result of this situation is that the relative causal contribution to any specific act of victimization, the relative responsibility of the offender on the one hand and/or that of the victim on the other, cannot be objectively assessed with any degree of accuracy. A secondary purpose of this chapter is, accordingly, to point out a method in which situations of victimization can be systematically observed in laboratory-like condition, as they develop, by objective, independent observers. The results of such empirical observations could subsequently be extrapolated to working hypotheses in real situations.

I have in mind the dynamically oriented psychotherapeutic work, carried out in prison with convicted criminals by clinical criminologists. These are mental health professionals that differ from others by the fact that their patients, who prefer to refer to themselves as 'clients', are convicted criminals in prison. In this kind of work it can regularly be observed that the therapists report frequent instances in which they feel themselves being victimized by their patients in various ways. They report being intimidated, cheated, humiliated, emotionally exploited, blackmailed into collusion against prison authorities, played out against each other, seduced, their privacy being invaded etc. Although external circumstances usually prevent any physical harm from being done to the therapists in this situation, the psychological anguish the therapists report is comparable to the anguish reported by victims in outside reality. At times this anguish may reach such intensity that it leads to unfavorable results, one of which is the wish on part of the therapist to terminate the therapeutic interaction prematurely. These complications need to be dealt with by continuous professional supervision. In these circumstances the supervisor is in position to monitor and analyze the ongoing process of victimization almost immediately as it occurs, with optimal accuracy and objectivity.

The underlying psychological processes that are operative in the creation of this mental victimization, in these "in vitro" circumstances are probably identical with transference — countertransference forces that are activated in all dynamic therapies. The analysis of these forces is a major tool in these therapies, not different from regular dynamic therapies.

Countertransference is well known to be painful not only when activated in dynamic work with criminals. Most deep-rooted personality configurations are notorious, each for more or less specific kinds of unpleasant countertransference reactions in the therapist. The specifically painful nature for the therapist of the creation of the feeling of being victimized that can be observed in work with criminals seems to be related to those parts of the patients' intra-psychic structure that tend to solve painful internal tensions by methods that involve the deliberate infliction of pain on the object. When these methods of relief of tension become activated in the transference, the therapist is chosen as the object-target-victim.

Theoretically, the following remarks seem to be in order. Winnicott (1969) and Schuller (1976) have described instances in which the therapist is also destructively attacked by his patient. In these cases the attacks come at the explicit invitation of the "victim"-therapist. In Winnicott's example the therapist is supposed to eventually survive and in Schuller's he is to succumb. In both instances, however, the act of victimization is more of a (self)-sacrifice on part of the therapist than a deliberate attack on part of the "offender" patient. In both cases the therapist encourages the attack via interpretations in order to invite the patient into the depressive position and secure him there.

The victimization described in the present chapter is different. The attack is deliberately, primarily premeditated by the "offender"-patient, in order to hurt, destroy, or forcefully conquer the therapist or parts of his personality, such as self-respect or integrity. All this is done for personal, sometimes defensive gain. No concern or any other component of the depressive position is involved.

The attack is directed at (sometimes part) objects that are envied, desired, or else experienced as persecutory. The personality parts involved here on part of the patients of this kind seem to be to be aspects that are firmly, unequivocally fixated in the schizoid-paranoid position. These considerations might tentatively serve as an alternative explanation for the particularly painful countertransference reactions in therapists who deal with this particular population of patients.

Prior to presenting two clinical examples, it ought to be emphasized that before being analyzed in supervision and despite the intensity of their plight, neither of the two therapists to be presented realized the countertransference significance of their reaction. They attributed it in one case to the "badness" or "intractability" of the patient and in the other to the therapist's shortcomings. As soon as the real, dynamic significance of their feelings of being victimized had become apparent, both therapists reported that that they felt immediately relieved. On top of this, the realization, via the intensity of their feelings, now recognized as countertransference, enabled the recognition of the nature and the intensity of their patients' emotional tension. This new insight not only prevented the breakdown of the therapies but actually helped the therapists to empathize with their patients' suffering from a deeper level and thus facilitated the therapeutic process.

It is not unusual for therapists to be unaware in this manner of the significance of their emotional reactions towards their patients. A supervisor will be more capable of detecting the existence of such feelings and of understanding their true significance. This is not necessarily because he is

more knowledgeable or experienced than his supervisee. Peer supervision will frequently do just as well. It is due to the fact that being situated one step removed from site of the interaction, thus being less liable to be caught up in the intense emotional turmoil and therefore in better position to utilize secondary process. On the other hand it should not be forgotten that the supervisor is just one step removed from the interaction and hence well in position to follow and monitor the development of transference — countertransference step-by-step, session by session. More about this being "one step removed" will repeatedly be presented in further Chapters.

One of the central ideas of the second part of this book has now been re-introduced and will be elaborated with the help of the two clinical examples. These examples are taken from real therapeutic work done with criminals who had been convicted of crimes of violence (e.g. armed robbery). In both cases the therapists were fairly young, married female clinical criminologists. In neither case was there any information of previous sexual violence. Nevertheless, both therapists presented (separately) with virtually the same (overt) complaint: "I can't stand my patient any longer. He makes me feel like a whore. I feel unable to continue treating him and would like to transfer him to someone else." Despite this virtual identity of the overt complaints, their dynamic significance turned out to be, from the point of view of their countertransferential contents and significance diametrically opposed and this contradiction could later be utilized in the construction of the differential countertransferential terms sought after and hinted at the end of the previous chapter.

Example One

This therapy had been going on for some time without having presented any particular difficulty. It had been established that an exceptionally stifling and castrating mother had raised the patient. One of his symptoms consisted of habitual, almost obsessive use of foul, denigrating language towards any female he could lay his eyes on. This included use of obscenities towards senior prison officers, a fact that had cost him many a day in solitary confinement. So far his therapist had been spared, and in the therapeutic sessions he addressed her in civil terms. This had now changed. He had started to address her in the same abusive manner, refer in a foul, obscene, denigrating language to her genitals etc. This behavior finally culminated in the therapist's refusal to continue the therapy because, as she said, it made her feel like a whore.

For lack of deeper understanding of what had happened, I encouraged the therapist in general terms to carry on with the therapy despite her revulsion, to try to look for an explanation for the patient's behavior. This she did, very reluctantly.

A few sessions later the patient reported a dream. In his dream he crossed the frontier and came upon a deserted house surrounded by a breached fence. In the house he met a woman, whom he could later associate with his mother and with his therapist. This woman seduced him to have intercourse with her. During the process, however, she produced a knife, castrated and threatened to devour him. All he could do was to flee in panic.

In order for this dream to be intelligible it has to be pointed out that in Hebrew, in which this therapy was being conducted, the word "breached"

is equivalent to “prostituted” (זֶוֹפֵּן). Freely translated the word “breached” could be substituted by the word “fallen,” the house would then be surrounded by a “fallen” fence, easily to be associated with “fallen woman.” In Hebrew this association would be even more natural and taken literally, the house would then be surrounded by a “prostituted fence.”

The implication was that this man had to regard all women as prostitutes, treat and incidentally make them feel as such, in order for this to constitute a fence. He had to defend himself from “crossing the frontier,” i.e. allowing himself to be attracted to women, a situation that was fraught with fear of being castrated or even devoured. Attraction and its concomitant calamity of being castrated and devoured had evidently become activated in the transference. The patient felt in danger of being attracted to his therapist and had to defend himself by invoking his habitual defense, which consisted of regarding his therapist and incidentally making her feel like a whore.

As soon as this situation had been clarified the therapist overcame her revulsion and was able to feel her humiliation to be an expression of the patient’s psychopathology. Consequently, she felt both able and willing to carry on the therapeutic endeavor.

Example Two

Just as in Example One, the therapist came to supervision complaining that she could not go on with her therapy: “He keeps trying to seduce me and this makes me feel like a whore.” It transpired that this patient had made clear insinuations that he desired his therapist sexually almost from the beginning of this therapy. The therapist had,

however, correctly regarded this as transference and had been able to deal with it professionally, as Winnicott would have put it. This had suddenly, unexpectedly become impossible for her. When questioned, she admitted that her inability to endure the patient's seduction had started when she began to fear that he might become desirable to her. She would not have intercourse with him, God forbid, but was afraid that she might dream of sleeping with him, and this would constitute a symbolic betrayal of her husband. These fantasies, which she attributed directly to her patient's incessant insinuations, had finally made her feel like a whore and made it ostensibly impossible for her to continue the therapy.

Very gradually and against strong resistance on her part, it subsequently transpired that the therapist had had a quarrel with her husband. After overcoming even more shame and resistance, she admitted that whenever such a quarrel took place, she used to revenge herself by dreaming of having sex with someone else. The patient's continuous seduction had evidently provided her with a possible object for doing just that. The attainment of this information clarified the situation immediately. The therapist regained her professional, abstaining position towards her patient and as had happened in the previous example, she was now both willing and able to continue the therapy as smoothly as before.

When viewed superficially these two cases of "in-vitro" victimization looked identical, (being made to feel like a whore). When compared from the point of view of victimology, it can be seen very clearly that in the first example the offender (patient) induced the act of victimization in order to defend himself against his unconscious fears of

being castrated and devoured. In other words: "Offender induced victimization." In the second example the therapeutic situation had been stable and was described as such by the therapist until the "victim" (therapist) unconsciously instigated "victimization" for temporarily unconscious reasons of her own. This constituted a clear-cut case of "victim-induced-victimization." The two cases could hence be regarded as polar points on the axis of "offender" vs. "victim" induced victimization.

All these considerations are obviously based on the therapists' emotional reactions towards their patients. So far I have referred to these reactions as "countertransference" without giving a theoretical excuse for doing so. At this point I would like to make explicit use of Heimann's (1950) subsuming all the feelings a therapist had toward his patient that in this case happened to be "being made to feel like a whore" and legitimately refer to them as countertransference. Consequently, they could also be regarded as polar points on the axis of countertransference. On the one pole would be countertransference initiated by the patient (in this case, offender), on the other pole, countertransference initiated by the therapist, (in this case, victim). To put it differently: Offender initiated victimization could now be substituted by "patient induced countertransference," whereas victim initiated victimization could be substituted by "therapist induced countertransference."

These two terms: **Therapist-induced-countertransference** and **patient-induced-countertransference**, respectively could subsequently be shown to be of applicability in supervision beyond the immediate context in

which they had been initially formulated, cornerstones for the self-explanatory terms I had been looking for. They will be further elaborated in the following Chapters.

The polarity of Example One and Example Two, constituted the reason that made me choose them for illustrations. The fact that both cases of victimization were of sexual nature is coincidental. Various other feelings of being victimized, such as intimidation, emotional blackmail and extortion, etc. as mentioned at the beginning of this chapter could regularly be shown to represent points on the axis of patient-induced vs. therapist-induced countertransference. When analyzed in supervision, the respective contribution of either therapist or patient could be established with relative ease, precision and expediency. Beside the insight gained into the underlying processes of transference — countertransference, which facilitated and expedited the therapeutic process, a better understanding of the process of victimization could also be established.

The conceptualization of the Analysis of Countertransference

After the two concepts, patient-induced-countertransference and therapist-induced-countertransference, had thus presented themselves, so to speak, closer scrutiny revealed their usefulness. When put in the hands of those who had to deal with complex countertransferential situations, they seemed to exceed the immediate context in which they had been formulated. Their self-explanatory nature and the congruence that could be found between theoretical concepts and practical applicability were particularly enticing. When used experimentally in supervisory sessions this differential applicability proved quite helpful in solving the countertransferential entanglements referred to in Chapter One.

Prior to demonstrating this with the help of further clinical vignettes, it seems appropriate to focus on the two terms, therapist-induced-countertransference, and patient-induced-countertransference, respectively and delineate their precise boundaries. As to the interchangeable use of the terms, “psychoanalysis and “dynamically oriented psychotherapy,” this interchangeable use has been referred to above. Henceforth I will restrict myself to the term “therapy,” unless the context dictates otherwise. I trust that the conceptualization of countertransference, as presented here, may be applied to any kind of dynamically oriented psychotherapy.

Therapist-induced-countertransference is more or less congruent with Winnicott's subjective countertransference. I feel justified in substituting Winnicott's concept with the one presented here for three reasons. The first reason is that Winnicott seems to have retracted his terminology in respect of countertransference. The second reason is that I feel the term presented here to be more self-explanatory and hence more accessible to the therapist in trouble. This same holds true *mutatis mutandi* to "objective" vs. "patient-induced." "A further reason for preferring the present conceptualization to Winnicott's one will become clearer further on.

Therapist-induced-countertransference would comprise those parts of countertransference that constitute direct expression of the therapist's intra-psycho configuration. They are to be considered as such insofar as in the form of current and longstanding unresolved conflicts or in any other way they interfere in the therapeutic interaction. They can do so by disrupting the therapist's capacity to perceive the presented material without distorting it, by interfering with his benevolent neutrality or by paralyzing his empathy. Roughly corresponding to Heimann's and Tower's "transference on part of the therapist," therapist-induced-countertransference would include, beside blind spots, all the therapist's idiosyncratic reactions to persons in general, or to particular types of persons in particular. The same holds true for his personal likes or dislikes, as they might be triggered off accidentally by external circumstances, such as the patient's physiognomic features, his gestures, or his political opinions. Until noticed and expelled (usually by supervision or self-supervision) these personal attributes of the therapist's would come

under the heading of therapist-induced-countertransference whenever they are inadvertently allowed to contaminate the therapeutic interaction.

Theoretically, the essential, defining factor of therapist-induced-countertransference that demarcates it sharply from patient-induced-countertransference, is the consideration that the patient, except for being its object and recipient, plays no significant part in its creation. To put it differently, therapist-induced-countertransference is activated by the therapist for reasons that are therapist specific and not patient specific. In this respect the definition of therapist-induced-countertransference cuts across the concentric model suggested by Kernberg, as described above, and differs, as will be demonstrated further on, from Freud's original definition of the term.

Patient-induced-countertransference, on the other hand, would comprise all those non-rational intra-psychic manifestations, feelings, fantasies, desires, etc. that become activated in the therapist as a result of the patient's specific, (usually, but not exclusively, unconscious) active influence. They include the therapist's deviation from objectivity that upon being, generally retrospectively analyzed, will be discovered to have been fitting responses to conscious or unconscious corresponding components in the patient's intra-psychic configuration. They are consciously or unconsciously evoked by the patient as complementary fulfillment of his internal needs, defensive, as in projective identification, or otherwise. Although diverting somewhat from Freud's negative connotation of the term, patient-induced-countertransference encompasses the therapist's emotional response to

the patient's transference, in general accordance with Freud's original definition of the term without, however, as just mentioned, not being entirely identical with it. (C.F. Example Four).

The therapist's personal attributes, his blind-spots, distortions, preferences and personal likes and dislikes, as referred to above, will come under the heading of patient-induced-countertransference whenever it transpires that the patient had played more than a passive or accidental role in their activation. In these cases it may be presumed that they constituted aspects of the patient's personality that had found expression via the therapist's feelings, fantasies, etc. as originally described by Heimann. They are, consequently, patient-induced-countertransference. In analogy to what has been said about therapist-induced-countertransference, above, patient-induced-countertransference also cuts across Kernberg's concentric model.

To repeat: Theoretically, patient-induced-countertransference is that aspect of countertransference, in its traditional, non-differentiated definition of the term, in the creation or activation of which the patient plays a significantly active, conscious or unconscious part.

The evidence to be presented below seems to indicate that from the operational point of view, therapist-induced-countertransference constitutes that aspect of countertransference, in the traditional, indiscriminate connotation, that should not be allowed to infiltrate and contaminate the therapeutic interaction. Whenever possible, it should be resolved by the therapist without involving the patient. It corresponds to those aspects of the therapist's attributes,

mentioned in Freud's "recommendations," and excluded by him from being referred to as "countertransference." In this context it seems to be justified to paraphrase Freud as follows: "Therapist-induced-countertransference should be recognized by the analyst in order to be overcome." Paraphrasing Heimann, as well, it might be said: "The patient ought not to be burdened by therapist-induced-countertransference." One exception to this rule would be those cases, to be met with when dealing with exceptionally perceptive patients, such as paranoids. Such patients will divine, disclose and confront their therapists with their non-resolved conflicts. In these exceptional cases it would be pointless, even detrimental to deny these aspects of therapist-induced-countertransference.

Patient-induced-countertransference, in turn, seems to be identifiable, from the operational point of view, with those aspects of the phenomenon, as diversely defined by diverse authors that constitute an integral part of the therapy. It should be introduced into the therapeutic interaction in accordance with the same judicious rules and precautions that govern the introduction into the therapy of any other material, transmitted consciously or unconsciously by the patient. Racker (1953, 1968) has been most explicit and prolific in defining these rules as they concern countertransference. He did not, however, as far as I could understand, provide clear-cut conceptual tools to differentiate those aspects of countertransference that ought to be introduced into the therapy from those that ought to be excluded.

Despite their clear-cut theoretical demarcation from each other, therapist-induced-

countertransference and patient-induced-countertransference will rarely be encountered isolated from each other in practice. On the contrary, they will usually be clinically observable in most intimate interaction with each other. In fact, it turned out to be no easy task to select clinical material for demonstration that would present the existence of each of the aspects more or less separately. This intimate interaction of the two aspects of countertransference makes their dissection from each other for practical, therapeutic or supervisory purposes more difficult, but no less mandatory. In order to do justice to this complex situation, one more term had to be coined. I chose that of "combined countertransference." Winnicott's conceptualizing of "objective" and "subjective" countertransference seems to lack a concept for this common complex situation in which both aspects of countertransference are intimately intertwined. This seemed to constitute the third reason to prefer the conceptualization presented here over that proposed by Winnicott.

When confronted with this complex situation of combined countertransference, composed of therapist-induced and patient-induced countertransference intimately intertwined, previous knowledge of the exact definition of these two participating vectors will facilitate their analysis from each other.

This situation can be compared to a parallelogram of forces. Pre-knowledge of the participating forces will facilitate their analysis from each other. Consequently I believe that each component having been given a clear-cut definition, emphasized by having been given a distinctive name, is more than of academic importance. Once

the task of analyzing the components from each other is performed, each component should be differentially applied and treated according to its nature. The therapist-induced component is to be dealt with by the therapist without involving the patient and the patient-induced component is to be utilized as legitimately useful clinical material. (C.F. Examples Nine and Ten, Chapter Six, also the analysis of Winnicott's contributions, Chapter Seven).

Therapist-Induced Countertransference

Transference is well accepted to exist from the very beginning of dynamically oriented psychotherapies (Ezriel, 1967, Kernberg, 1984). Sometimes, in the form of preconceived fears, or in the form of anticipatory expectations of secret wishes being fulfilled, it is known to precede the beginning of therapeutic intervention and if we follow Ezriel's suggestion, mentioned in Chapter Seven, Part One of this volume, it constitutes the very incentive for coming into analysis in the first place. It would, therefore, not be too surprising to find that therapist-induced countertransference, in form of "transference on part of the therapist," might also be observed to exist in a therapeutic interaction and threaten to handicap it from the moment of its inception. My next clinical example will be of this kind.

Example Three

In this case the therapeutic interaction took place on an in-patient basis in the open psychiatric ward of a general hospital. The patient, a corpulent man in his forties, had just emerged from a psychotic episode. The therapist was a fairly young, but by no means inexperienced male psychologist. After therapy had been going on for about two months, the therapist requested supervisory assistance complaining that he was unable to face his next session with his fat, dependent, passive patient. In that session he was supposed to announce the reduction, for technical reasons, of the frequency of sessions from three times to twice a week. "I simply cannot go on and

tell him that I have to reduce his sessions. He is so dependent on me. He will be so terribly hurt and rejected. I know I won't be able to face him." Further exploration revealed that the therapist had felt repulsed by his patient's explicit dependency needs from the moment he had first met him. Nevertheless, he had been doing his best to contain these feelings for fear of hurting his patient by making him feel rejected.

This was not the first time the therapist had had to deal with dependency needs. Consequently he was surprised by the intensity of his revulsion and according to his report he had not done a very good job at metabolizing these negative feelings or at concealing them. This conflict of compassion versus revulsion had now culminated in his inability to confront his patient in order to announce the reduction of the frequency of sessions. He felt that the patient would perceive this as an ultimate rejection.

For lack of more specific information, I encouraged the therapist to scan his own psychological environment in search of a similar conflict, which he might have repressed and then displaced into the therapeutic interaction. As soon as this simple, elementary advice had been given, the therapist became obviously relieved. At his next supervisory session he announced that he no longer loathed his fat, passive patient's excessive dependency. Then he added that the patient's response to the announcement of reduction of the frequency of his sessions was much better than he had expected. No further information was contributed by the therapist and as he was known to be in analysis, it did not seem appropriate to investigate him. It seems, however, to be relevant that a few months later the therapist filed for

divorce proceedings from his fat, passive, dependent wife.

As a clinical example, this case sounds almost too elementary, straightforward, to merit presentation. A therapist had displaced a temporarily repressed conflict into the therapeutic interaction, where it now acted as an obstruction. One simple question had provided him with introspective incentive, sufficient to enable him to clarify the situation and resolve what seemed at first glance to be a highly complex transference — countertransference therapeutic impasse. This very straightforwardness, however, makes this episode such a clear-cut example of therapist-induced-countertransference in an almost pure state. It is not, after all, the intention of these pages to describe new, complex, hitherto not described transference-countertransference interactions, but rather to suggest that various countertransference components can be sharply demarcated from each other and that this sharp demarcation may possess significance in application. Furthermore, it seems fair to assume that despite its being retrospectively analyzed as an uncomplicated situation, it might have, unless successfully resolved, resulted in probable dissolution of the therapeutic interaction. It can also serve as a partial substantiation of the statement that precise definition of the nature of an obstructing countertransferential element facilitates its resolution. It seems rather obvious that telling the patient about the revulsion the therapist had felt towards him before the situation had been clarified would have had counter-therapeutic results. Hence this example also seems to substantiate the claim that therapist-induced-countertransference ought to be resolved by the therapist without introducing it into the

therapeutic interaction, at least not at that early stage.

Example Four

This therapy took place on an outpatient basis. The therapist was a young psychiatric social worker who was in psychotherapeutic training. She had become impressively proficient in detecting and interpreting the “Here and Now” transferential implications of ostensibly unrelated material. Therapy had been going on in a satisfactory way for several months. Then, in supervision of a particular session, it was revealed that she had unexpectedly reverted to an attitude she had already outgrown, an external-reality-oriented, directive attitude, entirely missing the transferential, “Here and Now,” implications of the presented material.

In the therapeutic session the patient, a housewife with neurotic features, had related how she had lost her temper with her youngest child, who had become excessively clinging and demanding. Instead of attempting to understand his behavior, she had scolded, smacked and punished the boy by sending him up to his room. “Let him sulk there. A mother can stand only so much. I don’t think that you (therapist) would have reacted differently.” In the supervisory session the therapist promptly and spontaneously realized that she ought to have responded with some reference to the patient’s fear of being castigated, even abandoned, if she were to give full expression to her own needy, clinging demands.⁵ “How could I

⁵ Parenthetically, I might add here that this was another example proving that the therapeutic alliance grants no security for calamities not following the implementation of the avoided relationship.

have missed something as obvious as that? How come I did not think of it during the session?"

When the material presented at the therapeutic session was being reviewed, the therapist remembered the phrase: "You would not have reacted differently." She also remembered that it had triggered a chain of thoughts in which she was reminded of her ambivalent feelings towards her own daughter. The daughter had become sick, refused to go to kindergarten or to accept a baby-sitter and insisted that her mother, the therapist, stay with her all day. These demands had infuriated the therapist. In the supervisory session she now also became aware of the guilt feelings she still felt about having forsaken her sick daughter in anger for the sake of her career. When these facts had been clarified, the therapist easily understood the reason for her failure to respond professionally in the therapeutic session. The patient had obviously, albeit unintentionally, stumbled upon an unresolved conflict, thereby activating a blind spot that prevented the therapist from doing so. Just as described in Example Three, the therapist in the current example was also able to contain the situation once it had been clarified. The following sessions she reported showed the same dynamic proficiency she had shown in the ones that had preceded the incident.

Ostensibly, this was a clear-cut case of Freudian countertransference. The patient's transference had created a disturbance in the perception of a "not well enough analyzed" therapist, thus "tearing her down from the analytic *niveau*." Nevertheless it could not come under the heading of patient-

induced-countertransference, because it was therapist specific and not patient specific. Another therapist, or even the same therapist in a different frame of mind would have most probably responded professionally and not with a blind spot. Although triggered by the patient's remark, the therapist's mistaken response did not correspond to an internal, latent emotional problem of the patient's, at least not to a currently relevant one, but to her own defensive needs. The current example seems to indicate that the provisional inclusion of Freud's original definition of countertransference under the general heading of patient-induced-countertransference is not unconditionally valid. The definition of patient-induced-countertransference seems to cut across Freud's conceptualization just as it does across the one suggested by Kernbeg.

Reflection will also indicate that the inclusion into the therapy of the therapist's emotional reason for her failure to respond professionally at this point would have been pointless, if not harmful, just as had held true for the previous example. In both cases, the reasons for the therapists' deviation from professional benevolent neutrality had to be handled outside the therapy, without involving the patient. The congruence of the theoretical definition of therapist-induced-countertransference on the one hand and its implication, not to be included in the therapy, seems to have stood up to the test so far.

In the following pages I will stress several times the point that the therapist's capacity to contain therapist-induced-countertransference, and, for that matter, therapist-induced components of combined countertransference, once these have been recognized, is predicated upon the therapist's

emotional maturity. The following two examples are intended to highlight this point.

Example Five

This therapy was the same as described in Chapter Two of the first part of this book, concerning Gilbert. The chain of events to be described here preceded the negative therapeutic reaction described there. The therapist was an intern in the first year of his psychiatric training. He had just applied to be accepted to the school of psychotherapy. This would have been contrary to the rules of that school, which demanded that a resident be in training for at least a whole year before being accepted. The therapist, however, believed to have good reasons to constitute an exception to this rule because side by side with his medical studies he had acquired a B.A. in psychology and had accumulated considerable experience in his personal dynamic therapy. Nevertheless, his application was denied. In supervision I mentioned in passing that I hoped that this disappointment would not reflect negatively on his therapies. He replied that being conscious of the problem, he would probably be able to contend with it.

Three weeks later he reported that Gilbert's condition was in the process of deteriorating, complaining that he felt that no progress was being achieved. (In his own words he felt "stuck.") The point that seemed to be bothering him most was that the patient had intensified various ways of self-destructive acting out. This fact the therapist felt to be in surprising contradiction to his feeling at that time of being "such a good container."

In subsequent supervision the therapist realized that despite ostensibly being “such a good container” he had recently found himself addressing his patient in an impatient, unfriendly tone of voice. Consequently, the patient must have felt these interventions to be covertly rejecting. Encouraged to reflect, the therapist was now able to recognize his difficulty to grant real, internally felt acceptance. Real, internally felt acceptance would intensify the contradiction between the pain that had been generated in him by his being rejected on one hand and the total acceptance he was supposed to grant to his patient on the other. Once this insight into the therapist-induced nature of this countertransferential difficulty had been gained, the therapeutic interaction resumed its former positive quality and the patient’s auto-destructive acting-out diminished considerably.

In this example, the therapist continued to feel some bitterness about not having been accepted immediately for further studies. Once the countertransferential consequences of this bitterness had been clarified, he was able to contain it without its interfering with his therapeutic acceptance of his patient. In Example Six this was not the case. Here a therapist of less emotional maturity was faced by a deeper personal disappointment that despite being conscious of its countertransferential consequences, he was unable to contain. This situation caused a therapy that otherwise was going relatively well to break down with catastrophic consequences for the patient.

Example Six

In this case the therapist, this time a female, was also a psychiatric resident, somewhat more advanced in her residency than the one in the

previous example. She had, however, never undergone personal therapy and was less mature emotionally than the one described above. In fact, she was not really interested in the dynamic aspects of psychiatry. The only reason she took on a dynamically oriented therapy in the first place was because the presentation in writing and the oral discussion of such a case was one of the requirements for passing board examinations. For technical reasons she was given a patient of borderline personality organization, who occasionally slipped into temporary fleeting paranoid episodes. The patient had by now been discharged from hospital and the therapist was seeing her on an ambulatory basis. It was no easy job to train the therapist to “listen with her third ear.” It was even more difficult to make her way of thinking more resilient, and especially to convince her that her patient’s occasional regressions to paranoid ideation could be causally connected with transference-countertransference complications and, hence, amenable to transference interpretations. In order to encourage her to relinquish her linear thinking, to think indirectly, not necessarily in accordance with academic logic and replace it with primary process thinking, I suggested to her to attempt to solve the weekly crossword puzzle. The solution of this puzzle was not based on knowledge, but on primary process manipulating the hints in the definitions, in which the sought for word was being concealed. This was one way of trying to liberate her from the straightjacket of formal, causal thinking.

After about a year of hard work she showed up for one particular supervisory session, beaming. Her patient had again become paranoid against some neighbors, and she had been able to interpret that

this regression might be a result of the previous session having been cancelled. Also that for fear of losing her entirely by accusing her of desertion and thus alienating her, the patient had displaced and projected her anger into the neighbors. To her surprise, the patient accepted this interpretation and the paranoid ideation subsided instantly, making place for open admission of some angry disappointment concerning the previous session having been cancelled. "And," the therapist added with a smirk, "you might also be pleased to hear that I have succeeded to solve this week's crossword puzzle entirely." In other words, she had been converted. Therapy was now going on fairly well and both therapist and patient seemed to be progressing, each with his task, at a satisfactory rate.

When the board examination arrived, the case had been properly written up. The therapist, however, for reasons that were not so much connected with the case as such, but with her relative inability to function under stress, failed to pass the examination. Despite the difference in the intensity of the disappointment between the therapist in Example Five and that in Example Six, the content of both disappointments seems similar and may be compared. In the case presented here, the therapist was incapable of containing her angry disappointment despite being aware of it. Despite her also being aware of the devastating result for her patient, she reacted by obstinately refusing to go on with what had, hitherto, seemed to be a fairly promising therapy for a very difficult patient. Without offering any kind of explanation to her patient, she simply stopped seeing her. All my efforts to convince her to the contrary were in vain. No wonder that shortly thereafter the patient had to be re-

hospitalized. Both the “Mossad” and the FBI were after her, and she was communicating with creatures from other planets. It took two years of intensive drug treatment and psychotherapy by another therapist to re-assemble her to some degree.

In this catastrophic reaction, the creation of a psychotic breakdown as a result of being deserted in the midst of a therapeutic process without proper explanation, the patient in the present example resembled Mary, described in Chapter Eight in the first part of this book. In the incapacity of the therapist to contain therapist-induced-components of countertransference resulting in the breakdown of a therapy, in that case without a psychotic breakdown, it also resembles Example Thirteen, in Chapter Six, further down.

In accordance with Racker both reactions of these two therapists would come under the definition of indirect countertransference. Nevertheless, they are to be defined, in accordance with the definitions offered here, as therapist-induced-countertransference. In accordance with the principles of differential application of countertransference, they are therefore not to be allowed to intrude on the therapy. Theoretically, this should hold true regardless of the problem of the therapist’s capacity to contain them. This last point, the therapist’s capacity to contain therapist-induced-countertransference being predicated upon the therapist relative maturity is the reason for having chosen these particular two examples for presentation in the first place.

The clinical examples presented hitherto might leave the impression that the capacity to contain therapist-induced-countertransference without

involving the patient is true only in cases where this countertransferential complication is based on non-resolved conflicts only if these are merely temporary. Example Twelve, presented in Chapter Six, as well as examples Thirteen and Fourteen, presented in Chapter Eight, are intended, among other things, to illustrate that this is not necessarily so. These examples indicate that therapist-induced components of countertransference may be contained even when they are rooted in deep-seated, long-standing intra-psychic conflicts that have not yet been resolved. This holds true, provided the therapist is mature enough to deal with these conflicts, at least temporarily, so that they be prevented from contaminating the therapy.

Patient Induced Countertransference

The more or less clear-cut clinical examples of patient-induced-countertransference to be presented below have been arranged in a specific order so that those, in which patient-induced-countertransference and its significance could be discovered retrospectively, precede those in which its recognition could be translated into immediate therapeutic benefit. This ordering of the material is intended to accentuate one of the purposes of the second part of this book, namely the further enhancement of therapists' awareness of the therapeutic significance of patient-induced-countertransference. From being a mere indicator that retrospectively enables the therapist to empathize with the intensity of his patient's original conflict, it should evolve into a therapeutic tool, to be used in real time. In this I will be following in the footsteps of Searles, Kernberg and Ogden.

This statement ought not to be misunderstood to mean that beyond the contribution towards better empathic understanding of the patient's dynamics, retrospective recognition of patient-induced-countertransference is of no clinical significance. On the contrary, in all cases in which patient-induced-countertransference could be retrospectively identified as such, therapists felt perceptively relieved, and the therapeutic process, now carried on from a deeper level of empathic understanding, gained momentum. This would happen even when the connection could be made after many months had passed. Nevertheless, I believe, like Heimann, Searles, Kernberg, Ogden

and possibly others, that once therapists become more familiar with the therapeutic significance of patient-induced-countertransference, further goals than that can be set.

In the carefully controlled circumstances of the structural interview, Kernberg has shown that countertransferential manifestations, which in the present context would come under the heading of patient-induced-countertransference, become activated in the first diagnostic interaction. Despite this, the assumption that patient-induced-countertransference can be observed as a spontaneous operatively significant factor from the very inception of a therapy, is, at first glance, not as readily acceptable as the same claim concerning therapist-induced-countertransference. Nevertheless it will be demonstrated in Examples Seven and Eight, in which projective identification seems to have been deployed as an initial defense, that patient-induced-countertransference can complicate the beginning phases of a therapeutic interaction just as much as therapist-induced-countertransference.

Example Seven

In this case a mental-health professional in her early thirties came for therapy to a somewhat older, married, female therapist. The reasons for the patient's (self) referral were due to difficulties in her marital relations and in performing her job. Later on she could be diagnosed as a high-level borderline personality disorder. For technical reasons, supervision was instituted several months after the therapy had begun. When presenting the case, the therapist, who was by no means inexperienced and had undergone psychoanalysis, opened by stating that she felt

overwhelmed and intimidated by her patient from their very first meeting. These feelings were interfering with her capacity to deal with the presented material from an optimal perspective: "I feel that I have to deal with issues that are too big for me." This was the way these feelings were conveyed to me. Neither of us was able to correlate the intensity of these feelings with the manifest contents of the material presented by the patient. Primarily, tentatively, it was attributed to the fact that the therapist was experiencing some difficulties in her own marriage (therapist-induced-countertransference). This attempt relieved the therapist's feelings of being overwhelmed by her patient only to a very limited degree.

Several months later it transpired that one of this patient's central problems had originated from the fact that her mother used to confide in her from an extremely young age. Among the difficulties her mother forced her barely three year old daughter to share was her inability to cope with her domineering husband, the patient's father. Another problem shared with the patient was the mother's secret fear of her own death in the near future, probably in the course of her next pregnancy. It could now be conjectured that this patient was able to re-institute her feelings of inadequacy, based on her unconscious memory of having been burdened with issues she was too immature to handle properly via projecting them into her therapist. Only later was she able to remember, re-experience and work them through in herself. The disclosure of this material and its significance made the therapist feel immensely relieved. Her feeling of not being able to handle the presented material properly was not, after all, a sign of her inadequacy as a therapist, but rather a

feeling projected into her (via projective identification) by her patient. In later supervisory sessions she reported that she now felt comfortable in her patient's presence and could now better empathize with her.

Example Eight

It seems not to be irrelevant to describe the context in which the patient-induced-countertransference aspects of this case were disclosed. They dawned on me as I was reading the case-report prepared by a candidate for board examination, to be presented and discussed there with me as one of the examiners. The paper was very well done, introspectively and candidly written, thus enabling a good in depth view of the therapeutic intervention it described. The candidate presented the case of a forty year old married woman, who had come to therapy because of intense, persistent headaches that she correctly believed to be of psychological origin. The therapist was a male psychiatrist of approximately his patient's age. This was the patient's second experience of psychotherapy. The previous one had been several years before, for a different symptom and with a senior, well reputed therapist.

From the very start of this, the patient's second experience of therapy, the therapist, who, like the one described in the previous example was not inexperienced, described himself as feeling constantly threatened by his predecessor. This was the result of his being incessantly compared by the patient, to his disadvantage, with the previous famous therapist. This was not the therapist's first experience of being put into a competitive situation and he also described himself as not a highly competitive person. Just as

in Example One, above, he found himself surprised by the intensity of his feelings of being threatened whenever his “relatively young age” and “lack of experience” were repeatedly compared to the “wisdom,” “seniority” and “experience” of his predecessor. The paper prepared by the candidate contained no hint of his having problems with non-resolved competitiveness, nor with any other, relevant components in his personality.

When I reviewed the material for clues of patient-induced-countertransference it transpired that the patient had spent a considerable part of her early youth on a kibbutz, into which her parents who lived in town had deposited her. Being an outside child, she was not fostered there by any particular family. Further revision disclosed that one of her major problems at that time was that she had to compete for recognition, acceptance and social survival with the local children. These had the advantage of parental support; of being on their own territory as well as that most of them were older than the patient.

This plight of having to compete with impossible odds with hardly having hope of ever winning could retrospectively be recognized as playing a decisive role in her future symptom formation. I surmised that just as had been the case in Example Seven, the patient had found means of reviving this hopelessness in the face of insurmountable competition via arousing these very feelings in the therapist. Only later would she be able to remember, recognize and metabolize them in herself. In this case, and as will be demonstrated a few paragraphs further on, the creation of the feeling of having to compete hopelessly may have been done consciously. The

patients' reasons for the creation of these feelings in the therapist were, however, unconscious.

As I was then in the process of developing the concepts posited here, I thought it unfair to put them to the candidate in form of questions. He had excelled in all other aspects of the examination, including the description of this particular case. I decided, therefore, to discuss the case with him from my point of view as colleague to colleague, as if he were in supervision. As soon as I uttered my ideas about my supposition, the tension on his face disappeared, he smiled, the color returned to his pale face and he felt immensely relieved. This was particularly remarkable as the Israeli board examinations are notoriously stressful and about half the candidates regularly fail them.

It is logical to assume that if the countertransference nature of the therapists' negative feelings in Examples Seven and Eight had been discovered earlier than they actually were, this discovery might have resulted in more active probing for the origin of these feelings in the patients. This would have, probably, resulted in speeding up the therapeutic process and the gaining of valuable time. This assumption is in line with Kernberg's proposition (Kernberg, 1975) of putting countertransference, and more specifically patient-induced-countertransference to therapeutic use.

The patient in Example Seven was diagnosed as borderline, a configuration that habitually deploys projective-identification as a defense. This should have aroused the therapist, as well as me to this possibility at a much earlier stage of the supervision. Once the therapist's feelings had tentatively been identified as patient-induced,

their inclusion into the therapeutic interaction ought to have been judiciously considered at the first opportune moment. This will be exemplified in Examples Nine, Ten and Eleven, in which this was actually done.

As I was becoming more convinced of the clinical significance of therapists' negative feelings in therapy as possible indicators for the patients' early conflicts, I was able to discern this significance in other contexts as well. A case very similar to the one in Example Eight in terms of the structure and significance of patient-induced-countertransference was encountered several years later. It was presented by a junior therapist at a seminar on the psychotherapy of psychoses. He had initiated this therapy after the patient had been discharged from her second stay in the hospital. During the first stay she had been in therapy with the chief resident. Both hospitalizations were initiated for acute psychotic episodes. From the very beginning of this, her second experience at psychotherapy, the patient constantly deplored her therapist's inexperience. She consistently compared it to the performance of his seniors and devised various means to make the therapist feel the futility of his therapeutic endeavor, insisting that only the chief resident, who had treated her during her first hospitalization, could possibly help her. This attitude made the junior therapist feel constantly threatened by not being able to compete successfully with his predecessor. The case was presented for supervision after the therapy had been going on for about a year. Based on the experience gained in cases such as Example Eight, I encouraged the therapist to scan the patient's past for possible situations in which she had been in hopeless competition. Such a situation might

have created the same feelings of futility she now engendered in the therapist.

The therapist now recalled that this had, indeed, been so. The patient was the second child of her father. It transpired that during her childhood she had been forced to compete for her father's affection with a former child of his, an idealized, hardly ever mentioned son from a previous marriage, who had perished together with his mother in the holocaust.

Besides making the therapist feel relieved, this new information now also shed light on the dynamic structure of the patient's psychosis. The second psychotic episode, for which she had been re-hospitalized, had occurred after the death in rapid succession of both her parents and her delusions evolved about the resurrection of the dead. This idea of a "forthcoming resurrection" filled her with immense joy, but at the same time also with no less intense anxiety. All this could now be put into perspective. The joy that accompanied the idea of her parents' resurrection was the result of her intense yearning for their love, which she missed terribly. On the other hand, this resurrection would also include her idealized brother, so that her hope of gaining her father's love and preference would be negligible from the start. The understanding of the peculiar combination of elation and terror was now within grasp. It seems that patient-induced-countertransference could now be regarded not only as a therapeutic, but as a heuristic tool as well, beyond the diagnostic scope originally suggested by Kernberg. As mentioned in Example Eight, the patient described here was consciously making her therapist feel in hopeless competition,

but was most probably unconscious of her reason for doing so.

In the following three examples, immediate exploitation of the insight gained from understanding the patient-induced component of countertransference was actually implemented. The first example constituted one of those cases in which the therapist, a psychiatric social worker in dynamic training, presented for supervision in a state of acute distress. She claimed that she regarded that particular supervisory session as a last resort before finally declaring herself incapable of helping her patient.

Example Nine

This therapy took place on an inpatient basis. The patient had been discharged from prison, where he had been incarcerated for several months because of drug related offenses. He had requested hospitalization because he hoped this would help him to complete the psychological aspect of his abstinence, the physical aspect of which had been accomplished in prison. When the therapist presented for supervision, therapy had been going on for several months. In the supervisory session she related that during these months she had felt that a good rapport had been established and that her patient was showing promising progress. She was very satisfied with his progress, as well as with her own performance.

Then it happened that the patient was summoned to appear in court because of charges still pending. Two things happened in this context, and both combined, so deeply disappointed the therapist and disrupted her attitude towards her patient, that she felt she was no longer willing and

therefore no longer able to carry on with her therapeutic work.

The first of these two things was that the charges against the patient were very serious, and implied that he might be sent back to prison for a long period. This was a fact he had carefully concealed from his therapist all these months. The second thing offended her even more. When considering his sentence, the judge asked the patient if he was in therapy. He replied that he was, and completely ignoring the therapist, who had accompanied him to court and the considerable psychotherapeutic effort she had invested in him, he mentioned the physician who was in charge of his drug treatment. "Not only had he deceived me as to the severity of his offense, he behaved in court as if I was not even there!" she exclaimed. A great deal of containing on part of the supervisory group in which this material was presented was required to be able to wipe the tears of anger and frustration off her face.

During further exploration, she claimed time and again that she could not stand the humiliation she had been submitted to. She had irrevocably lost her therapeutic enthusiasm, a vital component in her relation to her patient. Without this enthusiasm she was unwilling and incapable of fulfilling any but the most routine tasks on his behalf.

At this point she was presented with the following suggestion: "Why not take your intense feelings of humiliating disappointment, generated by your patient's behavior and regard them as indicators for some intense disappointments he might have suffered during his formative years? Perhaps this disappointment he had made you feel was the only way open to him to be unconsciously sure that he

had conveyed his plight with any degree of certainty, so that it would be emotionally perceived in all its intensity?" It was suggested that the therapist share these feelings of hers with her patient and relate them, tentatively, to his own. After some more persuasion the therapist grudgingly agreed to attempt such an intervention and in the following session with her patient she actually did so. In her next supervisory session the therapist reported that the crisis had been overcome. She had not lost her therapeutic enthusiasm after all. Her premeditated intervention was rewarded by a flood of associations that indicated that the patient had indeed been able to establish contact with memories of the intensive feelings of having been mortified by all the female objects that had let him down during his formative years.

A point to be mentioned here is that this incident occurred while the ideas posited in these pages were in the process of being formulated. This made me very aware of the significance and prevalence of a therapist's plight possibly being patient-induced-countertransference not retrospectively, after their origin had been laboriously chipped out, but rather as a means for this very disclosure. The importance of a clear-cut, theoretical conceptualization seems thereby to have been substantiated yet again.

In the following example this idea of the auxiliary function of this theoretical conceptualization is to be further expounded.

Example Ten

This is the countertransference intervention hinted at in the description of Caleb in the first chapter of the first part of this volume. Here the

therapist, at that time also a young psychiatric social worker who had participated in seminars in which these ideas had been discussed, came to me on her own initiative, saying that she thought she might have stumbled on something important. As might be remembered, Caleb refused, during the first months of his therapy to discuss anything but his drug treatment and haggled endlessly about it. This endless rumination of her patient created in the therapist a feeling of being hopelessly “stuck.” By making use of what she had heard being discussed in the seminar, she felt encouraged sharing this feeling of helplessly being “stuck” with her patient and tentatively relate it to some feelings she postulated to exist in him. This intervention promptly resulted in the patient sharing with her, for the first time in his life, a complex religious delusion that he felt to be paralyzing his life, creating in him an intense feeling of frustration and helplessness. For fear of being ridiculed, he had never spoken of these crippling delusions to anyone. This intervention constituted a turning point in this therapy, which turned from being boring and frustrating into a highly cathected and impressively fruitful, psychotherapy of a chronic schizophrenic patient, at least until the forced leaving of this original therapist.

The therapeutic use of countertransference in this case, tentatively recognized as patient-induced, was instigated, not as a result of external supervision, but as a result of the therapist being aware of this possibility. In contrast to the previous example, this example highlights once more the importance as an internalized supervisory function of a theoretical concept.

I would now like to make use of the therapist's disappointment in Example Nine as a starting point for a theoretical digression. Any therapist experienced in the therapy of patients of less than neurotic maturity, as well as any supervisor experienced in supervision of such therapies will testify to the frequency in which such feelings of frustration and disappointment, indeed of any other related painful feelings, generated in the therapists of such cases, can be detected. It does not seem improbable to believe that the institution of such painful feelings in the therapist is an integral component of such therapies. As hinted at in Example Nine, these feelings seem to constitute the only way open to these patients to make certain that their therapists really empathize with the original plights they, the patients, had suffered in their formative years.

One such patient exemplified this, when he insisted that his therapist institute a session with his parents. The therapist emerged from this meeting emotionally shattered, confused and devastated. The patient then admitted that he had anticipated this result and that this exposure of his therapist to his parents' devastating influence had been his deliberate purpose. He had insisted on the therapist meeting his parents in order to be certain that he experience the same impossible situation he, the patient, had had to deal with in his childhood.

Disappointments, as well as related negative feelings are therefore to be expected to be a frequent patient-induced phenomenon. There seem to be several implications to this point. One would be technical: Freud admonished that patients ought not to be forewarned of the appearance of transference, as this would impede

their being spontaneous. The situation in therapist is different. They are expected, when treating these kinds of patients, to experience negative, patient-induced, countertransference feelings and should, in contrast to Freud's admonition, be forewarned. I believe that being consciously prepared for the implication of these feelings, they will all the better be able to cope with them professionally. I have learned and especially taught my students, to take these disappointments in stride. More specifically, I taught them to employ these negative experiences to the benefit of our patients.

This notion, of patients engendering negative situations for their therapist has to be carried one step further. Some patients, who had suffered particularly extreme psychic traumatization in their formative years, will not allow for any real intra-psychic repair to be achieved until one therapist has been driven to feel obliged to discontinue his therapeutic endeavor in utter despair. I realize that the picture I am painting here constitutes a rather sinister scenario. I trust, however that therapists, as well as supervisors, who have dealt with these kind of patients, especially those with a tendency for criminal acting out, will bear me out. Despite being apparently pessimistic, I feel that these thoughts lend some more optimistic implication to the positive operational meaning of what has been referred to as therapeutic despair. An intervention such as "You, patient, need me, therapist, to be in despair to be certain that I empathize with your despair in your formative years," not in these exact words, would possibly not be out of place in these circumstances.

Another point is of more theoretical implication. Analysis of quite a few cases, to which Examples Nine and Eleven, (second episode) to be described below belong, will reveal that for the therapist really to feel disappointed, the patient has to invest quite elaborate efforts. He has to carefully prepare the ground by such actions as lulling the therapist into a false sense of security and satisfaction in his work. In Example Nine this was achieved by making the therapist feel that valuable progress was being achieved. Nevertheless, all the time secretly, perhaps unconsciously, the trap of disappointment was prepared, in order for it to be sprung at the appropriate moment. The point I am leading to, to be even better substantiated in Example Eight and Example Eleven, is whether projective identification is sufficient to account for such complex, time consuming, preparation of patient-induced-countertransference of this kind.

It would be beyond the scope of this work to elaborate this point further here. Better-qualified authors, such as Ogden, (1979 & 1982) have done so before me. However, I would like to conclude this chapter by presenting two episodes in the therapy of a patient of low-level borderline personality disorder, who implanted intense feelings of his own in me. He managed to accomplish this without having to resort to either subliminal or non-verbal communication (i.e. projective identification). Two last points need to be mentioned before presenting this case. They concern questions I am frequently asked while discussing the ideas presented here. One is about the difference between patient-induced-countertransference and projective identification. The answer to this question has already been implied above. The answer I usually give is that

patient-induced-countertransference is a state of mind produced by the patient in the therapist by various, mostly defensive, means. Among these defensive means projective identification occupies a central, important place.

The second question I am frequently asked in this context concerns the distinction between projection and projective identification. Although authorities, beginning with Melanie Klein and her students through Bion and many others to this very day have dealt with this issue, I usually give the following abbreviation. Projection is a defense mechanism in which intra-psychic material is eliminated and put into an object that reflects it back, so that the patient feels the material as if it emanates from the object. The object does not participate in this process, other than serving as a mirror that merely reflects an image without being effected. The object into which the eliminated material is projected can be another person, an animal, an inanimate object like the sun or the wind, or may even be a non-existent object.

Projective identification, on the other hand, involves more than one person, generally the patient and the therapist. The recipient usually feels the projected material as an unpleasant intra-psychic foreign body. The material can subsequently be projected back into its original form, or in more beneficial circumstances it can be metabolized inside the recipient and given back in a less painful form, so that it can be tolerated by the new recipient, the actual originator of the process in the first place, in order to be re-integrated into the originator's intra-psychic apparatus.

Example Eleven

This case concerns a patient, diagnosed, as has been mentioned above, as a low-level borderline personality disorder. At a particular session he complained of what he referred to, despite the therapy being conducted in Hebrew, as a “splitting headache.” He attributed this “splitting” headache to the fact that he was now forced to constantly split his attention between two separate levels. On the one hand he had to live his everyday life, while on the other hand the issues discussed in the therapy constantly occupied his mind. As he was talking I felt an intense headache developing in my head. We were sitting more or less facing each other, separated by a table with a transparent top. Then I noticed that he had managed to split my attention by discussing issues of importance on one hand, and by rolling a joint of hashish beneath the transparent top of the table on the other hand. At that time the recognition of the patient-induced nature of my headache could only be of use to me in aiding me to get rid of my headache.

At a later opportunity, to be described a few lines below, I was already more familiar with the therapeutic utility (for the patient, not for me) of patient-induced negative feelings or situations. On this occasion he put me again in an unpleasant situation. This time I was able to use this as a therapeutic tool.

The sequence of events was as follows: after about one year of the therapy, the patient asked me how long I estimated the therapy to have to continue. All my efforts to evade this, at this point unanswerable question by attempting to pry for its purpose were in vain. He was extremely insistent and persevering in asking the question and in

repulsing all my efforts to evade it. Even by my open admission of my being unable to answer it at this point was refuted. I finally surrendered and gave an estimate of about two years. He seemed satisfied. Two years duly passed, and although we had gained some therapeutic ground, the therapy more or less dragged its legs, and the patient was still far from having reached any therapeutic goal of real consequence. Then he sprung his trap. He confronted me, "Do you remember when two years ago I asked you about the length of time that would be required for the completion of my therapy you answered that it would take about two years? These two years are now over and nothing of real consequence has been achieved. Do you have any idea of the damage you have caused me by your wrong prediction?" The fact that I had done my best not to give such a prediction was by now conveniently forgotten. He continued, "Now I insist on you giving me a real estimate of the length of time still required for completion of my therapy."

This time I realized that he had put me into a "damned if you do and damned if you don't" situation. I explained this to him and asked him to review his childhood for similar situations he might have experienced then. I was rewarded by relevant memories of his mother putting him in similar situations. He needed no more answer for his question and the therapy gained momentum.

It seems worthwhile to mention again that despite the fact that some degree of progress had been achieved in these two years, the patient had unconsciously essentially invested these valuable years in order to create a real, at least ostensibly effective trap. To continue the line of thought proposed above, he had probably done so in order

for me to really be able to empathize with his difficulties in his childhood.

The question of the use or non-use of projective identification in the creation of patient-induced-countertransference seems to have remained unanswered, at least as far as Example Eight, Example Nine and this last Example, Eleven, second episode, are concerned.

Combined Countertransference

As stated above, therapist-induced and patient-induced countertransference will hardly ever be met in practice in a pure form. On the contrary, these components of countertransference are usually discovered intimately intertwined with each other. The examples used so far were therefore far from being typical. Most of them were chosen for the very reason of representing one or the other aspect of the phenomenon in a more or less pure, easily discernable, state. From this point forwards, I would like to present examples in which therapist-induced and patient-induced countertransference were intertwined. In these cases that represent the majority of countertransferential phenomena, I hope to demonstrate that the analysis of these complex structures into their contributing factors can be followed by their differential application: (1) Therapist-induced components to be excluded from the therapy without involving the patient, whenever possible to be resolved by the therapist using his own resources and (2) patient-induced components to be judiciously applied as legitimately interpretable material.

Example Twelve

This is another case in which the therapist presented in despair. "This patient of mine has become untreatable" was the way she chose to present the problem. When questioned about the exact circumstances in which the therapist had reached this conclusion, the following details were disclosed. Therapy had been going on for quite some time. The patient, also diagnosed as a low-

level borderline personality disorder, was extremely clinging, demanding and intrusive. Crisis after crisis had been handled professionally, the therapist recognized guilt, frustration and similar negative feelings aroused in her as patient-induced, and had been able to contain and treat them professionally to the benefit of the patient.

Prior to the situation to be described below the therapist had gone on leave. This had been discussed with the patient, but apparently had not been accepted very well by him. He desperately attempted to contact his therapist by making ceaseless efforts to get hold of her phone-number and finally succeeded in contacting the therapist. The content of this phone-call was of little significance. It was not difficult for the therapist to realize that this had been another manifestation of the patient's tendency to cling and intrude, besides his need to be re-assured of the therapist's continued existence. What made this incident turn the patient into being "untreatable" transpired in the fact that the therapist was extremely anxious and secretive about her personal privacy. She was so afraid of its being invaded that only her closest friends knew her address. She had also gone to great lengths for her phone-number not to be listed. By breaching this particularly extreme need for seclusion, the patient had apparently gone one step too far in taxing the therapist's tolerance of his intrusiveness and had activated a therapist-induced component of countertransference. Thereby her capacity to endure the patient-induced component of the countertransference had become overloaded and this had turned the patient into being "untreatable."

Fortunately this therapist proved to be advanced enough in her own therapy to make use of the

connections disclosed in supervision to forestall the forthcoming breakdown of the therapy. With the help of this knowledge she managed to neutralize her anxieties, aroused by the patient's penetrating her defensive need for seclusion sufficiently to be in a position to keep it from disrupting future therapeutic interventions. Her capacity to metabolize patient-induced components was thus restored. The patient had become "treatable" again. In due time the therapist was able to make therapeutic use of her patient's need for her to feel intruded.

This favorable outcome of the analysis of countertransference into its therapist-induced and patient-induced components was evidently predicated on the therapist's maturity. The therapist's capacity to contain the therapist-induced-component of this combined countertransference and prevent it from contaminating the therapy was also predicated on this factor. In these circumstances, this can be achieved even when this therapist-induced component is the expression of a deep-rooted problem that need not and cannot be resolved immediately.

In the following example the therapist was not sufficiently mature to contain the therapist-induced component of countertransference, and although he was conscious of this component, the result was the dissolution of the therapy.

Example Thirteen

Here the therapist was a young, male psychologist, in the first stages of his analysis. The patient was a young woman who presented with difficulties in her relationships with men. Not unexpectedly, the patient became more and more provocative as

therapy went along, showing up in dresses that became shorter from session to session. The therapist felt more and more threatened and despite supervisory advice to the contrary, finally confronted his patient and demanded that she stop her provocative exhibitions because they made it impossible for him to concentrate.

This is a further example of the combination of patient-induced-countertransference (provocation was probably, even if unconsciously, intended) with therapist-induced-countertransference, the therapist's incapacity to deal professionally with seduction because of sexual conflicts that had not yet been resolved. In the previous example the therapist was able to prevent her anxieties from penetrating the therapy once they had been pointed out to her, despite the fact that they were far from being resolved. In the present example the therapist was not yet capable of doing so. His incapacity to respond to seduction professionally was based on sexual conflicts too intense and too deep to be controlled merely by supervision. The final breakdown of this therapy was inevitable.

Theoretically, however, it stands to reason that had the therapist reached a degree of maturity equivalent to the one in the previous example, he would have been able to contain his anxieties despite their not yet having been resolved. He might even have made therapeutic use both of the patient's provocative behavior as well as of his anxiety, e.g., by cautiously exploring the reason for the patient's provocation being anxiety provoking, such as hidden castration wishes on her part.

The claim that combined-countertransference can be analyzed into its contributing components and thus applied differentially, seems to have been

partly substantiated by the clinical material presented so far. It will be further substantiated in the clinical examples in Chapter Eight.

Analysis of Winnicott's Contributions

Making use of the point of view expressed in the previous chapters, it seems reasonable to attempt to analyze Winnicott's apparently contradictory, inconsistent view of countertransference, hoping to show that these contradictions and inconsistencies to be, indeed, resolvable.

For the sake of simplicity, it seems best to start with Winnicott's view of countertransference as expressed by him in a symposium on this subject. (Winnicott, 1960). Here Winnicott referred to countertransference as follows: "...the meaning of the word counter-transference can only be the neurotic features which **spoil the professional attitude** (highlighting in the original) and disturb the course of the analytic process as determined by the patient." As mentioned above, he suggested to **"let the term counter-transference revert to its meaning** (highlighting, again, in the original) of that which we hope to eliminate by selection and analysis and training." He then suggested the selection of the term "analyst's total response to his patient's needs," (a term coined by Margaret Little) to cover those "non-professional" responses required by patients who were of less than neurotic maturity. The fact that "that which we hope to eliminate by selection and analysis and training" did not concur to Freud's original definition of countertransference has already been pointed out.

In "Hate in the Countertransference" (Winnicott, 1947), two clinical examples are presented. The second one in that article is of a truant boy, fostered by Winnicott for some time. Describing

his emotional reactions to the boy's behavior, Winnicott wrote: "The important thing for the purpose of this paper is the way in which the evolution of the boy's personality engendered hate in me and what I did about it." In the next paragraph, Winnicott described his management of the child's acting out. He then wrote: "The important thing is that each time, just as I put him outside the door, I told him something; I said that what had happened had made me hate him..." In this case Winnicott seems to have had no hesitation in making therapeutic use of his feelings, defined by him as countertransference .

His other example (the first one in that article) is more complex. For the sake of demonstration I would like to begin by quoting Winnicott's own, poetically beautiful description of the evolvement of his countertransferential management of this case. In order to facilitate finding its place in the theoretical framework suggested in the present work, I would like to take the liberty of later following this verbatim quotation with a description of the same events in my own words.

The verbatim quotation of Winnicott's description is as follows:

"Recently for a period of a few days I found I was doing bad work. I made mistakes in respect of each of my patients. The difficulty was in myself and it was partly personal but chiefly associate with a climax that I had reached in relation to one particular psychotic (research) patient. The difficulty cleared up when I had what is sometimes called a 'healing dream'. (Incidentally, I would like to add that during my analysis, and in the years since the end of my analysis, I have had a long series of these healing dreams, which, although in many cases unpleasant, have each one of them marked

my arrival at a new stage in emotional development.).

On this particular occasion I was aware of the meaning of the dream as I woke or even before I woke. The dream had two phases. In the first I was sitting in the 'gods' in a theater and looking down on the people a long way below in the stalls. I felt severe anxiety as if I might lose a limb. This was associated with the feeling I have had at the top of the Eiffel Tower that if I put my hand over the edge it would fall off on the ground below. This would be ordinary castration anxiety.

In the next stage of the dream I was aware that the people in the stalls were watching a play and I was now related through them with what was going on on the stage. A new anxiety now developed. What I knew was that I had no right side of my body at all. This was not a castration dream. It was a sense of not having that part of the body.

As I woke up I was aware of having understood at a very deep level what was my difficulty at that time. The first part of the dream represented ordinary anxieties that might develop in respect of unconscious fantasies of my neurotic patients. I would be in danger of losing my hand or my fingers if these patients should become interested in them. With this kind of anxiety I was familiar, and it was comparatively tolerable.

The second part of the dream, however, referred to my relation to the psychotic patient. This patient was requiring of me that I should have no relation to her body at all, not even an imaginative one; there was no body that she recognized as hers and if she existed at all, she could only feel herself as a mind. Any reference to her body produced paranoid anxieties, because to claim that she had a body

was to persecute her. What she needed of me was that I should only have a mind speaking to her mind. At the culmination of my difficulties on the evening before the dream I had become irritated with her and said that what she needed of me was little better than hairsplitting. This had a disastrous effect and it took many weeks for the analysis to recover from my lapse. The essential thing, however, was that I should understand my own anxiety and this was represented in the dream by the absence of the right side of my body when I tried to get into relation to the play that the people in the stalls were watching. This right side of my body was the side related to this particular patient and was therefore affected by her need to deny absolutely even an imaginative relationship of our bodies. This denial was producing in me this psychotic type of anxiety, much less tolerable than ordinary castration anxiety. Whatever other interpretations might be made in respect of this dream, the result of my having dreamed it and remembered it, was that I was able to take up this analysis again and even to heal the harm done to it by my irritability which had its origin in a reactive anxiety of a quality that was appropriate to my contact with a patient with no body.

The analyst must be prepared to bear strain without expecting the patient to know anything about what he was doing, perhaps over a long period of time. To do this he must be easily aware of his own fear and hate. Eventually, he ought to tell his patient what he had been through on the patient's behalf, but an analysis might never get as far as this". etc.

Re-written in other words, Winnicott's description of this case might have been as follows: I had been treating a psychotic patient for several months.

During the particular week to be described here, I was feeling very irritable, making quite a few mistakes with several patients. With this particular psychotic woman I found myself being drawn into an argument, during which I accused her of demanding things from me that were no less than hairsplitting. I already knew that she had to be related to as if she were composed of mind only, forbidding any reference to her having a body and reacting to any such reference with severe persecutory anxiety. I had, however, no idea why I was not able to respond to this need of hers with professional empathy. Then I had a dream that I would like to refer to as a healing (self-supervisory, [R.S.]) dream. In this dream I experienced for the first time in my life the extreme anxiety engendered by the feeling that part of me had no existence. This anxiety was related to castration fears, but of a much more primitive, primordial origin, possibly related to fear of annihilation, therefore of much greater intensity, never consciously experienced by me before.

As long as this anxiety had not been resolved by having had and having remembered and understood this dream, this anxiety interfered with my capacity to relate professionally to my patient's transferenceal need that I ignore her body. With the help of the dream I was able to resolve my contribution to the countertransference, which stemmed from my never before consciously experienced, and therefore outside my conscious control, primordial, psychotic fear of annihilation. Only then I became free to apply myself professionally, with empathy, to the countertransferenceal task of relating to my patient as if she had no body. I also felt free to contemplate an appropriate time for

sharing my experience with her at a later date, which might, however, never arrive.

An attempt to fit Winnicott's apparently contradictory attitude towards countertransference into the framework of the concepts presented here will show that in 1960 Winnicott clearly spoke of therapist-induced-countertransference: "that which we hope to eliminate by selection and analysis and training of analysts." This he unequivocally regarded as "...the neurotic features (in the analyst) that spoil the professional attitude" thereby sharing Freud's original, negative view of counter-transference as he (erroneously, as I repeatedly presumed) accepted it to have been defined by Freud. He was just as unequivocal in his praise of countertransference as a therapeutic tool in 1947. In that case, however, it is relatively easy to discern that this is especially so in the description of the therapeutic use he made of his temporary hatred towards the boy he had fostered. In respect of this hatred he clearly declared that it was induced by the boy and corresponded to the boy's internal needs, not to his. What he suggested to be used therapeutically was, accordingly, patient-induced-countertransference.

The countertransference in the case of the woman-who-had-no-body seems to have been of the combined type. It was composed of Winnicott's therapist-induced component, his non-resolved fear of annihilation on the one hand and of the patient-induced component, the influence on Winnicott of the woman's need for her body not to be acknowledged. Only after having resolved the therapist-induced component without introducing it into the therapy, was Winnicott able to separate it from the patient-induced component, relate to

the patient-induced one and contemplate using this component at an appropriate moment.

Analyzed in this manner, the pseudo contradiction in Winnicott's attitude towards countertransference seems to boil down to the following state of affairs: It is regarded by him as an asset that can be used as a therapeutic tool when it is patient-induced. When it is therapist-induced, it constitutes a liability, to be resolved outside the therapy by "selection, analysis and training." In the case of combined countertransference the two components have to be analyzed from each other, each component to be treated according to its nature and origin.

The apparent contradiction, when viewed from this perspective, seems to have resolved itself. For the sake of precision it might be mentioned that between the year 1947 and the year 1960, Winnicott's spelling of the term countertransference acquired a hyphen. Would it merit an accusation of hairsplitting if any significance were to be attributed to this change in spelling?

Not unlike Winnicott, McDougall has, without spelling it out in so many words, also used countertransference in a similar, differential way, resolving therapist-induced components by herself, without involving the patient and using patient-induced components as therapeutic tools. In "The Female Analyst and the Female Analysand," (1995) she described the analysis of Madam T., a case of phobia. In her description she included an unequivocal example of a therapist-induced blind spot that was resolved by her outside the therapy, by self-analysis of one of her dreams. Winnicott would refer to such a dream as a "healing" dream. In the present context I would

refer to it as a “self-supervisory” dream. The dream evolved about a non-resolved conflict of McDougall’s with her mother. As long as this conflict had not been resolved by “having dreamed and having remembered and having understood the dream,” as Winnicott would have put it, it obstructed her ability to analyze a similar situation in her patient that happened to be the core of the patient’s phobia. Here again, therapist-induced-countertransference obstructed the therapy, at least until McDougall resolved it outside the therapeutic interaction.

In “Identifications, Neoneeds and Neosexuality” (1986 & personal communication) McDougall described a male patient who suffered, among other things, from multiple, highly complex perversions. The description of this therapy abounded with examples in which McDougall had internal images that coincided with the patient’s fears, needs etc., as the case might be. She did not hesitate to introduce these images into the therapy, share them with her patient at the moments she felt this to be appropriate. These images, she related, had probably been induced in her by the patient’s projective identification and hence constituted parts of his psychic structure. They were, therefore, to be interpreted to him. In the present context they would be referred to as a patient-induced-countertransference, and hence, legitimately to be used as therapeutic tools.

The Role of the Supervisor in the Differential Application of Countertransference

It seems most convenient to start this chapter by the immediate introduction of clinical material.

Example Fourteen

In this case the therapist, a clinical psychologist, opened her first supervisory session with me by the following remark: "I don't understand how you can concentrate in such an untidy room. Just look at your aquarium. It looks as if you have not cleansed it in months." Later she apologized and conceded that she regarded her critical, faultfinding attitude as a liability and considered going into further analysis to get rid of it. In time, a mutually respectful supervisory relationship could be established.

Several months later she presented an initial session with a new patient. She complained that the patient had made her inexplicably angry and that she found herself hardly being able to withhold remarks that the patient would rightfully perceive as criticism of her behavior. The therapist even expressed considerable doubts concerning her ability to accept this patient for therapy in the first place because of this anger she had evoked in her. Revision of this initial session with the patient disclosed that the patient presented material in which she described her behavior in a manner that did, indeed, provoke criticism. During the supervisory session it was not difficult for the therapist to realize spontaneously that an appropriate way to respond to such material

would have been an intervention that would explore the patient's need to present herself in this way. This spontaneous discovery in the supervisory session was just as had been the case in Example Four, (Chapter Four and C.F. footnote in Chapter Nine). An attempt to look for covert guilt-feelings would, perhaps, have been in place.

The therapist wondered, just as had been the case in the example just mentioned, why this had not occurred to her during the therapeutic session. At this point I reminded her of her criticizing, faultfinding behavior during our initial supervisory session and of our discussion of this liability. Further analysis of the therapeutic session now revealed that the therapist had felt herself forcefully being manipulated into a position in which this criticizing, faultfinding attitude of hers, which she was trying to control by suppression, was being activated. This forceful activation of her liability had made her angry with the patient and undermined her capacity to professionally perceive her need to be criticized, to be empathic and attempt to interpret this very behavior. Once all this had been clarified, the therapist was able to respond to her patient's need to provoke criticism with professional empathy and initiate the search for the roots of this need. From now on the therapy proceeded without any undue difficulties for several years.

In other words, the very inception of a therapeutic interaction had been obstructed by countertransference reaction that turned out to be of the combined type. It was composed of the therapist's disavowed critical, faultfinding attitude (therapist-induced-countertransference) and the patient's need to evoke criticism, (patient-induced-countertransference). Fortunately, the therapist

proved to be mature enough to contain the therapist-induced component of this combined countertransference despite the fact that this component would be resolved only in some time in the far future. Consequently, she was able to utilize the patient-induced component to the benefit of her patient.

This example has been chosen for presentation for three main reasons. One is that it exemplifies the possible existence of combined countertransference and its possible deleterious effect on the therapy, from the very inception of a therapeutic interaction. In this characteristic it is no different from therapist-induced-countertransference and patient-induced-countertransference. It also exemplifies its possible analyzability once the contributing components have been identified, thus enabling the continuation of a therapy that had initially seemed to be doomed before it had even started.

The second reason is the perfect complementary relationship between the therapist-induced component and the patient-induced one. This complementing nature of both components would have made it very difficult, even for a trained and experienced therapist, to extricate himself from such a countertransferential complication unless there existed a way of defining both components differentially.

The third reason is as follows: This particular therapist was very much aware of the theoretical concepts involved; they had been discussed with her previously on several occasions. Nevertheless, in such a complementary relationship between both components of countertransference, the therapist's acquaintance with the appropriate terms and their way of enabling the analysis of

both components from each other did not suffice to disentangle her and let her act professionally. She had to be assisted from the outside by supervision (Carsky, 1986).

This last point will now be exemplified by a further clinical example.

Example Fifteen

In the previous example the therapist-induced component of the combined countertransference interference was evident and could be identified from its very start. It was recognized, albeit not as a countertransference phenomenon, even before it made its appearance as such. In the following example it manifested itself, despite its having existed from the inception of the therapy in question, in the very last moments of a supervisory session, almost as an afterthought. This occurred in the context of group supervision. This group had heard a series of lectures consisting of a concise edition of the content of this book, including a discussion of countertransference, its composition and differential applicability. These concepts had also been discussed in previously presented cases, so that the therapist who presented at that particular occasion was in possession of the concepts involved at least on a cognitive level. She was the third therapist who treated the patient to be presented, as two previous ones had given up therapy with that particular patient in despair.

She presented the case of a patient who complained of "fits" that he had been having periodically ever since he had suffered a slight head injury. No one had ever witnessed these fits, but the patient persisted in complaining about them, coming to session after session and

defeating therapist after therapist. The present one was also on the verge of giving up on him.

The material presented revealed a family situation in which the relationship between various family members was based on helping each other. The helper was always regarded as being in a superior position to the one being helped, and the patient was at the bottom of this peculiar pecking order, always being helped, never being allowed to help anyone else. Even when he offered to help his father by granting him a loan to improve his living conditions, his offer was bluntly turned down. The biblical story of Cain was coming to mind, and an idea was formulated: This patient could not afford to be in a position in which he was to be helped because this would put him in an inferior position. This might be the reason for all the previous therapists not being able to help him. The therapist now supported this supposition by adding that her patient had repeatedly asked her if she was not looking down on him, regarding him as "worthless."

A tentative interpretation was formulated: "You cannot allow yourself be helped by me, because you are afraid that if I did help you, I might look down on you and regard you as worthless." The usefulness, or un-usefulness, of this interpretative hypothesis could not be assessed at that time. Nevertheless, it suggested some order in an otherwise chaotic situation, and the therapist seemed to be relieved and indicated that she thought she might offer some variation of this interpretation to her patient without it being immediately ignored or repulsed. At this moment I commented: "It seems to me that you now feel a little better prepared for your next session with your patient." Her answer was, "I believe that I

think that I feel that you might be right.” The irony that could be heard both from the content of her words as well as in their intonation was so obvious that it immediately revealed the therapist-induced component of this countertransferential complex. When we were in a private, face-to-face conversation I asked the therapist if she might not find it sometimes difficult to be in the position of needing help. She then conceded that this was indeed so.

Here, as in the previous example, there was a match between therapist-induced components of countertransference and patient-induced ones. In the previous example the two components were complementary; in the present one they were identical. A patient who could not afford to be helped was in treatment by a therapist who also could not afford to be helped. In contrast, however, to the previous example in which the therapist proved to be mature enough to contain the therapist-induced component of her countertransference and consequently prevent it from further obstructing the therapy, the therapist in the present example proved too immature to do so. This was despite her admission that she had understood the complexity of her situation. She was not mature enough to implement this new understanding and soon discontinued the therapy.

Nevertheless, I regard this as another example that indicates that when the two components of countertransference are perfectly matched, the theoretical pre-knowledge of the concepts does not always help to solve such a complex situation. In such a situation, in which the therapist-induced component and the patient-induced one are either complementary or identical, external help by supervision is usually needed.

This argument seems to suggest that helping the supervisee understand his patient's dynamics, a task the therapist is prepared for by his studies and ought to be able to accomplish unaided, is not sufficient. The main task of the supervisor is to assist the supervisee to deal with his countertransference. This he should do not just in general terms. He should help his supervisee to analyze his countertransference into its components. Once this has been done, he ought to aid the therapist to prevent the therapist-induced component from contaminating the therapeutic interaction and help him to find ways in which the patient-induced component might be introduced into the therapy. The means and depth in which this supervisory intervention ought to be done will be discussed in Chapter Ten.

The point of assisting the therapist/therapists to apply countertransferential components differentially will now be illustrated by a further example.

Example Sixteen

This example took place during the first, chaotic days of the October war in 1973. Quite a few psychiatric casualties who were in no condition to be treated in the field were being treated for acute post-traumatic-stress-disorder by what might be referred to as very brief dynamically oriented crisis interventions. These therapies took place in a civilian recreation resort that had been converted into a kind of inland psychiatric field hospital. A great deal of grief, real or imagined guilt, rage at the authorities who had not anticipated the seriousness of the situation could be located and abreacted, not infrequently with surprisingly good results. Each evening the therapists assembled in a tent, where they exchanged their experiences,

compared their therapeutic results and ventilated their feelings. Senior therapists were enlisted and served mainly as supervisors.

After several days a general feeling of frustration began to be felt among the therapists, and on one evening they presented in such a group meeting reporting that their therapies were "stuck." With the help of supervisory support it gradually transpired that the therapists, most of whom were young men, were beginning to feel guilty about "curing" their patients. This was because the "cured" were then to be sent back to the front. Once these guilt feelings were revealed and openly discussed, the therapies became effective again. It was the supervisory function of these group meetings that enabled these guilt feelings to be regarded indiscriminately as countertransference as a mass phenomenon and when they were recognized as such they could be overcome. Consequently, the unobstructed progress of the various therapies was re-expedited.

At that time the concepts described here had not yet been developed. When regarded retrospectively, they can be defined as the therapists'-induced components of a combined countertransference. The latter was composed of the patients'-induced component, their accusations of their therapists, (perceived by them as representatives of the authorities that had failed,) on one hand. On the other hand was the therapists'-induced component, (their guilt feelings about having to send their patients/comrades back to their units, where they might be injured or killed). These guilt feelings were enhanced by the fact that most of the therapists were young men, only recently discharged from reserve duty in combat units, in

which they had served in times like those. Now that they had completed their studies, they felt more guilt because they could stay safely behind in the field hospital while sending their comrades of a few years ago back into danger.

Incidentally, it might be added that in this particular situation the presence of senior mental-health professionals as supervisors was most probably not unconditionally necessary. The junior therapists might have achieved the same results by peer supervision. Nevertheless, I believe that self-supervision, as opposed to mutual peer supervision, would not have been able to solve this particular countertransference complication. This would not necessarily be because the situation was unusually complex, or because the therapist-induced components and the patient-induced ones were complementary. (Justified, albeit displaced, accusations versus genuine guilt-feelings). This would rather be because the issues involved were issues of life and death and hence extremely intensively cathected. The significance of the point, of outside versus peer or self-supervision will be further discussed in Chapter Eleven.

At a later stage, after they had finished their tour of duty, newly recruited ones replaced the therapists. These new recruits had now to face the same type of problems their predecessors had faced. They were forewarned of the countertransference complication they might face in form of guilt feelings, as just described. Once they had been forewarned, the phenomenon did not repeat itself. This is in line with the claim proposed in Chapter Five, namely that the forewarning of countertransference phenomena,

as opposed to transferencial ones, is helpful in preventing future complications.

The Parallel process in Reverse⁶

The parallel process is well known in supervisory situations. It consists of the appearance in the supervisory process of dynamic phenomena, especially countertransference phenomena that had not been dealt with well enough in the therapeutic process. Its existence in reverse, the appearance, usually to the disadvantage of the patient in the therapy of unresolved supervisory phenomena is less well documented.

As has been the case in the previous chapter, I find it most convenient to start the present chapter with a clinical example, too.

Example Seventeen

Here a clinical psychologist was in supervision for a therapy of a young man whose presenting symptom was that he had developed intensive, not entirely ego-alien, obsessive thoughts about killing his ex-girlfriend, who had developed a new relationship with another man. The intensity of these thoughts gradually decreased, and when they flared up again, it was not too difficult to relate this to transference-countertransference complications. Whenever these complications could be undone, the intensity of the lethal thoughts reduced again. At a particular supervisory session the therapist reported an intensification of her patient's rage. This time it

⁶ Some time after the original article on the parallel process in reverse had been published, I came across an almost identical term, "Reverse parallel process," used in a similar context, without, however, being elaborated, by Epstein, (1986).

was an extremely frightening one, so much so, that she had found it necessary to request the patient's permission to alert his father so that he could restrain him. Circumstances were as follows. The patient had requested an extra session. The therapist had been 'unable' to find a vacancy and refused the patient's request. During the session the patient had also remarked, ostensibly in passing, that this was his birthday. While telling this in supervision, the therapist spontaneously realized that she had failed to see, and consequently grant, or at least interpret, that the requested extra session was meant to be a kind of birthday present⁷. This seemed to explain the intensity of her patient's disappointment upon being refused as well as the intensification of his rage, displaced on his ex-girlfriend.

Both the therapist and I, her supervisor, were, however, still puzzled by the therapist's failure to see the significance of the patient's request during the therapeutic session. Lack of a vacancy for the extra session seemed no longer to constitute an adequate reason for refusing it. Further thought on part of the therapist now resulted in her being able to recall a thought she had almost forgotten. While looking through her diary to find a possible vacancy, a fleeting thought had passed through her mind: "He (I, her supervisor) does not provide me with extra sessions whenever I want them, either." This thought could then be retraced to the fact that the therapist's supervision had recently turned from being institutional, and therefore

⁷ The realization of the therapist of his/her mistake during supervision, before any supervisory intervention had taken place, is another example of the importance of the therapist being "one step removed."

gratis, into private supervision for which she had to pay. The therapist had suggested this continuation of her supervision, despite the fact that she now had to pay for it and the issue had been discussed and apparently accepted by both parties. Nevertheless, it seemed that the therapist still carried a grudge. This grudge for not receiving presents, symbolically expressed by her having to pay for something she had previously been granted for free, was generated within the supervisory situation. Despite its having been generated there, it had adversely affected her capacity as a therapist to react professionally to her patient's request for receiving a birthday present, in the form of an extra session.

Revision of material presented by other therapists on other occasions did seem to indicate that there was a certain, almost regular correlation between supervisory relations and therapeutic results, at least as far as short-term results were concerned. The supervisor's going on vacation was frequently accompanied by therapists' reports of exacerbation of symptoms in their patients. Breaks in supervision because of the termination of academic periods were often followed by concerned telephone calls from therapists who reported "unexplained" acting out on part of their more disturbed patients.

On the other hand, on quite a few occasions therapists spontaneously reported that their patients had improved as soon as a supervisory session had been scheduled on the telephone, before the relevant material could possibly be discussed. This could probably be attributed to the fact that the thought of the forthcoming supervisory session granted sufficient security for the therapist that could then (probably

subliminally) be transmitted to the patients. Another related phenomenon would be the fact that whenever central supervisory figures in psychotherapeutic institutes go on leave, the writing up of therapeutic sessions tends to be remarkably reduced in quantity. The material presented by the patients during these periods would become “resistant,” “uninteresting” or “repetitive.”

As a result of the implications of these observations, it seemed reasonable to assume that besides the well documented parallel process, mentioned above, another, probably no less important process existed. The “parallel process in reverse” as it might be referred to. In this process dynamic forces generated in supervision permeated into the therapeutic interaction and became operative there. This will now be exemplified by another clinical example.

Example Eighteen

In this case a psychiatrist in training had been in supervision for several months, presenting two deluded patients, whom he was seeing separately. Both patients had previously been in the hospital because of delusions and both were by now doing fairly well in therapy, having gained considerable insight into the dynamic roots of their problems. They were, at the moment, free of delusions. All was going fairly well until I had to unexpectedly cancel several consecutive supervisory sessions at very short notice. When supervision was renewed after a break of several weeks, the therapist said in distress, “I badly need your help.” It transpired that both his patients were psychotic again, and he was considering hospitalizing both of them, or at least re-starting them on anti-psychotic drug therapy.

There seemed to be no immediate recognizable intrinsic dynamic reason for this simultaneously occurring de-compensation of both patients. The consideration mentioned in the previous paragraph, in addition to the fact that both patients had started to de-compensate simultaneously started a train of thought that led to the assumption that the exacerbation of symptoms might have resulted from the patients' subliminal perception of the therapist's insecurity, a result, in turn, of the therapist having been unexpectedly abandoned by his supervisor without an adequate explanation.

After this had been discussed between us, the therapist remarked that he had not mentioned something one of the patients had said. He had not mentioned it earlier because it seemed to him to be irrelevant. What he now said was that one of his patients unexpectedly mentioned the significant role in his psychological development of an unreliable grandparent figure. This figure had never been mentioned before, and was never to re-appear in the material presented by this patient, later. It seems logical to assume that this grandfather figure was a representation of an unconsciously acknowledged disappointing supervisor, perhaps a personification of Ogden's analytic third.

After this supervisory session both patients gradually improved without the therapist having to resort to re-hospitalization or drug therapy. As mentioned, the unreliable grandparent figure also disappeared from the material presented by one of the patients.

Here again, there appeared to be a "parallel process in reverse," in which the therapist's feeling of being abandoned, transferentially generated in

the supervisory situation, adversely affected the therapeutic situation. Fortunately, realization of the significance of this “parallel process in reverse,” subsequently and gradually rectified the situation despite the fact that it occurred after the damage it caused had already been done,

The premature discontinuation of my therapy of Herbert and that of Leonard, described in the first part of this book, can be regarded as variations on the same theme with more or less malignant consequences.

These facts and considerations seem to imply at least two practical points.

One point would be retrospective, namely that whenever a patient’s state inexplicably deteriorates, besides the aforementioned negative therapeutic reaction or a mistake on part of the therapist, one of the places to look for the reason for such a deterioration would be in the dynamic aspects of the supervisory situation.

The second point would be prospective. I make it a rule, whenever possible, to forestall such adverse reactions in therapy by discussing with the therapists any foreseeable supervisory empathic failures. These might consist of supervisory separations, or indeed, of any intense transference phenomena that might be detected contaminating the supervisory relationship. These adverse interactions could be the perception of the supervisor by his supervisee as too cool and distant, physically or emotionally unreachable, too critical and non-supportive, presenting a condescending attitude etc. Such empathic failures would eventually find their way into the therapeutic transaction, acting as a particular kind of therapist induced-countertransference. My

impression was that detecting and interpreting such phenomena inside the supervisory situation seemed to diminish negative reactions to events such as supervisory separations quite considerably. In view of the severity of adverse reactions on part of patients, as just described, when this is not done, doing so seems to be justified. (Exacerbation of psychotic symptoms, intensification of murderous fantasies and in cases not mentioned in detail here, the appearance of suicidal ideation).

This is despite the fact that these interventions on part of the supervisor seem to constitute an ostensible blatant transgression of the boundary between supervision and “therapy to the therapist.” The material presented here seems to indicate that failure to point out such transference processes in the supervisory interaction would be a mistake the patients would have to pay for, even irreversibly so in extreme situations.

Further contemplation on the points made above has made me come to a decision. Whenever I was able to detect a dynamic significance my supervisees had failed to see in the material presented to them by their patients, I explained to them that this ability of mine was related to my not being directly involved in the therapeutic interaction, in other words, to my not being at the front, under fire, so to speak. Had the supervisee been in my position, being able to observe the interaction from my perspective, even having the privilege of having the therapeutic session described to him a second time, he would have done just as well. (C.F. Example Twenty-Three).

One further prospective kind of supervisory intervention deserves to be mentioned here. It

concerns those extreme intensively emotionally cathected therapies that are regularly encountered when psychotherapy or psychoanalysis is to be practiced with hospitalized psychotic or borderline patients. These therapies are well known to constitute extremely difficult experiences for the prospective therapists, who are frequently reluctant to take on such therapies and later to persevere with them. Retrospective supervision is frequently not felt by the therapists involved to be sufficiently supportive. Therapists in this kind of predicament have occasionally been found to be feeling supported by supervisory attempts to pre-analyze forthcoming sessions. Previous sessions with the patients are used to construct possible premeditated interventions. (C.F., for example, the prefabricated, non-interpretative intervention in the case of the young psychiatric social worker who was to treat a psychotic social worker, older than herself, [Chapter Seven, Part One])

Therapists have repeatedly reported that they did not have to adhere to these pre-fabricated interventions as such, verbatim, but felt supported by a sort of imaginary supervisory supportive presence inside the session, something to “fall back on.” It was found to be helpful in momentarily extracting the therapists from being immersed in the emotional turmoil, thereby regaining their therapeutic perspective. In extremely stressful situations, such as the case of Caleb, described in the first chapter of the first part of this book, the therapist demanded that I sit in the next room. In this way my supportive presence could be felt all the better. She later reported that my presence, as a matter of fact the presence of any other supervisory figure being theoretically within reach, enabled her to persevere with her task. Other therapists reported

similar feelings of being in need, in such situations, of the physical proximity of a supervisor.

Gauging the Depth of Supervisory Interventions

The examples and considerations presented in the preceding chapters highlight the dilemma of the demarcation between the supervisee's analysis and his supervision, (Caligor, 1981). The question of the transgression of the border, of introducing "therapy for the therapist" into the supervisory situation has repeatedly been discussed. The two polar points on the axis of abstention versus intervention seem, probably, to be most explicitly represented on one end by Levenson (1982), who advocated extreme abstention. Grotjahn has represented the other end in the past (1955). More recently it was represented by Caligor (1981) and Issacharoff (1982). They advocated the interpretation of blind spots via the interpretation of the parallel process.

In the preceding chapter of this book, ideas have been posited that were close to those expressed by Caligor and Issacharoff. It has, however, to be pointed out that the last mentioned authors dealt with the parallel process, the expression in the supervisory situation of dynamic forces usually consisting of what would be referred to here as patient-induced-countertransference. These are, as a rule, generated inside the therapy, whereas in the present context I attempt to deal with dynamic forces that are primarily generated inside the supervisory situation and constitute transference manifestations of the therapist towards his supervisor, affecting the therapy only secondarily. These forces are identical with the transference manifestations the therapist ought to have

manifested towards his original analyst, (provided there had been one in the first place), to have been interpreted by him and resolved. Nevertheless, the material presented above seems to indicate that interpretation of these transference manifestations within the supervisory situation by the supervisor is of vital importance for the optimal conduction of the patient's therapy. As Issacharoff has already pointed out, it has to be considered that some therapists come to be supervised after having completed their analysis. Others, who are still in analysis, might be dealing with issues that are irrelevant at the time, and still others may not have had the benefit of analysis at all.

One of the points that constitute a difficulty in this context is the question of gauging the extent of such interventions performed by the supervisor inside the supervisory interaction. The following examples might provide a provisional solution for this dilemma.

Example Nineteen

Here the therapist, a psychiatric social worker, well experienced in dynamic therapy and having had an analysis, was intermittently presenting the case of a truck driver who gradually became more and more passive without ever presenting signs of an active psychosis. He left his job, neglected to collect the money owed to him by previous clients of his, completely neglected his apartment, and had to be nourished by family members. At the relevant time his therapy had been going on for several years. After several months spent in the hospital, he was in his apartment. Now he was looking after himself, still not employed and refusing to collect the money owed to him, eating at the table of his extended family. Otherwise, he

led a life he enjoyed. He made friends, enjoyed the beach and occasionally went to the theater. In other words, despite not being employed, he was leading a life neither devoid of pleasure nor of satisfaction.

Previously a sworn bachelor, he formed a relationship with a female companion, whom he invited to live with him. This woman, however, turned out to be a "Xantippe," denigrated and emotionally and financially exploited him. Encouraged by his therapist, he was finally able to rid himself of her without too much regret. All this time pressure was being relentlessly put on the therapist to discontinue the therapy, which on the face produced no tangible results with the patient not being employed, living on social security and supported by his family. His enjoying this kind of life and deriving satisfaction from it was not taken into account by the authorities.

The therapist courageously withstood this pressure. When, however, four years had passed she began showing signs of being prepared to give up: "Just look at all these families waiting their turn to come into therapy, while I waste valuable therapeutic hours on a patient who does not even earn his keeping." It took some effort on my part to convince the therapist that she was not wasting these valuable therapeutic hours but investing them. I also tried to convince her that discontinuation of her patient's therapy would probably result in his regression into his former total passivity. I added that his very ability to lead, what for him was a satisfying way of life was a result of her investment. The therapist was still not convinced.

Then it suddenly occurred to her that she had discontinued her analysis after four years. At that

time she had felt that she had resolved her problems. Now she knew that she had been on the verge of problems that she had not been ready to confront. I intervened and suggested that if she continued her therapy with her patient for longer than the four years of her analysis, this might prove that her patient was a better patient than she had been. Even more, that she was a better therapist than her original analyst. Her immediate, unpremeditated, automatic response was, "No one can imaginably be better understanding than Dr. X" (her original analyst). Further reflection on her part, however, enabled her to see the connection and the patient's therapy was rescued, at least for the time being.

Example Twenty

In this case the patient was a paranoid schizophrenic woman in her thirties, treated at home by an experienced and well-known female clinical psychologist. Her case was primarily presented at a seminar and enabled no really detailed description of all the dynamics involved. A general history and psychopathology were presented and the main point in this presentation was that the patient was deteriorating. The therapist's exact words were "I feel that I am losing her." As will be shown later, this choice of words might not have been a coincident.

Several months later the case was presented again, this time in an on-going supervisory situation that enabled deeper insight into the patient's dynamics. By now the patient was in hospital because she was gradually passively committing suicide by utterly neglecting herself to death, refusing all outside help, including food. While hospitalized, she continued to be seen by the same therapist who had been treating her at

home. Despite the fact that this was not entirely in line with hospital regulations, I insisted on such arrangements and usually encouraged them, provided the therapist cooperate with hospital staff. Otherwise, I felt the patient would feel abandoned by his therapist at a moment of crisis, when he needed his therapist most.

Now that the supervision could be carried out at length, I asked the therapist for a possible reason for her patient's gradual decline. The answer was that the patient had developed her psychotic deterioration a short time after her father had committed suicide by shooting himself. This extremely important topic had barely been discussed with the patient, and had never before been mentioned in supervision. I now expressed some amazement at the fact that such a highly cathected subject had been swept under the carpet, so to speak.

As gently as I could I asked the therapist if she had any difficulty with the topic of suicide. She now told me a secret that she insisted hardly anyone but the closest members of her family were familiar with. Her future mother-in-law had committed a serious, fortunately unsuccessful suicide attempt on the very day of her, the therapist's, wedding-day. The therapist's expression during her first description of this therapy, "losing the patient" now acquired a specific meaning, as the Hebrew equivalent to committing suicide is "causing oneself to be lost." No further prying into the meaning for the therapist of her mother-in-law's action was needed, nor appropriate. The therapist was now able to find the inner space for containing her patient's feelings about her father's suicide. The therapeutic interaction, which had been going on

in a sluggish way despite the therapist's being in constant contact with her patient in the hospital, now gained new momentum. Shortly thereafter, the patient could be discharged and both she and the therapy have been going on relatively well for as long as could be observed.

These two examples are fairly representative of therapist-induced-countertransference. The therapist's non-resolved conflict in Example Nineteen, which had caused her to discontinue her own analysis, had bred a secondary derivative that was now sabotaging her capacity to fulfill her role as the leading partner in the therapeutic dyad. Not interpreting this secondary derivative would most probably have cost the patient the immediate continuation of his therapy. Referring the therapist to further analysis would have been pointless. For one thing, no analysis was available at that time. The basic conflict that had made the therapist discontinue her own analysis in the first place was, however, at least knowingly, not touched at all, and doing so did not seem to be indicated or even appropriate. The same holds true concerning the therapist in the second example. There seems to have been no need to delve any deeper into the emotional meaning for the therapist of her mother-in-law's suicidal gesture on this particularly important day in her life. On the other hand, the mere pointing out, in supervision, of those aspects of the unresolved emotional problem that in the form of therapist-induced-countertransference had obstructed the therapist's capacity to contain her patient's reaction to her father's suicide, enabled her to act in such a way as to maintain the therapeutic dyad at an optimal level. This was just as it had enabled the therapist in the previous example to re-establish the same capacity.

Looking back on several examples presented in the previous chapters in other contexts, the same seems to hold true. The same phenomenon could be observed in many cases. Hinting at the problem in the therapist's life seemed to be enough. This holds true for Example Three in Chapter Four, for Example Seven and Example Nine in Chapter Five, for Example Twelve in Chapter Six, for Example Five in Chapter Four, as well as in many other cases.

The act of pointing out to the therapist a problem more times than not sufficed for the problem to no longer act as a therapist-induced obstruction. Resolving, or not resolving the problem, was now up to the therapist and it no longer influenced the therapy. There seem to be two exceptions to this rule. The first exception concerns those countertransferential complications that result from disturbances in the supervisory situation. Unless the therapist is at that time in analysis, and sometimes even if he is, these therapist-induced countertransferential complications ought to be resolved on the spot, preferably inside the supervisory situation. The second exception concerns those therapists who are not emotionally mature enough to contain their countertransferential problems when these had been pointed out to them. For those therapists, the only solution would be further analysis.

As an internal adjuvant to help me resist the temptation to intrude too deeply into the therapist's problem, to do "therapy for the therapist," I used an internal reminder. Its content was that it was neither the patient, nor even the therapist who was the target of supervision, but the optimal functioning of the therapeutic dyad as such. This could be accomplished by exerting

some influence on the therapist, without, however intruding into his life, just enough for him to assume, or in other cases to re-assume the role of the leading partner in the therapeutic dyad. Doing so, I kept reminding myself, was not entirely unlike doing marital counseling, with one spouse being unavailable for interventions, in other words, "***Ex Parte.***"

The Supervisory Situation as a Learning Experience for Medical Students

As mentioned in Chapter Four of the first part of this book, the medical students' participation in ward meetings proved to be a learning experience in vivo of psychotherapy being conducted. Nevertheless, this participation did not always enable the students to feel it as a good enough example at first hand of experiencing individual psychotherapy being carried out.

A better way was being looked for and it was suggested that after having asked the permission of the therapists involved, the students would be invited to participate actively in supervisory sessions. This arrangement had the advantage that the identity of the patients, whose most intimate secrets were being discussed, would not be compromised. Surprisingly enough, obtaining the therapists' permission proved much easier than I had expected. They even showed signs of enthusiasm at the suggestion of the idea. The following is an example that shows how, during their six weeks stay at the hospital, the students witnessed a real intra-psychic change, resulting from the implementation of an interpretation, in the construction of which they took an active part.

Example Twenty-One

The patient chosen for one of these weekly supervisory discussions was a holocaust survivor, whose fate had suffered a particularly cruel twist. She had been hospitalized for severe anxiety states that developed after her regular therapist, who

had been seeing her for several years as an outpatient, had retired. Besides being sedated, she was put in the hands of one of the more experienced therapists of the ward. One of her characteristics was that she used to accuse herself of being worthless, of having made a mess of her own, as well as her now grownup daughter's life. At the relevant time she had already improved to a degree that she could be seen twice a week on an ambulatory basis. Nevertheless, her anxiety states continued at a lesser severity. Now she developed the habit of frequently calling her therapist on the phone at his home between sessions, bitterly complaining in a hysterical tone of voice that she was worthless and that he was seeing her only because this was his duty and not because he really liked her.

During the supervisory sessions her complete history was unfolded. It transpired that when she was at the climax of her Oedipal attraction to her father, the Germans occupied her hometown in Poland. On the very next day her father was shot in front of her eyes, whereupon her mother committed suicide by jumping out the window. After she had somehow survived the years of persecutions, an uncle of hers who had also survived fostered her. Now a girl in her teens, her uncle sexually molested her on one hand, and named her a slut whenever she dared go out in what, in his eyes, seemed immodest clothes. Later her aunt found out about the affair and evicted her from home. All this must have made her feel her being a sexual being was even more of a sin than before.

These issues were discussed in the supervisory situation with active participation on part of the students and the following interpretative

supposition was hammered out. Her father being killed during the climax of her Oedipal attraction to him must have made her feel that her love for him was lethal. Her mother's suicide must have made her feel that she was not worth living for. Her uncle's behavior and its consequences must have complicated things even more. It was now further surmised that whenever she felt, consciously or unconsciously sexually attracted to her therapist, she had to call him immediately in order to be reassured that no harm had befallen him. Also to re-ensure herself that she was not worthless, unworthy to be an object of his affection and that he was not merely doing his duty by her.

This interpretation was gradually, not in these exact words, spelled out to her in consecutive therapeutic sessions, and her hysterical phone calls disappeared almost completely. Here I had a Q.E.D. in vivo of the effectiveness of an interpretation being performed for the students, right before their very eyes. Later they told me that these, as well as other supervisory sessions concerning other patients, were an even more impressive experience for them than participation in the ward meetings. A few of them later decided to choose psychiatry as their field of specialization a result of their having been impressed with these supervisory meetings. I felt a particularly intensive sense of satisfaction when the students admitted at the end of their psychiatric clerkship that they had not expected psychiatry to be such a complex, trying and demanding discipline. This was even more so as they had just emerged from stressful clerkships in internal medicine or surgery and now expected a period of relaxation in the "easy" clerkship in psychiatry.

I would like to conclude this chapter with a few more words concerning the medical students. At the start of his clerkship, each student would be allotted a given number of patients whom he had to follow up and know as many biological and mainly psychological facts about as possible. I used to assemble the students and instruct them to politely introduce themselves as such to their patients. To politely and understandingly accept any refusal of patients to be interviewed and, most important of all, inform the patients of the temporary nature of their mutual relationship. At the end of the clerkship the students were instructed to thank each patient for his cooperation and discuss with him/her the consequences of separation. All these actions on my part might be connected with the unforgettable memory of many years ago of the conclusion of my clerkship. For my final examination I was allotted a completely disorganized schizophrenic young woman who could hardly join two sentences coherently to each other. When I had finished seeing her and was about to leave the room in order to write up what I had been able to understand from the interview, she turned to me and said in a sad voice but entirely coherently, "How I envy you. You have seen me for one hour and now you go out, collect your reward and then go on with your career, while I am destined to stay in this damned place for the rest of my life."

Concluding remarks

This is probably the place to raise some further points.

I would maintain that the appropriate question to be asked at the end of a supervisory session, especially one in which the therapeutic relationship with a more deeply disturbed patient had been discussed with is not necessarily: "do you, therapist, now better understand your patient's dynamics?" As stated above, this ought to be taken for granted. The real question I should ask myself and the therapist at the end of such a supervisory session is: "Do you, therapist, now feel more secure in your relationship with your patient? Do you feel that you are better equipped to be a container, where you previously may have felt to have failed?" The following is intended to exemplify this point.

Example Twenty-Two

In this case, a young female clinical psychologist was presenting in group-supervision that consisted of the mental-health professionals of her ward, a very closely-knit unit. The case she presented was that of a chronic schizophrenic male patient. By the time she presented him she had been seeing him for about one year, a period that more or less coincided with the length of stay she had been in that ward. She had replaced a former therapist of this patient who had left the ward because of being pregnant. She realized that for "some reason" she had not found it necessary to present this patient for supervision previously, despite the fact that from the very beginning of his therapy she had felt him to be a burden. Now she

was beginning to feel even more repulsed by her patient and inundated by the material he was presenting her with. She could no longer hold-in the material without sharing it. As she later put it, "He must have crossed a certain threshold of tolerance in me."

She brought to supervision the content of a recent session with him, a session the patient had referred to as a "confession." He wanted to "confess" two "sins" he had never previously confided in anyone. The human body, and especially the female one, had always been of great interest to him. Now he started on a very detailed and plastic description of female anatomy, pointing at his own body in order to better locate the place of the various female characteristics: the ovaries, the womb, the vagina, the breasts etc. One of the "sins" he now disclosed was a childhood secret. He had always found opportunities to watch female genitals very carefully from close distance, again giving a very detailed and plastic description of what he used to see there.

At this point the group members interfered with some remarks, the therapist, however, asking everybody's forgiveness for what she still had to disclose, insisted quite irritably on finishing her description of the therapeutic session. She related that the patient had told her that his mother had acquainted him with the "facts of life" from a very early age. The patient's mother's description of these "facts of life" consisted of a not physiologically correct, but very detailed description of the female menstrual cycle. He related this, pointing again at the various locations in his body of the organs involved in the process, to loan more effect to his plastic

description. Then he confided his second “sin.” He had always been fascinated by everything that had to do with menstruation, which had always been described to him by his mother as something mysterious and dangerous. She had told him that having intercourse with a menstruating woman might even prove to be fatal. Nevertheless, he could not help being fascinated by everything connected with the process and always asked his girlfriends to show him their used sanitary equipment. Now he re-entered into a very plastic and realistic description of the blood absorbed by the material and of the pleasure he derived from these sights.

All this was being told by the therapist in a very constrained tone, her face was stern and she was obviously in great distress. Later she described her feelings at this point as one of deep heaviness, not unlike depression, of not being understood and contained. At this point I intervened and said that by her asking everybody’s pardon before going on with her description, she may have indirectly indicated that she felt she was about to do something that in her eyes she might feel to be offensive and I then asked her feelings about this. She was still feeling semi-consciously being inundated and mainly exposed, while at the same time she was trying to co-operate with the continuation of the supervisory process. Several interpretative alternatives came to my mind, among them the possibility that the therapist might feel guilty about using the group to evacuate her disgust, just as the patient had forced her to absorb his mental excretions. I felt, however, that addressing myself to the therapist’s distress was more relevant, and selected a different alternative. I remarked that the therapist must have felt forced by her patient’s vivid description of his perversion,

and even more so by his pointing at the various relevant locations on his own body, to become conscious of her own femininity, especially to those aspects of this femininity she regarded as intimate. I added that she might be furious with me and with the group for having indirectly, brutally been forced to expose this intimacy before us. This must have been most extremely embarrassing for her. Then I followed with a brief "lecture" on the problems of menstruation in general, especially on its being associated with anal inability to control excretions. In retrospect this "lecture" seems to have been superfluous. The therapist was already smiling, feeling that what she later described as being contained. Her plight had been understood, her fury had been legitimized, and for the rest of the supervisory session she felt obviously relieved. The "container" had now been "contained."

Retrospectively she described this session as a deeply emotional experience, rather than a cognitive one. This experience enabled her to verbalize for herself feelings about her femininity that had previously existed only at a pre-verbal level. Her following sessions with her patient were not exactly enjoyable, neither were they different in content from the previous ones, but having undergone this particular supervisory experience, these following therapeutic sessions proved to be non-problematic. Her being inundated and later contained enabled her to empathize from a deeper perspective with her patient's having to cope at too early an age with being inundated by his mother's descriptions of the "facts of life." This is the way she related to this episode in further supervisory sessions.

This episode might also be an example for gauging the depth of the supervisor's intervention, going just as deep as to make the therapist aware of the nature of her predicament. Thereby I felt to have made it possible for her to contain and prevent this predicament from contaminating her capacity to relate to her patient with professional empathy. Going any further would indeed be a transgression. Speaking retrospectively the therapist admitted that while I was speaking, referring in public, albeit by implication, to her intimate problems, she for a moment panicked and felt to be again on the verge of being intruded upon.

In my private practice I have made it a point that whenever a therapist, who is no M.D., feels that either he or his patient can no longer cope with depression and/or anxiety, and attempts to refer the patient to me to review the case and possibly suggest drug treatment, to interview the therapist first. Besides the complication of adding a further figure into the intimacy of the transference relationship, I believe such an action on part of the therapist to be perceived by the patient as a sign of the therapist's incapacity to contain him, thus increasing the patient's anxiety even further. In quite a few cases the therapists reported that after they had been interviewed in what later turned out to be a supervisory session, they felt reassured and consequently the therapy could be carried on without having to resort to drug treatment. In these interviews, *a posteriori*, turned into supervision, the therapist's difficulties frequently turned out to be patient-induced-countertransference projected feelings of incompetence that existed in the patients. In the few cases I gave in and saw the patients in consultation, the results were usually unclear,

ambiguous, complicating the transference relationship and unsatisfactory.

A further remark seems to be in order. I call it the James Bond technique. In Fleming's stories, James Bond is supposed to discover traps set for him by his enemies. He is, however, told not to avoid them but deliberately to fall into them and solve them from the inside. I frequently used to tell my supervisees to adopt the same tactic. Patients often set traps for their therapists and Example Nine is relevant here.

Yet another point refers back to Chapter Seven in Part One, in which I attempted to deal with non-interpretative interventions. In my position as supervisor, supervisees frequently came to me asking: "The patient asked me to do this or that for him," or, "I feel like making this or that non-interpretative intervention." I tended to answer, "I cannot predict the outcome unless we analyze the situation and even then it will be no more than an educated guess. The final outcome that would test whether what you said or did as a non-interpretative intervention can only be measured retrospectively by the result"

One of the reasons that seem to make supervision so vitally important in the first place is the fact that the therapists cannot really abstain from becoming emotionally involved, caught up in the interaction, as it were. This seems to be the case even when dealing with "purely neurotic" patients. It is not necessarily the supervisor's wisdom or experience that makes it easier for him to spot and diagnose the dynamics of what goes on in the therapy. Neither is it exclusively the therapist's knowledge and experience that enables him to divine aspects of the patient's personality he, the patient, had not been able to see in himself. In

both cases it seems that the fact that the observer is one step removed from the action, not directly involved and caught up in the intensity of the emotional turmoil, that enables the supervisor to be of vital importance. I sometimes regard the supervisory situation as one in which I have one intact, albeit threatened, ego interposed between myself and the turmoil of the patient's emotions, an ego that functions as a partially filtering and organizing entity. This seems to be the reason that peer supervision, and paradoxically, retrospective self-supervision, frequently functions no worse than supervision by a senior supervisor. "One step removed" has to be understood literally. "Removed" but only one-step so, still in intimate contact with the interaction, without being in danger of being caught up in it. From my own experience I know that the dynamic significance of any particular session frequently dawned on me when I was writing up the session. This seems to be because while writing up the session, I was already one step removed, being in position to reflect on the session out of the direct fire-line. I believe this is one of the reasons that writing up sessions is of vital importance, beyond the option it offers to refer to the session again at a later time for comparison.

In this context, quite unexpectedly, the real flesh and blood external supervisor comes in through the back door, so to speak. I remember myself writing up sessions with my supervisor of that period, (Dr. Malan), always in the back of my mind, causing me to think how he would have responded in this or in that situation. These thoughts always inspired me to attempt to come up with better and deeper understanding of the dynamic meaning of what had happened in the session in question and helped me to formulate

appropriate interventions for the future ones. This coin seems, however, to have another face as well. I remember different supervisors constantly occupying the back of my mind, reminding me that they would have understood and interpreted the situation much better than I ever could. It took me several years to liberate myself of these persecutory internalized supervisory entities, which for some years took the form of some felt difficulty to distinguish between supervision and castration until I developed a style of my own. This development is possibly reflected in the way this very book has gradually been written.

The widening of indications for analytic treatments has resulted in the inclusion of patients of far less maturity and integration than neurotic ones, such as borderline and psychotically organized ones. Their, by definition, tendency for projective identification, has made this being “one step removed” more problematic for the therapist and more vitally important for the position of being “one step removed” to be occupied by a third person. Here are two examples:

Example Twenty-Three

A schizophrenic patient had told his young therapist some secrets about his (the patient's) sexual deviation. A few sessions later the patient told his therapist that he had lent a substantial sum of money to a friend and was now worried about the friend returning the money. The therapist mentioned no connection between the two stories and I am certain that had I been in his place I would not have seen any connection either. But being one step removed, not directly in the “line of fire,” it sprang to my eyes that what the patient was really worried about was the question of how the secrets he had deposited with his

therapist were to be returned to him to his benefit. I told this to the therapist, and made it a point to mention that had I been in his place, I probably would also have missed the connection. The therapist used this intervention in his next sessions with his patient without being intimidated by having missed it previously.

Example Twenty-Four

This happened in a peer supervision situation. A senior, experienced therapist was speaking of a suspected schizophrenic patient of his. The patient spoke of her duty in the army, which was to search the clothes of female civilians legally crossing the border, to make sure that they carried no explosives. The patient added that she was afraid that the explosives might blow up in her face. The psychologist, a very good one at that, saw no “Here and Now” relevance in this story. It was a much younger, inexperienced therapist, who was sitting literally and figuratively “one step removed,” who remarked that the patient was implicitly warning her therapist to pry very carefully, for fear of the “explosives” hidden in her psyche going off.

Two further examples seem to be relevant at this point:

Example Twenty-Five

In this case an experienced psychologist was telling about a session with one of his patients. The patient had been transferred from another hospital in which he was employed tearing down ancient buildings. He said that he had to be very careful not to touch the supporting pillars because the building would collapse. Listening, it occurred to me that he was also talking about his therapy, that the therapist, while tearing down un-

necessary defenses should be careful not to touch vital structures in the patient's psyche, because the entire psychic apparatus might collapse. It seems that I was able to see this implication because I was not directly involved.

It seems not to be out of place to come back in this context to Rubin, the man who deprived his wife of sex because he envied her. In his therapy I found it necessary to explain to him time after time that my ability to see things in him that he was unable to see for himself was the result of my being able to see him from outside, "one step removed." In this way his envy of me ameliorated to a degree he was better able to accept interpretations.

Example Twenty-Six

Here two therapists, a female and a male one where giving a lift to a patient. Without paying attention to his presence, they discussed matters that concerned issues going on in the ward they worked in. During the next session with one of them the patient began talking about his being present during his parents' intercourse. In this case, once more, the relationship between the therapists' discussion of ward affairs and the patients associations jumped to my eyes because I was "one step removed."

This position, however, of being "one step removed," seems to me to be the one advocated originally by Freud for the ideal therapist to occupy. This thought would imply that it is the supervisor, and not the therapist, who should nowadays be identified with Freud's "projection screen" or "surgeon." That the one capable of reflecting the unconscious objectively, unemotionally, free of distortions can no longer be

the therapist alone but the supervisor, perhaps even the “supervisory dyad.”

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ISBN 965-90450-1-6 ? '«''