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Recurrent Psychotic Depression Is Treatable by Psychoanalytic Therapy Without Medication

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Psychotic depression is best treated by psychotherapy without medication. If medication is used it should be withdrawn as the patient can tolerate it. Every affect, including depression, has meaning. Depressed patients may feel sad, frightened, angry, undifferentiated negative affect, or no feelings at all. How to deal with sleep disturbances and with suicidal danger is discussed. Several clinical cases are discussed, including a man who was "cured" of depression with insulin coma treatment in his 20s and was rehospitalized nearly every year thereafter for depression. He also suffered from "spontaneous" panic attacks. Medications only partially helped. He began psychoanalytic therapy without medication in his 60s. When the meanings of his panic attacks and his depressions were discovered, he permanently recovered.

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In most of my papers (e.g., Karon, 2003) and in my book (Karon & VandenBos, 1981) I have repeatedly made the point that schizophrenic patients are treatable by psychoanalytic therapy, that psychoanalytic therapy without medication is the treatment that is most effective, and that medication may be used as a temporary adjunct but it should be withdrawn as rapidly as the patient can tolerate. As we found in my Detroit project, with randomized assignment and blind evaluations, even 70 sessions of psychoanalytic therapy, as compared to medication properly used, led to a much greater improvement in the thought disorder and a more human life in a variety of ways, and consequently a much lower rate of rehospitalization. But the effectiveness of psychoanalytic therapy for deeply disturbed human beings is not confined to schizophrenics. As Michael Teixeira has written in his classic paper on the treatment of manic-depressive disorders by psychoanalytic therapy (Teixeira, 1992), similar approaches to psychoanalytic therapy are similarly effective with these patients as well. And again, patients are more likely to make optimal progress without the use of medication, or with temporary medication which is withdrawn as rapidly as the patient can tolerate.

Every diagnostic category consists of a highly varied group of people. Among others, Harry Stack Sullivan (1953) and Karl Menninger (Menninger, Mayman, & Pruyser, 1963) emphasized how poorly diagnostic categories characterize patients. Luckily, psychoanalysts and other serious therapists treat people, not symptoms. For depressed

patients, as with anyone, the conscious and unconscious fantasies underlying any symptom always result from the interaction of their actual life experiences with pre-existing fantasies so that the patient's whole life history from early infancy onward is relevant. The defense mechanism of isolation is an almost invariable defense of severely depressed patients. If you ask a depressed patient what was going on in their life just before the depression started, they usually will say, "Nothing." If you persist, they will typically say, "Nothing important." If you persist, that you want to know the unimportant things that were going on, they will tell you things which would depress anyone, but which they do not connect with their feelings.

Unfortunately, it is not fashionable these days to get an accurate case history. After I presented a Grand Rounds at a major department of psychiatry 2 years ago, one of a group of advanced psychiatric residents said with a puzzled look, as if it were a new idea, "I guess what you are talking about might be called historicity. If we knew the patient's history, what they're talking about would make sense."

Just because a patient calls him or herself depressed, or professionals have diagnosed the patient as depressed, does not mean you know what the affective experience of the patient really is. As Henry Krystal has pointed out (personal communication, 1980), one should always try to find out what the actual affect is. It may be sadness, terror, self-disgust, shame, guilt, anger, undifferentiated negative affect, or no feeling at all, to name some of the possibilities. Every depressive has moments (or long periods) of terror, just as every schizophrenic endures periods of depression even when getting better. Psychotic depressives often have no feelings at all, and when they begin to feel sad and/or weep they are usually improving. One way of understanding this process is that the lack of feeling is repression in order to avoid unbearable pain, and the re-experiencing of sadness in bearable quantities is frequently a part of the process of recovery.

Severely depressed patients are geniuses at convincing therapists that the patients' lives are hopeless and the therapy is of no value. But unconsciously they desparately hope that they will not convince you. A clear statement that you do not share their pessimism is very helpful. While other determinants of depression are more fashionable, the role of anger should not be neglected.

One of the mistakes of psychology, psychiatry, and even psychoanalysis was the puritanical belief that feelings are irrational. But Rapaport (1950) a long time ago said there were no thoughts without feelings, and Tomkins (1962, 1963, 1991, 1992) pointed out that emotions are a central part of rational thinking. If we are happy, something good has happened; if we are depressed, there is something to be depressed about; if we are angry, something is hurting us; if we are frightened, there is something to be scared of. If it is not in consciousness, then it is unconscious, and if it is not in the present, it is in the past, and something in the present symbolizes it.

I remember discussing this with Viggo Jensen early in my career. I said that he had treated many more depressives than I had, but every endogenous depression I had ever treated had very good reasons for being depressed. He said, "Don't you know what an endogenous depression is? That's a very severe depression in someone whom you haven't talked to long enough to find out why they are depressed."

Thus, I was recently referred a woman in her 70s, diagnosed with an endogenous depression, who was hospitalized for the second time within a year. She had been treated with medication during both hospitalizations and the intervening period. The medication was accompanied by some kind of counseling when she was not in the hospital, but the so-called therapist acted as if the medication was the real treatment, and the patient felt she had learned nothing from the counseling. During my first interview with the

patient, and my telephone conversation with the referring professional (a friend of the family who was concerned about the adequacy of the treatment), the same fact was disclosed. The patient's husband of many decades had died. The patient held together for a month, and then fell apart, and was hospitalized. When I mentioned on the phone to the ward chief (who is also a faculty member at our Department of Psychiatry) that this was a mistake even Kraepelin would not have made, there was a pause, and a puzzled voice said, "He's not a recent psychiatrist, is he?"

I arranged for her to begin psychoanalytic therapy with me after discharge and her medications (they had her on three) to be withdrawn in a medically responsible way. Later, a relative, impatient with the slowness of psychoanalytic therapy, thought she should be treated with medication, and arranged for her to be tested by a psychologist who agreed and suggested that the patient should see a psychiatrist and be treated with medication.

The relative asked me to tell the patient to comply with the recommendation, but I pointed out that the psychologist's husband was a psychiatrist who had once bragged to me that he had treated 700 patients simultaneously. "That is not the kind of psychiatrist she needs."

I reminded the patient that she had already tried medication, and it had probably helped at first, and then did not seem to help.

"You're wrong," she said. "The medication did not help at all."

I then suggested that if she saw a psychiatrist, she should see a competent one, and recommended a medical psychoanalyst I trusted. The patient reminded me that I had already mentioned that name as a reasonable alternative if she were unhappy with me, or preferred a medical professional, but that she was not interested in a psychiatrist.

"Yes, I guess you have seen a number of psychiatrists before you saw me."

She said, "I saw them. But they never saw me." Patients often say it more clearly than we do.

Unfortunately, there is a professional zeitgeist that suggests that depressive affect does not have meaning, and is not related to the life history. A chronically depressed man, who had been treated for 20 years by a series of psychiatrists, some of whom were psychoanalysts, was referred to me for treatment. All of his previous treatments involved medication, usually accompanied by psychotherapy. Given his long history of treatment, I informed him that he should be seen 3 times a week and that the treatment would probably take 2 or 3 years. He said he had friends who were physicians who worked for an HMO and he knew that no one needs to be seen more than once a week and no one needs to be seen for more than 20 sessions, and I was just trying to run a bill on him.

I suggested I would see him once a week for 20 weeks, and we would do what we could. After 10 weeks, as I always do when there is a time limit, I pointed out that we only had 10 more sessions. He got mad at me for being such a son of a bitch that I would not see him more than 20 sessions. I said that if he felt that strongly we did not have to stop at 20 sessions. In later sessions he got furious at me because I would not see him more than once a week. I said that if he felt that strongly, I could see him more than once a week. He later got angry because I would not see him more than twice a week. I said that if he felt that strongly, I could see him three times a week. The treatment lasted 3 years. At the end this man who had been in treatment for 20 years said that no professional before me had ever related his depressions to the way his mother and his father had related to him. "I guess they helped. I limped through life getting along, sort of. But I don't think I was ever really in therapy until now."

Antidepressant medications have been over-sold. They are more effective than placebos, but the difference seems to be surprisingly small (Kirsch, Moore, Scoboria, & Nicholls, 2002). They are particularly ineffective with children and adolescents, a fact which has been hidden until England banned the use of all but one for children and adolescents, and that "one" must have a warning on the label that it is not recommended for children and adolescents. The ban is not merely because they are ineffective but because they dramatically increase suicide and homicide (Healy, 2004). Luckily, most people even on antidepressants will not commit suicide. An even smaller group will commit murder. But the rates are increased, and the manufacturers have withheld this information from physicians. That is why I prefer not to have patients medicated. I tell patients I will never ask them to give up anything they need. However, the odds are that they will eventually get off medication if they are in treatment with me. If they ask for information, I will summarize what I know about the current research data and suggest readily available sources, like Breggin and Cohen's (1999) *Your Drug May Be Your Problem*, where the known side effects, and the known withdrawal effects of most currently used psychiatric medications are accurately summarized along with advice, drawn from the general literature in pharmacology, on how best to safely withdraw from a medication, both in terms of general advice and of specific medications. The research literature suggests that several types of psychotherapy are as effective for depression as medication; adding medication to psychotherapy does not increase effectiveness, but does increase the relapse rate (e.g., Antonuccio, Danton, & Denelsky, 1995). You are not likely to have heard this because most continuing medical education seminars are prepared and the lecturers hired by pharmaceutical manufacturers. Whether the patient is a new patient or a patient already in treatment, I will always summarize the research literature as I know it at least once, to explain why I do not recommend medication. Further, patients have a right to accurate information, which they probably do not already have. However, patients, especially those who are doctors or nurses, have taught me that, after the first time, they bring up the issue of medication at a later time as a resistance, knowing that I tend to give a little lecture on the subject. I have learned to point out that patients know I do this, and therefore bring it up when there is something else important that they do not wish to talk about.

If a depressed patient is a new patient, not yet on medication (which is rare these days) I will tell them that some professionals would treat them only with medication, some with both medication and psychotherapy, and some professionals would treat them as I do, because I think it is best, with psychoanalytic therapy.

If they would like to be treated with medication, I would be glad to refer them to Dr. A, who reads the literature, and will give them the right medication at the right dosage and check for side effects. If they want a combination, I would be glad to refer them to Dr. B, who also reads the literature and will give them the right medication at the right dosage and check for side effects, but also talks to his patients. And if they want to work hard, they should stay here and work with me. I say the same thing to patients working with me, who ask about being put on medication. In either case, they ask, "Won't you work with me if I go on medication?'

"No" I say. "But I'll be here after you try it. You can come back, if you want to." They typically get mad at me, but stay in treatment.

Not sleeping is an issue which frequently comes up with depressed patients. They try to panic the therapist. But Alfred Adler (1968), pointed out many years ago that people do not need to sleep, they need to rest. Rest includes a reasonable amount of tossing and turning; no one is absolutely still even when asleep. Eight hours of rest while wide awake

is as good as 5 hours of the deepest soundest sleep. It is an extremely boring way to spend a night, but you can function the next day.

For any patient with a sleep problem, including depressives, you first give this advice. If the patient can do it, they will discover it works. Frequently, the sleep problem goes away, but if it does not they can still function. About two-thirds of patients can make use of this advice.

For those who say that it does not work or who cannot even try it, the next step is to give an Adlerian interpretation. Using the example of the student who cannot sleep the night before an exam, Adler suggests neurotics create a distance between themselves and their lives by creating an unconscious alibi in advance: How can anyone expect me to pass when I did not even get a good night's sleep? And if I do well, think how much better I would have done if I had had a night's sleep. Like a good neurotic you are perfect no matter what happens, but like a good neurotic you are more likely to fail in the real world.

After explaining this, you ask the patient, "What do you need an alibi for failing at?"

Such an Adlerian interpretation will help approximately two-thirds of those who were not helped by advice. The one patient in nine that neither of these procedures help requires that their dynamics be investigated individually.

Suicide is always a troubling concern. Depressives are no more likely to commit suicide than schizophrenics, but it is a troubling concern in any event. Hopelessness is a necessary but not sufficient cause for suicide. No one kills themselves if they have a strong hope of getting something important by staying alive.

There are only three theories of suicide that I find worth being concerned with. The first is the idea that suicide is an attempt to get even with someone else. As the folk-culture puts it, "I'll eat me some worms and then I'll die and then they'll be sorry." Every child has thought this, and anything every child has thought is in the unconscious of every adult. This leads to the idea that, on the one hand, you must create hope by the patient's relationship with you. It's not that you can solve everything today, but most of the things that people commit suicide over are solvable. Secondly, you should tell them that many people commit suicide to get even with someone else, and it's stupid because it means that the other person is a lot more important than you are, if you are willing to hurt yourself a lot to hurt them a little. Besides, it is surprising how quickly spouses, and ex-lovers, and even parents get over it. (As you probably know, the one set of people who do not get over it are the children of suicides. I don't usually describe that to patients unless they have young children they seem to care about.)

The second view is the rescue fantasy, originally described by Jensen and Petty (1958). Their view was that the suicide really does not want to die, that he or she projects their superego onto someone else, and asks them implicitly "Do I deserve to die?" That is why suicides almost always tell someone else, and if that person does nothing to save them, the message is "You deserve to die." From this standpoint, the one thing a therapist should *not* do is do nothing. The therapist should indicate by words or actions that they don't think the patient deserves to die.

The third view is that the suicide has internalized a parent whom they felt wanted them dead.

The Thematic Apperception Test (TAT) can be useful when you are not sure about suicide (Karon, 1981). The most dangerous protocol consists of stories in which the hero of the same age and sex and under similar circumstances as the patient commits suicide. Symbolic suicides and suicidal thoughts do not predict suicide. The TAT may suggest the specific circumstances under which the patient may or may not be suicidal.

When in doubt, always ask the patient whether they are thinking of killing themselves. Most dangerous is a matter-of-fact statement that they intend to kill themselves in a realistic manner. Fantastic techniques are not generally dangerous. Patients who are agitated and afraid are not as dangerous as those who are matter-of-fact.

It is well known that some seriously depressed patients kill themselves when it looks like they are getting better. The usual explanation is that they did not have enough energy before, but George Atwood (1972) pointed out that is not what is going on. Some patients decide to solve their problems by killing themselves. They then seem to be improving and then carry out their solution.

Deeply depressed patients who are improving show increased insight into why they are depressed. They also talk more about the future. If you ask them about suicide, they will discuss it.

Patients who appear to be getting better because they are going to kill themselves seem to be getting better but have no more insight into why they were depressed. They don't talk more about the future because they don't have any. If you raise the subject of suicide, they either will not talk about it, or will unemotionally tell you they are going to kill themselves.

These three indices will tell you whether the patient is genuinely getting better or whether you need to take effective action.

Hispanic patients who are hospitalized or in jails have a high risk of suicide. The family is typically more important in everyday functioning than for Anglos or for African-Americans, and jail or hospitalization interferes with the relationship with the family. If there is a further impairment of the relationship with their family, like the family moving out of town, they are likely to become suicidal. However, if watched for 24 hours, the crisis is usually over.

Having someone with a suicidal patient is in general very helpful. But it is most helpful to deal with the issues. SSRI antidepressants are not useful for suicidal patients. Even some patients who are not suicidal become suicidal on SSRIs. Healy's (2004) research found that 10% of normal volunteers who had never been in treatment or clinically depressed became suicidal on SSRIs.

With almost any kind of patient, the more frequently the patient is seen the easier it is for both patient and therapist. The one exception I can think of was a psychotic depressive woman who had been hospitalized several times. She was given ECT the first time, but it was discontinued because of spinal damage. This time she saw me instead of going to the hospital. One of her daughters had taken my undergraduate class in personality and wanted her mother to get first-rate treatment.

Instead of going to the hospital, she stayed at her parents' house, which was 50 miles away. They could only bring her in once a week. In this case that was lucky. She was so irritating that I usually was very angry at her by the end of each hour. A week later I had forgotten my irritation, and she had a kind and accepting therapist for almost all of the hour. I might not have been able to do that, especially early in therapy, if I had seen her more frequently.

As she improved, I discussed her return to her own home with her husband. I pointed out to her husband as well as to the patient that her husband knew how to take care of the house and their five children without her, as he had whenever she was hospitalized, or now when she was living with her parents. I suggested that he continue to run the house as if she were not there when she first moved back. Expect nothing from her at first, and she would take over functioning and helping at her own pace as she could.

When she moved back, I tried to help her avoid likely mistakes in parenting. In one session I talked about the normality of masturbation and how she must not punish her

children, but let them know that it is impolite to masturbate in front of other people. Not sick, not bad, just impolite in front of other people. Of course, she was angry at me.

She started the next hour by saying, "I do that." I did not know what she was talking about, so I asked her. She said, "I do that. I masturbate. I do that because I'm crazy."

"No," I said, " You do that because you're human. You don't enjoy it, because you're crazy." She got mad at me and insisted, and I repeated my view. If I had agreed with her puritanical statement, I would have made her insanity necessary to cope with her guilt over masturbation.

She stopped masturbating after a year of treatment because sex with her husband was so much better. "It's like we just got married."

Very often depressed people, even when their judgment is poor, try to control the other people in their family. She would not allow her husband to make decisions about his job, the car, insurance, or an accident settlement. It is one of my principles, that I tell patients, that the person in the family who knows the most about something should be the one who makes the decision about that matter. She stopped trying to control him about these matters and others where he clearly knew more than she did. He grew, making better decisions about his job and other matters. She was impressed and she liked him more. She became a pleasant person toward the end of therapy, which was after only a year or two, at which time she was taking care of her home and children. She was also working for the first time at a part-time job as a school aid.

Finally, I will discuss a man in his 60s who suffered from recurrent severe and sometimes psychotic depression and "spontaneous" panic attacks. In his depression there was also a terror dimension, because he was afraid he might die. If he died, he would go to Hell. Hell, he described, is a lake of burning fire in which you burn forever. He deserved to burn forever because he had committed "the unpardonable sin." The unpardonable sin, he believed, was masturbation. He knew about the lake of burning fire and about masturbation because he had been told these things by his Fundamentalist minister and by his mother.

His father also had a low opinion of him, but his father did not go to church, and therefore his opinion did not matter. But his mother also had a low opinion of him, and her opinion mattered.

The patient had been "cured" of his depression in his 20s by insulin coma treatment, and consequently was rehospitalized nearly every year for the rest of his life. Despite this, he had managed to have a successful career as an executive by lying to his employers, and telling them he had gone into the hospital for physical disorders. He had been treated for both his depression and panic attacks primarily by medications, which helped a little. His daughter's fiancé was a graduate student in clinical psychology doing his internship in Boston at Massachusetts General Hospital. He asked Gerald Borofsky, then chief psychologist, about his prospective father-in law's problems, and was advised, "If I had serious problems and lived near East Lansing, there's someone at Michigan State I would try to see," and suggested me. Just before seeing me, the patient had been treated by a well-respected faculty member of our Department of Psychiatry who told him that with the best of modern treatment, by which that psychiatrist meant medication, they could decrease his pain and misery by 20%.

When the patient told me this, I asked, "Is that good enough for you?"

"What choice do I have?" he said.

Classically, I said, "Well, you do have a choice. I can't guarantee that I can help you. All I can say is that people with similar problems have been helped. What I can guarantee you is it's going to take time, it's going to be hard work, it's going to be painful, and it's going to be expensive. But if it is successful, you won't be 20% better. You'll be better."

We then discussed fees, and I lowered my fee so that he could afford three times a week. He took a week to think about it, and then began treatment. He was my first patient over the age of 60, and I discovered that when an older patient decides to come into analysis, they work hard and make good use of the time. As he described it later, "You were right. It's taking a lot of my time, it's expensive, and it's certainly painful." The patient's analysis took 3 years.

In an early session he described his treatment with insulin comas when he was hospitalized in his 20s. I told him that it was very unpleasant. He said that it wasn't. I suggested I would get a textbook from the next room and read him a description of insulin coma treatment. He said that wasn't necessary, because he was scared now, and didn't need any more evidence. Then I said, "There's something to be learned here. If you can repress the memory of this very unpleasant experience, then it is likely that there are other unpleasant experiences you can also repress and have no memory of."

Within a couple of weeks he was able to use the couch. As I always do, I told the patient that I would never ask him to give up anything that helped, but the odds were that if he continued to talk to me, eventually he would be off all medication. He and I agreed that he would stop all medications immediately, and begin real treatment.

While neither he nor his previous psychiatrists had found any precipitant to his "spontaneous" panic attacks, 18 to 24 months into the treatment I noticed his "spontaneous" panic attacks seemed to occur whenever he made a presentation to executives on the same level as he, but not when presenting to superiors or inferiors. He also had a "spontaneous" panic attack when he was feeling good. This became especially problematic when his depression began lifting, and he began to have increasing and intolerable panic attacks as a result of feeling good, which fits the rubric of a negative therapeutic reaction. It was not hard to make a reasonable clinical guess as to who executives on the same level might represent. He at first angrily rejected my interpretation that maybe his brothers envied him.

"I wonder if your brothers envied you."

"No. We got along fine. There was no envy between us."

"Sometimes brothers do envy each other."

But later in the same hour, he suddenly said, "I told you about the hanging, didn't I?"

"No."

"I must have."

"I might forget some details, but if you had ever told me you had been hanged, I'm not likely to forget it."

"Well, when I was 5 years old, my older brother and I were playing Cowboys and Indians, and he lynched me." He went on to say that his brother had tied a rope to a tree branch, had the patient stand on a box, put the rope around his neck, and then kicked the box out from under him. He was hanged until he was unconscious, and his mother had to cut him down.

"You must have been panicked, terrified."

"Oh, no, no."

He was told it was a biological reflex, that whenever we cannot breathe, we go into a panic.

"Oh, no, there was no anxiety."

"Yes, there was. You have the panic now without the memory, and the memory without the panic."

He still denied it, but then remembered other situations in which he could not breathe, and in those other situations he had gone into a panic. He then remembered

another incident with his brother, a year later. He remembered his brother telling him he was Batman, giving him an umbrella, and getting him to jump off the roof of a three-story building. Luckily, children are rugged, and he was not seriously injured. But that was not his brother's fault.

"Tell me," I asked, "Were you having fun?"

"Yes, of course. You know, he never used to let me play with him. But he let me play with him those two times, and I was really enjoying it."

"And now whenever you feel good, or whenever you make a presentation to someone who represents your brother, you feel like your brother is going to kill you."

"Oh, he wouldn't do a thing like that!'

"But he tried twice."

The patient said, "Oh, no, he wouldn't do a thing like that," and I had to remind him of what he had just said. This seemed to resolve not only his negative therapeutic reaction, but all of his "spontaneous" panic attacks.

I felt I had done brilliant work. I was proud of myself. But 2 weeks later I received a phone call from him saying he could not keep his appointment. He was very angry because he had had another panic attack and one leg was now paralyzed.

I wondered whether at his age this could be a stroke, and tried to think of a good neurologist to recommend. However, when he came in, he informed me that he had already made an appointment with a neurologist. He expected me to be angry at him, as his parents would have been, for challenging my judgment. He was startled when I said,

"Very good. This could be caused by emotional factors or it could be caused by neurological ones. You are seeing me to check out the emotional factors and a neurologist to check out the neurological possibilities. I can't imagine anything more rational."

He had chosen his neurologist well. The neurologist checked him over very carefully and concluded that the paralysis was not neurological in origin. The patient was furious at his competent neurologist. He then told me that something like this had happened once before when he was a teenager. His leg had been paralyzed and he had been bedridden. The doctors never did find out what caused it, but it got better in a couple of months.

I asked what was going on in his life at that time. Like a typical depressive, he said,

"Nothing."

"Something must have been going on. You were alive."

"No. Nothing."

"Something must have been going on."

"Nothing important."

"Tell me the unimportant things."

"The only thing I can remember from around that time was that a cousin came to visit us. [They lived on a farm.] He spent the day with my older brother, and I tried to tag along. Eventually, they started to walk into town. I started to follow them. My brother turned around and said, 'If you take one more step, I'll kill you.'"

"Would you believe he had such a mean expression on his face that I believed him?"

"Of course, you believed him. He already tried to kill you twice."

"My brother wouldn't do a thing like that!"

I then reminded him again of what he had so recently told me. Then I pointed out that his unconscious was trying to protect him. His brother had said, "If you take one more step, I'll kill you," and his unconscious prevented him from taking one more step. He began to have some movement in his leg after that session and it fully remitted fairly quickly, and, with some working through, his "spontaneous" panic attacks permanently

remitted. I wondered why the symptom of a paralyzed leg had recurred at this time. It seemed as if there was a part of him that wanted to understand what it was all about.

The patient had been raised as a Fundamentalist. His mother's father had been a minister in the same Fundamentalist church, a self-taught man who had written several books and preached and was very strict. Indeed, he said his grandfather was considered practically a saint by the religious community.

His first wife belonged to the same Fundamentalist group. From his description, she seemed very unpleasant and very much like his mother. However, she told him and their grown-up children that he was a sinner who would go to Hell for divorcing her. He believed her, and avoided his children because he believed they would never forgive him for having gotten a divorce. From his description his second wife seemed like a very nice person and an extraordinary improvement. She was a Methodist, and they both now went to a Methodist church. He said the people at the Methodist church were very nice, but "it doesn't feel much like religion."

In the course of the analysis I suggested that his children were much more likely to be concerned about working out their own sexual lives than they were about his. He contacted them with trepidation and discovered they liked him and were glad he reached out to them. Much to his surprise he also discovered that they liked his second wife, thought she was a nice person, and thought that he had been very sensible to divorce their mother and had been very sensible in his choice of a second wife.

When he talked about the unpardonable crime, his hand twitched at his side. His father had been a depressed man who did not think the patient was worthwhile or of much value and "bad-mouthed" him frequently. But the patient knew his father was not a good person, because he did not go to church. His mother was the good one because she always went to church. She taught the patient all about God. She used to whip him with a switch for misbehavior. He was not mad at her for that, because he knew that she only punished him for his own good. He was told to go cut a switch which she then used to whip him, and if he had not cut a thick enough switch, he would get extra strokes. She would do this with all the children, but she beat him, the youngest, the most. She often beat him for offenses he had not committed. His brothers and sister often blamed him for what they had done, and he would get beaten, but she also beat him for offenses he had not committed even without anyone blaming him. He resented that a little bit. It didn't seem fair. But mostly he knew she punished him for his own good.

Sometimes she would whip him until the blood ran. He did not blame his mother for that, however. As children and adolescents, she and her sister had been punished by his grandfather by being stripped to the waist, tied to a tree, and whipped them until the blood ran from their backs. What he received was nothing compared to their beatings.

And, after all, his grandfather was a saint.

At first I accepted his statements, but eventually said I did not consider a man who got his sexual kicks by stripping his daughters to the waist and whipping them much of a saint. This made the patient very angry. He said, of course, his grandfather did not enjoy it, and there was nothing sexual about it. But then, he noted, I seemed to have a dirty mind.

His mother used to frequently show him a picture of her sister. The sister had burned to death when the two of them were teenagers, and the picture was of the horribly burned corpse of the aunt in her coffin. He said the picture was horrible. The sister had been ironing in the basement with an old-fashioned iron that had gasoline in it. The sister had spilled gasoline on herself and her clothes. The gasoline caught fire and killed

her. His mother from time to time showed him the gruesome picture and told him the story.

I suggested, "I wonder if your mother thought she was responsible in some way. Sometimes sisters are angry at each other, or siblings are. If they are, and something bad happens, they think they are responsible."

He remembered more details. His mother told him that she had been with her sister when her sister died. The two girls were ironing the laundry in the basement with the old-fashioned irons when the accident occurred. He began to wonder if she used to show that picture to his brothers and sisters the way she would show it to him. He concluded that, as a matter of fact, he did not remember her showing the picture and telling the story repeatedly to them, but only showing it to him repeatedly.

"I wonder if she showed the picture to the other kids. I think she did, but not like she did with me. She always showed it to me."

Then I said she treated him as if he were the bad part of her. "As if you deserved to burn to death for what she did." After all, spending eternity burning in a lake of fire would be the appropriate punishment for burning someone to death.

To check his memory, he asked his own sister if their mother used to show the picture to her, and, as he had remembered in treatment, their mother had not. But he learned more about the death of their aunt from his sister, who had obtained an old newspaper clipping.

It seems that the two girls (his mother and her sister) were ironing in the basement. They were quarreling as teenage sisters sometimes do. But no quarreling was allowed in the saint's house. So he came downstairs, and the sister was so terrified of her saintly father that she backed into the iron, spilled the gasoline on herself, and burned to death. There even had been a police investigation at the time to see if his grandfather was not in some way responsible for his daughter's death, but they finally concluded that he was not.

It became increasingly clear to the patient that his mother had indeed treated him as if he were the bad part of her and that is why he deserved to burn forever, for having burned her sister to death. Obviously, his mother could not allow herself to get angry at her saintly father. Instead of feeling—which would have been appropriate—that her father had caused the death of her sister with his terrorizing tactics, she blamed herself. But then instead of blaming herself, she had blamed the patient. That is why she had punished him and that is why she had encouraged the fear of eternal burning for his sins.

The patient eventually discovered that for him, the "unforgivable crime" was feeling angry at his mother and wanting to punish her. He unconsciously wanted to beat his mother the way she beat him. That is why his hand twitched.

The analysis was a success. He was able to enjoy his marriage, his children, and his life. He was able to work more comfortably and plan for the transition to retirement.

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