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DIVERSITY WITHOUT FANFARE:

Some Reflections on Contemporary Psychoanalytic Technique[1]

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In tandem with the divergent psychoanalytic views regarding development and mental organization, there exist varying perspectives on analytic technique. Beginning with early Freud-Ferenczi disagreements, sharply differing views on analytic listening and intervening have repeatedly surfaced in the history of our profession. This is evident in the Klein-Balint schism, the Kohut-Kernberg controversy, and the contemporary North American tension between the ego

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psychological approach on the one hand and relational and intersubjective conceptualizations on the other. While the protagonists in these scenarios push for technical fiefdoms and only reluctantly concede to the confederation of pluralism, those standing outside the arena often seek integrative solutions to such splits. Take Kohut, for instance, who triumphantly declared that 'self psychology has freed itself from the distorted view of psychological man espoused by traditional analysis' (p.402) only to be followed by Wallerstein's (1983) and Pine's (1988) effort to integrate his views within a broad and flexible perspective of theory and technique, one that accommodated the vantage points of drives, ego, object relations, and self-coherence. Relational and intersubjective viewpoints, currently in vogue within the North American psychoanalysis, also seem to follow a similar trajectory. Their proponents (Mitchell, 1993; Ogden ,1994) make it appear that such views are not only entirely novel but fundamentally irreconcilable with a so-called classical stance, while others (e.g. Dunn, 1995) argue that these viewpoints can co-exist with the more traditional, ego psychological perspective. This raises an important question. Are multiple perspectives on technique actually incompatible or can they be synthesized into a harmonious gestalt?

In this paper, I will attempt to address this question by way of commenting upon the clinical material provided by Dr. Helmut Thomä[2]. The material is brief. Its brevity is, however, compensated by our having access to Dr. Thomä's co-

[2] Thomä, H. und H. Kächele (2007): Comparative psychoanalysis on the basis of a new form of treatment reports. *Psychoanalytic Inquiry*, 27, 650-689.

authored book with Dr. Horst Kächele (Thomä and Kächele, 1994b) which provides further information on this case and on analytic technique in general. I will divide my comments into three parts. The first part will discuss Dr. Thomä's understanding of his patient Amalia's symptomatology. The second part will focus upon the principles of Dr. Thomä's analytic technique, as described in his book. The third part will return to Amalia and attempt to discern the movements of attunement, intervention, and patient response through the process material provided. I will conclude with brief remarks that bring us back full circle to the question whether a plurality of technical approaches is essential or it is possible to have a unified technique of psychoanalysis.

CLINICAL UNDERSTANDING

Amalia, the patient under consideration, presented with a mixture of anxious, compulsive and depressive symptomatology. Her life was professionally cultivated but impoverished in the social realm, especially with regards to heterosexual relationships. Her suffering began 'before puberty' but had worsened since then. Central to her difficulties was the 'virile growth of hair all over her body' which had resulted in hesitation about intimacy and 'extreme social insecurity'.

In understanding the pathology underlying this clinical picture, especially the role of hirsutism in causing the patient's problems, Dr. Thomä offers the proposition that 'our body is not our only destiny and that the attitude which significant others and we ourselves have towards our bodies can also be decisive' (Thomä and Kächele, 1994, p.79). Here he is positioning himself in contrast to Freud who declared that 'anatomy is destiny' (1924, p. 189) and meticulously described the 'psychical consequences of anatomical differences between the sexes' (1925, p. 243). In doing so, Dr. Thomä cites the work of Lichtenstein (1961) and Stoller (1968) who have elucidated the powerful role of early environmental input on the evocation and shaping of gender identity. This line of thinking is supported by the views of Jacobson (1964), Weil (1970), and Mahler et al (1975) who see the psychic core of personality as an inevitable amalgam of the child's temperamental proclivities and their uniquely selective evocation by the mother.

Early developmental context is, however, not the only locale to witness that it is the interaction between ‘anatomy’ and environmental forces acting upon it that results in the ultimate clinical picture we encounter. The manner in which adult individuals respond to physical handicaps and loss of body parts via dysfunction or surgical amputation demonstrates such interplay as well. One person psychologically falls apart upon losing a limb or becoming hemiplegic while another finds alternate channels for sublimation and even becomes an inspirational figure while confined to a wheelchair. The lives of the renowned physicist Stephen Hawking (White and Gribbin, 1992) and movie actor Christopher Reeve (Reeve and Rosenblatt, 1998) are shinning illustrations of such resilience. Clearly, ‘anatomy’ is not the sole determinant of ‘destiny’.

It is in this spirit that Dr. Thomä notes that Amalia’s mother’s illness during her childhood and her preferential treatment of Amalia’s brothers (Thomä and Kächele, 1994b, p.459) also made it hard for Amalia to establish a feminine identity; her hirsutism was not the only factor. While congenial, this explanation leaves us with the pain of incompleteness. How old was Amalia when the mother became ill? How severe was the mother’s illness? For how long did it last? Was she hospitalized? Was Amalia separated from her mother? If so, who took care of her and how was that caretaking?

All this we are not told. We are also not told about the nature of her childhood obsessions and the precise time ‘before puberty’ when first she became symptomatic. And, we are not informed about the birth order of siblings, and the chronological gap and ‘developmental distance’ (Solnit, 1983, p.283)

between them. Nor is there any comment made about how did her brothers treat her. Such omissions are troubling. And, yet somehow we feel impressed by the elegance, even correctness, of Dr. Thomä's developmental view i.e. anatomy is made psychologically meaningful by how it is treated by significant others and later, via the internalization of such relational scenarios, by ourselves.

Just when we are about to lay the developmental matter to rest, Dr. Thomä deepens the picture. Commenting upon the patient's hirsutism, he now declares that 'a virile stigma strengthens penis envy and reactivates oedipal conflicts' (Thomä and Kächele, 1994, p.79). This formulation is opposite to his first proposal. The former says that environmental input can alter the psychological impact of anatomical characteristics. The latter declares that anatomical characteristics can have psychological ramifications of their own; which, in turn, elicit different environmental responses. Pursuing the latter route, Dr. Thomä notes that hirsutism can make it harder to develop a feminine identity by intensifying penis envy (i.e. if one is manly, why not be a man all the way) and thus rendering one perpetually conflicted about who one is and who one should be with in terms of a partner. Ambivalence then dominates the mind, as it did in the case of Amalia.

The striking feature of Dr. Thomä's thinking is the ease with which it accommodates the dialectics between anatomical (and, by extension, temperamental) characteristics and the environmental responses to it. For him, what ultimately counts is the interplay of reality, drives, object relations, and

fantasies. And, make no mistake about it: the traffic between anatomy and environment moves in both directions and psychology is the music of this street.

TECHNICAL INTERVENTIONS

Like his developmental understanding, Dr. Thomä's technique shows flexibility, resilience, and broad-mindness. It is centered upon helping the patient achieve ego freedom though interpretation and transference resolution. However, it incorporates a variety of listening attitudes and a broad range of interventions that can be seen as preparatory for, as well as in lieu of, the interpretive enterprise. Six such measures, evident in his approach, are the following:

Forming a helping alliance

Dr. Thomä emphasizes that forming a 'helping alliance' (Luborsky, 1984) is an important therapeutic task in the beginning phase of the analysis. Far from fostering regressive dependence, encouragement of realistic hope and assistance in developing unused mental abilities goes a long way in enhancing the 'working alliance' (Greenson, 1967) and thus the analysis of transference. The analyst's open acknowledgement of the inherent awkardness of the psychoanalytic situation, for instance, paradoxically causes the patient to relax. The analyst's explanatory attitude towards pauses in the flow of their dialogue serves the same function. Discussions of how the analytic dialogue differs from social discourse, how free association facilitates the discovery of hidden meanings, and how the analyst's not providing factual answers to the patient's

questions also lead to the patient's greater participation in the analytic process (Thomä and Kächele, 1994b, p. 35-38). Helping to get analyzed and analyzing are not enemies; they are friendly cousins.

Titrating the asymmetry gradient

Dr. Thomä acknowledges that a certain asymmetry within the dyad is essential for the analytic process to occur. However, the gradient of this asymmetry needs to be carefully titrated lest it add to the patient's feeling inferior and alienated. All this is important because the patient must experience both affinity and difference within the dyad; the former facilitates trust and self-revelation, and the latter helps in learning about oneself and assimilation of insights. In Stone's (1980) words, the former meets the condition of 'resemblance' that is necessary for the development of transference and the latter places the analyst in a position to interpret the transference.

Dr. Thomä's equanimity and his viewing a patient's desire to read his papers and books as quite natural, even healthy, is a testimony to his respect for the patient's need for affinity. His stance on accepting gifts from a patient also exemplifies this point. He is opposed to categorically rejecting all such offers. In opposition to the prevalent view that accepting gifts derails analysis of such a gesture, he posits that 'rejecting presents often prevents analysts from recognizing their true meanings' (p. 301). He acknowledges that accepting gifts can complicate matters but emphasizes that rejecting them can increase the asymmetry of the dyad to a painful extreme and the consequences might sometimes be irremediable. It is in the same spirit that Pine's (1998) reminds us

that the usually helpful aspects of psychoanalytic frame (e.g. couch, time limits, not giving information about where one is going for vacation) can be traumatic to some individuals, is in the same spirit.

Correcting major distortions of reality

As analysts we constantly bear and 'contain' (Bion, 1967) patient's distorted views of us as well as of external reality. We hope that a piecemeal deconstruction of such scenarios would provide the patient a greater ego dominance over internal realities. Dr. Thomä certainly concurs with this stance but adds that the analyst must provide corrective information when there is a genuine matter of ignorance (e.g. in the treatment of fresh immigrants, an example he does not mention but I think would find agreeable) and when the patient's reality testing is getting seriously compromised.

Demystifying the basis for interventions

In an earlier contribution, (Akhtar, 1992), I had noted that once the analyst has made a recommendation for analysis, he must answer patient's questions about the procedure, arrangements, and the rationale for such treatment, on a factual basis and

> '…..should not derail or mystify the patient by 'interpreting' the reasons behind such questions. For instance, the patient may ask about the difference between psychoanalysis and psychotherapy. Subtle controversies in the field notwithstanding, it is possible to answer this question in a simple,

> straightforward way. One might explain the difference not only in terms of frequency of visits and the use of couch but, to a certain extent, in terms of the nature of the patient's expected role and the therapist's stance vis-à-vis the patient's report of his thoughts, feelings, fantasies, and dreams' (p. 297).

Dr. Thomä takes this stance a step further. He suggests that the analyst not only explain, at the outset, why free association is required but, from time to time during the treatment, share with the patient his reasons for making a particular intervention. He states that 'it is nothing special for me to offer a patient insight into my psychoanalytic thinking' (Thomä and Kächele, 1994b, p.86). In fact, he feels that decisive and salutary shifts in the relationship between transference and therapeutic alliance can occur as a result of such disclosures.

A related matter here is the use of the analyst's own free associations. Working from a decidedly intersubjective stance, Ogden (1994) and Jacobs (2001) consider the ideational and affective movements in their reverie as highly significant indicators of patient's inner reality. Bollas (1992) describes the analyst's occasionally sharing his own free associations with the patient: 'You know, as you are speaking I have a picture of a little girl of three….' (p.121), and so on. He discusses the risks of such an intervention and provides guidelines for its use. I have often found myself disclosing a snippet of my association right after the patient has arrived at a certain understanding that to me seems correct.

For example, I might say 'You know, just when you connected this guilty feeling to your mother, I, too, was thinking about your relationship with her, especially when….' and so on. Lewin (Lewin and Schulz, 1992) has taken such 'role sanctioned self-disclosure' a step further by including information from his childhood in such exchanges with the patient. To me this appears excessive, as it might burden the patient. I am therefore relieved to note that Dr. Thomä's revelations are not of Lewin's sort. In fact, he stresses that letting the patient's witness the 'behind the scenes' aspects of analytic interventions is not to be confused with disclosures of personal matters and countertransference reactions.

Respecting the ever present potential for development

An important aspect of Dr. Thomä's technique is its respect for restraining and modulating the desire to interpret. He recommends an attitude of patience and waiting. For instance, a patient of his left each session a minute or two before the time was actually over and Dr. Thomä left it unquestioned for a very long period in her analysis. It was only when the patient began talking about it that this matter truly entered analysis. Besides believing that some issues become more interpretable as time passes on, Dr Thomä considers it possible that some things take care of themselves over time anyway. The inner dynamic shifts that continually take place during analysis can lead to silent relief from minor symptoms. In other words, development is not once and for all; it is constant, on-going, and often subtle.

This, coupled with his firm reminder that the analyst must be open to the 'direction of change' (Thomä and Kächele, 1994, p.293), testifies to a

developmental slant to his technical approach. Pine's (1998) reminders that 'developmental tasks are never ending' and that 'developmental process continually presents us with new, age-related, adaptive demands' (pp. 200, 201) have their counterparts in the technically optimistic view that growth and change is possible at any stage of life. Such orientation on the analyst's part 'imparts to the patient the possibility of hope, of belief in a future, of transformation and change' (Pine, 1998, p. 210). Dr. Thomä's approach amply demonstrates this.

Maintaining informed naturalness

Using accidental, extra-analytic encounters between the analyst and analysand as an illustration – though extending the implications of his notions beyond it – Dr. Thomä advocates an attitude of informed naturalness on the analyst's part. His aphoristic recommendation is 'if in doubt, act naturally' (Thomä and Kächele, 1994, p. 298). And, he goes on to say that this recommendation 'is oriented on the rules of accepted social behavior, which meet in common sense' (p. 301).

> 'It would be inappropriate for the patient to let himself freely associate in public, and the analyst would behave conspicuously if he refused to talk about the weather or vacation plans and instead remained silent or interpreted the conversation' (p.298).

It is Dr. Thomä's sense that informed naturalness in extra-analytic encounters should be matched with a similar attitude in the clinical situation. Not only 'acting naturally is therapeutically necessary' (p.298), it can protect the

patient from the potentially traumatizing effects of a stereotypically remote and silent analytic attitude. To be sure, the patient can misunderstand and be burdened by the relative intermingling of roles as a result of seeing his or her analyst outside and within the clinical situation. However, lack of naturalness on the analyst's part can also hurt the patient. The special importance of these matters to training analyses also receives attention from Dr. Thomä who goes on to say that

> 'It is therefore essential that in their training candidates develop an uncomplicated relationship to the various roles they will play in and outside their professional lives. The degree of natural behavior by their analysts that candidates experience both in and outside psychoanalysis is an instructive measure for such tolerance toward the diversity of roles' (p.299).

All in all, Dr. Thomä advances a working stance that accommodates discipline and spontaneity, tradition and freedom, and by implication, both the prose and the poetry of our clinical enterprise. He emphatically states that 'rules that exclude spontaneity and stipulate that the analyst must first reflect before reacting demand the impossible' (p. 298). Such respect for disciplined fearlessness and for capacity for surprise is also evident in the remarkable contribution of Parsons (2000; see also Akhtar, 2002, for a detailed assessment of Parsons' work) which appeared six years after the work of Dr. Thomä.

BACK TO AMALIA

The phase of Amalia's treatment presented was characterized by her preoccupation with the analyst's head. Dr. Thomä's understanding of it is solidly anchored in the 'principle of multiple function' (Waelder, 1936). He notes that through her preoccupation with his head the patient was attempting to ascertain whether the analyst was using her as a narcissistic object ('looking for confirmation of what was already there' i.e. in his head). While fearing this, the patient was also expressing hope that the analyst could be genuinely empathic and contain her specific projections in order to decipher them ('she wished that something new would come out' of the analyst's head, because of her).

A second level at which Dr. Thomä understood Amalia's preoccupation with his head was that it represented the 'secret and well-guarded treasure' of sexual knowledge and, if I might add, of 'sexual superego' since the patient had held a life-long guilty fantasy of having sex with one of her brothers. This extension seems supported by the fact that the patient wielded her Christian Bible (her strict superego which, in past, had driven her to a pious confinement as well as to considering suicide) with the analyst's presumed 'Freud Bible' (which, I am sure, she presumed existed in his head).

While these hypotheses seem correct, one thing is missing here. This pertains to shame (and the resulting hostility) about body parts; after all Amalia had chronic shame about her hirsutism. Is it not possible that by constantly talking about the analyst's head (the location of hair; we are not told whether Dr. Thomä has a full head of hair or not and also how he does feel in reality feel about his head) she was attempting to make him painfully self conscious?

'Rather than talk about my body, I will talk about yours….let us see how that feels' she might have thought.

Moving on to the process material itself, let me enter two caveats. There are too many condensations of the verbatim material ('we continued on the topic'; 'this topic was discussed for a long period of time'; 'we exchanged a few more thoughts', and so on) for it to be really useable. The material suffers from the 'average-expectable' mishaps of translation from one language to another as well. It is therefore difficult to monitor the process closely. Any comments that can be made would be in the spirit of looking at a large acrylic canvas and not a fine Indian miniature.

After initial hesitations and fears of analyst's criticism, Amalia reveals her preoccupation with his head. First she mentions her fascination with its physical aspects and then her desire 'to get inside' it which she says is the more important of the two facets of her preoccupation. She then adds that 'the point is to get inside and to get something out'. Dr. Thomä sees this last mentioned in the context of fighting and also as an upwardly displaced, symbolic castration. I am inclined to view it differently. To my mind, Amalia's wish is to project herself into the analyst's mind ('head') and then retrieve that projection to understand herself. Bion's (1967) notion of 'beta elements' (i.e. unbearable affects and unknown thoughts) being pushed into the mind of another in order for them to be returned in a palatable form applies here. Fonagy and Target's (1997) notion of mother's auxiliary ego help in the development of 'mentalization' is also pertinent in this context.

When Dr. Thomä intervenes based upon his hypothesis, Amalia switches to ‘a completely different topic’ for about ten minutes. We are not told what that topic was and hence not given the opportunity to enter either of their ‘heads’. This leaves us with slightly irritated state and a gap in mentalization. We have now become projectively identified with Amalia who had not found Dr. Thomä’s intervention empathic and was therefore left holding her unthought mental contents by herself.

A little later in the session, Dr. Thomä seems more attuned to his patient’s deep concerns to know and be known. He says that ‘by thinking about the head you are attempting to find out what you are and what I am’. The patient relaxes and goes on to describe her associations to a picture of the analyst she had seen sometime ago. This says that she ‘knows’ him and is a confirmatory association to her having felt understand (‘known’) by the analyst. She then talks of her envy of his head. The analyst, correctly and gently, makes an attempt to explore the reasons of this envy. The patient goes on to wonder if his head was hard (i.e. could he bear her aggression) and contrasts it with her father’s, who could not take anything. Soon afterwards, however, this seemingly physical and aggressive concern is replaced by the mention of her university studies and her intellectual competitiveness with her peers.

Dr. Thomä regards this shift from physical-hostile to intellectually acquisitive and curious as a displacement from body to mind. I view the situation in an opposite manner. To my mind, the physical metaphor (most prominently, the knife and the fight) was introduced by Dr. Thomä and not by the patient. Her

concern throughout had been to know and be known. Therefore, to me, the displacement occurred from mind to body and not the other way round.

Their discourse does return to the matters of the mind. Amalia now expresses her wish to be fully inside Dr. Thomä's head, even 'be able to go for a walk' inside it. She then reveals having had a fantasy to sit on a bench inside his head and relax; what a lovely and peaceful experience that would be! The analyst, correctly, views this as a search for blissful, thoughtless symbiosis with mother. In conveying this understanding to Amalia, he adds, however, that there also remains, in her, a parallel desire to separate, grow, and change. Why does he add this so quickly, one wonders.

WHAT DOES ALL THIS DEMONSTRATE?

As we consider putting the manner in which Dr. Thomä seems to understand Amalia's psychopathology and the way he intervenes in the specific session described together with his overall approach to analysis, many things become clear. It becomes readily apparent, for instance, that his understanding of the patient's suffering is complex and he views her symptoms as multidetermined. For instance, her preoccupation with his head is viewed by him as emanating from phallic-penetrative drive derivates, search for pregenital harmony, ego-motivations for understanding and being understood, early objects relations with a weak father and a 'hard-headed' aunt, and so on.

Dr. Thomä's technique is centered upon helping the patient achieve ego-freedom through interpretation and transference resolution but it incorporates a broad range of interventions. He listens to the patient both credulously and

skeptically, (see Strenger, 1989 in this connection) using both the 'introspective' and 'behavioral' methods of observation. 'In the former, the analyst puts himself in the position of the analysand and derives clinical understanding from the latter's perspective. In the latter, the analyst adopts the view of a spectator, without regard to the subject's own thoughts or feelings' (Spencer and Balter, 1990, p.402). The two methods, often yielding different sets of information, are complementary, each modifying the other in the service of deepening the grasp of the analysand's mental functioning. Such an approach seems to synthesize what Cooper (1988) noted to be the Strachey-Loewald divergence regarding technique. Strachey's (1934) model of the therapeutic action seems

> 'based on classical instinct theory and resistance analysis, and interlarded with a bit of Kleinian object relations theory. The role of the analyst is as a neutral, benign interpreter of reality, internalized as a temporary new object, helping to make the unconscious conscious, and modifying the superego. Classical analytic neutrality is preserved' (Cooper, 1988, p.19).

In contrast, the model analyst for Loewald (1960) offers himself to the patient as a contemporary object. He works by being

> 'an emotionally related object, with an important gradient of organizational maturity between him and his patient, mindful of the patient's core of potential

> being, which he senses as a parent does, oriented toward the future, offering the patient opportunities to create new integrations on the armature of maturity that the analyst provides. His task is empathic communication, uncovering, and guidance towards new synthesis' (Cooper, 1988, p.26).

Cooper concluded that these two sets of ideas regarding how psychoanalysis works remain unintegrated and that 'it is a major task of psychoanalysis today to unify these two forms of description' (p.26). It is my sense that Dr. Thomä's work has actually succeeded in such synthesis. While maintaining focus on interpretation, the author's stance leaves space for 'developmental work' (Pine, 1998) and other non-interpretive interventions, seeing the various measures to work in a synergetic and dialectical fashion. In addition, the approach favors a disciplined spontaneity of the sort explicated in the recent work of Parsons (2000). The fact that an unabashedly therapeutic, flexible yet firm, supportive yet interpretive, and deliberate yet spontaneous approach can exist within a theoretical frame that appears rather classical and feels no need to invoke the notions of relationalism and intersubjectivity, currently popular in the United States, is certainly intriguing.

What is one to make of this? It is possible that the long lasting dominance of the ego psychology paradigm in North American psychoanalysis has resulted in the rebellious outgrowth of alternate vantage points including self psychology (Kohut, 1977), relationalism (Mitchell, 1993), and intersubjectivity (Ogden, 1994)?

Could it be that United States, which happens to be the land of fads and fashions, is a fertile ground for psychoanalytic fictions as well? Or, is there really a unified psychoanalysis in the realm of technique as it has been proposed to exist in the realm of theory? Indeed, many investigators (Killingmo, 1989; Strenger, 1989; Wallerstein, 1983, 1988) have come to such a conclusion. I too have (Akhtar, 2000) attempted to show that this might be the case. If true, this shows that attempts to create new and 'alternate' models are often nothing but elaborations and nuanced reformulations of the old and established paradigms. Helene Deutsch (1963) expressed such a view beautifully when she wrote:

> 'There is talk of 'old' and 'new' analysis, and one even introduces the term 'modern' in contrast to 'classical' analysis. Indeed, one can hardly deny that in recent years there have been interesting developments in analysis. In this respect analysis shares the fate of other sciences which remain which remain vital through progress. Such a rigid separation of 'old' and 'new', however, appears to me to be an artifact. Many of the so-called 'new ideas' are continuations and sometimes only reformulations of concepts originated by 'classical' analysis. The origins of the 'new; are contained in the 'old', and vice-versa, the 'new' carries the legacy of the 'old' (p.228).

That this passage was written forty years ago is indeed sobering.

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