COMPARATIVE PSYCHOANALYSIS ON THE BASIS OF A NEW FORM OF TREATMENT REPORT:

THE CASE AMALIA X[1]

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Comparative Psychoanalysis

Although making comparisons, i.e. judging similarities and differences, is part and parcel of our life and of our professional thinking and acting, the phrase ”comparative psychoanalysis” has recently made its way into our professional vocabulary (Scarfone, 2002). It refers to a qualitative comparison of various forms of psychoanalysis. In view of the official recognition of psychoanalytic pluralism brought about by the courage of Wallerstein (1988), we are now obliged to compare various psychoanalytic techniques and theoretical assumptions with each other. To make the comparison reasonable, reliable and fruitful, shared criteria are needed. In membership papers and published case reports, criteria are usually only implied, if not totally missing.

A corollary of “comparative psychoanalysis” is the growing interest in different ways of documenting clinical facts. Within the

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[1] Based on chapter 5.1 in Kächele, H., Schachter, J., & Thomä, H. (Eds.). (2008). *From Psychoanalytic Narrative to Empirical Single Case Research. Implications for Psychoanalytic Practice*. New York: The Analytic Press.

last decade an impressive number of original papers on this topic have been published. In his foreword to the special 75th anniversary edition of the *International Journal of Psychoanalysis*, devoted to ”Conceptualisation and Communication of Clinical Facts in Psychoanalysis” Tuckett (1994) wrote: ”After 75 years it is time not only to review our methodology for assessing our truth, but also to develop approaches that will make it possible to be open to new ideas while also being able to evaluate their usefulness by reasoned argument. The alternative is the tower of Babel” (p. 865). Therefore to make ”comparative psychoanalysis” a fruitful enterprise, it is essential to evaluate how the treating analyst applies his professional knowledge in specific interactions.

In many respects, psychoanalysis is an applied science based on clinical observation, but for all kinds of practical reasons the analyst as participant observer would be overburdened by having to combine his therapeutic task with being at the same time the researcher. Therapy research in psychoanalysis is a most complex endeavor far beyond the capacity of the treating clinician working in isolation.

Only a team can do the job implied by Freud’s "inseparable bond" thesis, namely that of testing the validity of causal connections observed in the analytic situation. The psychoanalytic literature abounds in vignettes about new discoveries which often even lack a convincing description. The

”contemporary countertransference subjectivism” seems to solve all practical and scientific problems: If the emotions of the analyst indeed mirrored the unconscious of the patient correctly, if the ”third ear or eye” heard or saw the unconscious voices and scenes then without further ado psychoanalysts would be in a unique godlike position. Although we enjoy similar fantasies, we don’t think they offer solutions.

To bring symptomatic - and let alone structural - changes into correlation with intersubjective processes and eventually with unconscious schemata as their determining conditions is a difficult undertaking. In other words: micro-analytic descriptions of intersubjective processes have to be related to whatever unconscious clichés generate typical patterns of symptomatic conflict-resolution. We will demonstrate the relationship between hypothesised unconscious processes and detailed interpretations in two session reports of Amalia X.

Our interpretation of the Junktim stresses the responsibility of the treating analyst. Clinical research originates in the analytic situation; everything depends on the participation of the analyst. To this extent there is some truth in the 'inseparable bond' thesis, especially if the context of the phrase is taken seriously. The Junktim is only fulfilled if its ”beneficent effect” is proven. As those processes refer to manifest experiences and behavior and their assumed unconscious roots (Freud’s template or schema), it is essential to discuss their relationship to the intersubjective

processes in the psychoanalytic situation. Only parts of the patient's experience can be expressed in a "language of observation"; but to deny such a language to psychoanalysis is from our point of view unjustified.

Introductory Comments to the Audio-recording of Analytic Treatments

It is remarkable how many problems an analyst has to cope with when he gives a colleague the data from his work even more so if the dialogue is audio-taped and transcribed. Colleagues confirm more or less bluntly what one's self evaluation actually cannot overlook, namely that there can be a significant discrepancy between one's professional ideal and reality. The very idiosyncratic style of interpreting of any analyst makes some editing of the original text necessary.

Tape recording is a relative neutral procedure with respect to the contents of recording; it will not miss spoken words as long they are loud enough to be recorded. Transcripts often seem paltry in comparison to the recollections that the analyst has of the session. When reading a transcript or listening to a tape one has to revitalize the clinical situation by identifying with both, the patient or the analyst. It is the rich cognitive and emotional context that adds vitality to the sentences expressed by the patient and the analyst. It certainly will be a matter of training to fill

in the gaps with the aid of one's imagination and one's own experience (like musicians able to read scores). In the traditional presentation of case material, which in general contains much less of the original data, this enrichment is provided by the author's narrative comments. Even the use of generalizations, for example, of the abstract concepts that are regularly employed in clinical narratives, probably contributes to making the reader feel at home. The concepts that are used are filled – automatically, as it were – with the views that the reader associates with them. If a report refers to trauma or orality, we all attribute it a meaning on the basis of our own understanding of these and other concepts that is in itself suited to lead us into approving or skeptical dialogue with the author.

For Sandler and Sandler (1984, p. 396) the ”major task for future researchers” is “to discover why it is that the transcribed material of other analysts' sessions so often makes one feel that they are very bad analysts indeed.” They qualify this by adding that this reaction ”is far too frequent to reflect reality” and ask “can so many analysts really be so bad?”

It is remarkable that the Sandlers made this comment in a special issue of the “Psychoanalytic Inquiry”, devoted to Merton Gill's innovative contribution to psychoanalytic technique. Our somewhat ironic rejoinder to this observation is the following: Both of the Sandlers would belong to those bad analysts, if they had presented audio-taped dialogues without giving their thoughts and feelings to put the flesh on the verbal skeleton. In other words, oral reports convey some of the emotional climate of the analytic situation to the audience; but without additional editing, and an augmentation of the transcribed material by the treating analyst, the pure written record alone is, indeed, paltry.

In retrospect we can say that the introduction of tape-recordings into psychoanalytic treatment was linked with the

beginning of a critical reappraisal of therapeutic processes (Gill et al., 1968). This simple technical tool was, and still is the object of a subsiding controversy among psychoanalysts (Wallerstein 2003).

We believe that the introduction of research into the psychoanalytic situation is of great benefit to the patient. It enables the analyst to learn more than from any other kind of supervision. Clinical discussions based on audio-taped sessions come very close to the heart of the matter, if the analyst gives background information. A transcript creates the impression of being one-dimensional: the analyst's interpretation and the patient's answers do not automatically reflect latent structures, although typical interpretations disclose which school the analyst belongs to. Some 20 years after our empirical investigations of audio-recordings of psychoanalytic dialogues (Kächele et al., 1988) we would like to encourage our colleagues to use that instrument in order to improve their therapeutic capacities.

Two Sessions of the Case of Amalia[2]

The Need for Annotation

In order to enrich the understanding of the following sessions the treating analyst, H. Thomä, gives to each intervention some background information. These "considerations" are subsequently added to the exchange between patient's and analyst´s

[2] Note the change the style of our text. The treating analyst (H.T.) speaks now in the first person.

responses. It is obvious that in arriving at his interventions he was led not only by the ideas described in the text. Whatever way interpretations have been created, any interpretation actually made must be aligned along ‘cognitive’ criteria. His comments refer to the ‘cognitively’ and ‘rationally’ determined "end-products" (the interventions themselves) and neglect the intuitive, unconscious components in their genesis. The source of each of his analytic thoughts remains an open question. If we assume that the analyst's perceptive apparatus is steered by his personality, values and hopefully theoretical knowledge, which may have become preconscious, then it is very difficult to trace the genesis of interpretations back to their starting points. For example, theoretical knowledge about displacement also facilitates preconscious perception; it pervades the analyst's intuition and blends with his emotional reactions. These ”considerations” are his second thoughts.

Some Remarks about the Psychodynamic Background of the Two Sessions

In retrospect, almost thirty years later, thinks that he was quite successful in establishing a helping alliance which made it possible to make transference interpretations with regard to processes of ”displacement and condensation”. You will hear about the head which is the symbol for understanding and

communication and simultaneously a symbolic expression of the penis and the phallus in the sense of Lacan.

The two excerpts of sessions given below are linked by the fact that each is concerned with enabling the patient to make new identifications as a result of the analysis of transference. The analyst's "head" became the surrogate of old, unconscious "objects," and its contents the representative of new opportunities. The representation of the "object," which is simultaneously a self-representation, made it possible to establish a distance, because the analyst made his head available and kept it too. Thus he became a model for both closeness and distance. This example clearly demonstrates the therapeutic effect that insight into unconscious connections mediated by the analyst’s interpretations can have.

This material was selected because it is suited to provide several lines of support to his argument. Although the head acquired sexual importance as a result of the process of unconscious displacement, this displacement did not alter anything regarding the primacy of emotional and intellectual communication, between the patient and the analyst, about what she was looking for as if it were hidden inside my head. The search for knowledge was directed at sexuality. This secret and well-guarded (repressed) treasure was assumed to be in the head (as the object of transference) because of the unconscious

displacement. The revelation of "displacement" brought something to light that was "new" to the patient.

The two sessions 152 and 153 are taken from a period of the treatment when the patient explicitly experienced severe feelings of guilt, which were actualized in her relationship to him. The Biblical law of an eye for an eye and a tooth for a tooth was reinforced in the patient´s experience because of her sexual desires. Her life-historical role-model for the contents of her transference was a fantasized incestuous relationship to her brother. The increase in inner tension led the patient on the one hand to reconsider the idea of dedicating her life to the church as a missionary and on the other to contemplate committing suicide.

(As a young girl she had wanted to become a nun and nurse, but gave up this idea after a trial period because the pious confinement became too much for her. Leaving also helped her to establish some distance from the strict biblical commandments.)

Now she wielded her "old" Bible against the analyst, "in a fight to the finish." This fight took place at different levels, and the patient invented a series of similes for them. She had the feeling that the analyst's dogma, the "Freud Bible," could not be reconciled with her Christian Bible. Both bibles, however, contained a prohibition of sexual relations with the analyst.

The patient struggled for her independence and needs, which she defended against both of these bibles. She developed an intense defense against his interpretations, and she had the feeling that he knew in advance exactly "what's going to happen." She felt humiliated because her detours and distractions had been detected. She had the intense desire to mean something to him and to live inside of him; she thought about giving him an old,

lovely, and wonderful clock that would strike every hour for me (and for her).

In this phase of the treatment one topic took on special significance and intensity: this was her interest in his head. What had she learned from measuring his head? In a similar situation Amalia X had once said that for a long time she had thought that he was looking for her in books, in his thoughts, in his head. She wished that something completely new would come out. She herself looked for interpretations and made an effort to understand his ideas.

Transcripts of Parts of Sessions 152 and 153

At the beginning of the session Amalia reported an uncanny dream in which she was stabbed in the back by a man, thus she introduced the general topic of a fight between a man and herself with all the different levels and meanings of fights between the sexes. Then Amalia changed her role as a victim and became a perpetrator. In the next session she remembered that she had completely forgotten that she had looked on him as a young man with a head symbolizing a phallus.

At first Amalia reporting about her chief fell into a role of masochistic subordination and I commented by saying:

A: *You presume that I'm sitting behind you and saying "wrong, wrong*.

Consideration. This transference interpretation was based on the following assumption. The patient attributed to him a "superego function." This interpretation took the burden off her and gave her the courage to rebel. The analyst assumed that she had much more intense transference feelings and that both the patient and the analyst could tolerate an increase in tension. He repeated her concern that he could not bear it, and finally formulated the following statement: "*Thus it's a kind of a fight to the finish, with a knife*" (not specifying who has the knife). He made this allusion to phallic symbolism to stimulate her unconscious desires. It was an overdose! The patient reacted by withdrawing. Thus the analyst thought of self-punishment.

P: *Sometimes I have the feeling that I would like to rush at you, grab your neck, and hold you tight. Then I think, "He can't take it and will suddenly fall over dead".*

A: *That I can't take it*.

The patient varied this topic, expressing her overall concern about asking too much of me and of my not being able to tolerate the struggle.

A: *It's a kind of a fight to the finish, with a knife*.

(This interpretation alludes to Amalia‘s dream about being stabbed, reported at the beginning of the session..)

P: *Probably.*

She then reflected that she had always, throughout the years, given up prematurely, before the struggle had really begun, and withdrawn.

P: *And I don't doubt any more that it was right for me to withdraw. After such a long time I have the urge to give up again.*

A: *Withdrawal and self-sacrifice in the service of the mission instead of struggling to the end.*

P: *Exactly, nerve-racking.*

Consideration. She was very anxious about losing her object.

A: *Then I would have the guarantee of being preserved. Then you would have broken off my test prematurely*.

The session continued on the topic of what he can take and whether her let himself be carried along by her "delusion." The patient had previously made comparisons to a tree, asking whether she could take anything from it, and what it would be. The analyst returned to this image and raised the question of what she wanted to take along by breaking off branches.

Consideration. Tree of knowledge – aggression.

P: *It's your neck, it's your head. I'm often preoccupied with your head.*

A: *Does it stay on? You're often preoccupied with my head?*

P: *Yes, yes, incredibly often. From the beginning I've measured it in every direction.*

A: *Hum, it is . .*

P: *It's peculiar, from the back to the front and from the bottom. I believe I'm practicing a real cult with your head. This is just too funny. With other people I'm more likely to see what they have on, just instinctively, without having to study them.*

Consideration. To create shared things as primary identification.

[This topic was discussed for a long period of time, with some pauses and "hums" by the analyst.]

P: *It's simply too much for me. I sometimes ask myself afterwards why I didn't see it; it's such a simple connection. I am incredibly interested in your head. Naturally, what's inside too. No, not just to take it along, but to get inside your head, yes above all, to get inside.*

Consideration. The partial withdrawal of the object increased her unconscious phallic aggressiveness.

The patient spoke so softly that he did not even understand "get inside" at first, mistaking it for "put inside." The patient corrected him and added a peculiar image, "*Yes, it's so hard to say in front of 100 eyes*."

P: Get inside, the point is to get inside and to get something out.

Consideration: The analyst saw this getting inside and taking something out in connection with the subject of fighting. It was possible to put the sexual symbolism, resulting from the displacement from the bottom to the top, to therapeutic use by referring to a story that the patient had told in an earlier session. A woman she knew had prevented her boyfriend from having

intercourse with her and had masturbated him, which she had described by analogy to head-hunter jargon as "head-shrinking." The unconscious castration-intention dictated by her penis envy created profound sexual anxiety and was paralleled by general and specific defloration anxieties. These anxieties led in turn to frustration, but one which she herself had instinctively caused, as a neurotic self-perpetuating cycle. The repression of her sexual and erotic desires that now occurred unconsciously strengthened the aggressive components of her wanting to have and possess (penis desire and penis envy).

A: *That you want to have the knife in order to be able to force your way in, in order to get more out.*

After they exchanged a few more thoughts, the analyst gave an explanation, saying that there was something very concrete behind the shared concern with the topics of getting inside, head, and the fight to the end with a knife.

A: *The woman you mentioned didn't speak of "head shrinkers"*[3] *for nothing*.

Then for about ten minutes the patient switched to a completely different subject finally admitting:

P: *That's just the reason I broke off this line of thought*

After expressing her insight into her resistance to an intensification of transference, she again evaded the topic. She

[3] The derogatory colloquial "headshrinker" (=psychiatrist) has no German counterpart and is unknown to Amalia. Her expression "Schrumpfköpfe machen" refers to a custom of Polynesian cannibalistic warriors who dry up the heads of enemies they have killed.

interrupted the intensification, making numerous critical comments.

P: *Because at the moment it can be so stupid, so distant. Yes, my wishes and desires are the point, but it's tricky, and I get real mad, and when head and head shrinking are now . . .*

She laughed, immediately expressed her regret, and was silent. I attempted to encourage her.

A: *You know what's in your head.*

P: *Right now I'm not at all at home in mine. How do I know what will happen tomorrow. I have to think back. I was just on dogma and your head, and if you want to go down . . .[to a shrunken head]. It's really grotesque.*

Consideration. The analyst first mentioned the shrunken heads because he assumed that the patient would be more cooperative if the envious object relationship could be replaced by a pleasurable one.

Then the patient came to speak of external things. She described how she saw him and how she saw herself, independent of the head, which then again became the focus of attention in a general sense.

A: *By thinking about the head you're attempting to find out what you are and what I am.*

P: *I sometimes measure your head as if I wanted to bend your brain.*

The patient then described the associations she had once had when she had seen the analyst´s picture printed somewhere.

P: *I discovered something completely different at the time. There was an incredible amount of envy of your head. An incredible amount. Now I'm getting somewhere at any rate. Whenever I think of the dagger and of some lovely dream.*

Consideration. The patient obviously felt caught. She felt humiliated by her own association, as if she had guessed the analyst´sassumption as to what the envy might refer to. In this case he would have rushed ahead of her, so to speak.

A: *Humiliating, apparently to you, as if I already knew which category to put it in when you express envy, as if I already knew what you are envious of.*

P: *That came just now because you had referred to the shrunken heads, which I didn't even make. But what fascinated me is this fight to the finish, for the knife, to get to the hard part . . . .Yes, I was afraid that you couldn't take it. My fear that you can't take it is very old. My father could never take anything. You wouldn't believe how bland I think my father is. He couldn't take anything.*

Consideration. A surprising turn. The patient's insecurity and her anxiety about taking hold developed "unspecifically" on her father.

A: *It's all the more important whether my head is hard. That increases the hardness when you take hold.*

P: *Yes, you can take hold harder . . .and can - simply - fight better.*

The patient then made numerous comments to the effect of how important it was that the analyst did not let myself be capsized, and she returned to her envy. Then she mentioned her university studies again, and how she used to "measure" the heads of the others. Then she introduced a new thought.

P: *I want to cut a little hole in your head and put in some of my thoughts.*

Consideration. An objectivistic image of "intellectual" exchange as a displacement?

The patient's idea about the two-sided nature of the exchange led the analyst to recognize another aspect of this fight. It was also an expression of how important it was to him that she remains a part of the world (and in contact with me), and digress neither into masochistic self-sacrifice nor into suicide.

P: *That came to me recently. Couldn't I exchange a little of your dogma for mine. The thought of such an exchange made it easier for me to say all of this about your head.*

A: *That you continue coming here so that you can continue filling my head with your thoughts.*

Consideration. Fertilization in numerous senses – balance and acknowledgment of reciprocity.

P: *Oh yes, and mentioning really productive ideas*.

The patient returned to the thoughts and fantasies she had had before the session, about how she had been torn back and forth. Whether she had a future at all, and whether she shouldn't withdraw in some way or other and put an end to it all.
At the beginning the analyst had attempted to relieve her intense feelings of guilt with regard to her destructiveness. He picked up the idea once again that her thoughts about his stability were in proportion to her degree of aggressiveness. The patient could only gain security and further unfold her destructiveness if she found strong, unshakable stability. The topic of dogmatism probably belonged in this context. Although she criticized it - both her own Bible and the analyst´s presumed belief in the Freud bible - it also provided her security, and for this reason the dogmatism could not be too rigorous or pronounced.

A: *Naturally you wouldn't like a small hole; you would like to put in a lot, not a little. The idea of a small or large hole was your shy attempt to test my head's stability.*

The analyst´s subsequent interpretation was that the patient could also see more through a larger hole and could touch it. She picked up this idea:

P: *I would even like to be able to go for a walk in your head.*

She elaborated on this idea and emphasized that even earlier, i.e., before that day's session, she had often thought to herself how nice it would be to relax in him, to have a bench in his head. Very peacefully she mentioned that he could say, when looking

back on his life when he dies, that he had had a lovely, quiet, and peaceful place to work. (His office was opposite a very old cemetery, now used as a park.)

Consideration. Quiet and peacefulness clearly had a regressive quality, namely of completely avoiding the struggle for life.

The patient now viewed her entering the nunnery as if a door had been wide open and she had turned away from life. She then drew a parallel to the beginning of the session, when the door was open.

P: *I really didn't have to drill my way in. Yes, there I could leave the struggle outside, I could also leave you outside, and you could keep your dogmas.*

A: *Hum.*

P: *And then I wouldn't fight with you.*

A: *Yes, but then you and your dogma would not be afraid of mine. In that setting of peace and quiet everything would remain unchanged, but the fact that you interfere in my thoughts and enter my head shows that you do want to change something, that you can and want to change something.*

About five minutes into the next session (153), the patient returned to the analyst´s head and measuring it and to the fact that it had disturbed her that he had started talking about the shrunken heads.

P: *I told you so. Why do you simply want to slip down from the head?*

She then described how she had hardly arrived at home before she recalled the thoughts she had had when she had said hello but then had completely forgotten during the session.

P: *To me, he [the analyst] looks as if he is in his prime, and then I thought about the genitals and the shrunken heads. [But she quickly pushed this thought aside, and it was completely gone.] When you started with the shrunken heads, I thought, "Where has he got that again?"*

The next topic was the question of his security and his dogmatism, and it was clear that the patient had taken a comment he had once completely undogmatically made about Freud and Jung to be dogmatic. She then thought about living a full life, about the moment when everything stopped for her and she became "ascetic," and about whether everything could be revived. Then she again mentioned fighting and his head.

P: *I was really afraid of tearing it off. And today I think that it's so stiff and straight, and I think to myself, "I somehow can't really get into my head. I'm not at home. Then how should I get into yours?"*

The patient then began to speak about an aunt who was sometimes so very hard that you might think you were facing a wall. She then continued about how hard and how soft she would like her head to be. Her fantasies revolved, on the one hand,

around quiet and security; on the other hand, she was concerned about what might be hidden in her head and the danger of it consuming her.

Consideration. This obviously involved a regressive movement. The patient could not find any quiet and relaxation because her sexual desires were linked with pregenital fantasies, which returned in projected form because they were in danger of being consumed. These components were given their clearest, and in a certain sense also their ultimate, expression in an Indian story the patient later associated, in which mothers gave pleasure to their little sons by sucking on their penises but bit them off in the process.

The comparisons of the heads and their contents always revolved around the question of whether they went together or not.

P: *The question of how you have your thoughts and how I have mine . . .Thoughts stand for many things . . . .*

A: *How they meet, how they rub off on one another, how far they penetrate, how friendly or unfriendly they are.*

P: *Yes, exactly.*

A: *Hum, well.*

P: *You said that a little too smooth.*

The patient thought about all the things that scared her and returned again to the shrunken heads.

P: *There I feel too tied to sexuality. The jump was too big.*

The topic was continued in the question of her speed and of the consideration I pay to her and her speed.

P: *But it is true; naturally it wasn't just your head but your penis too.*

Amalia X was now in a position, with phases of increasing and receding anxiety, to distinguish between pleasure from discovering intellectual connections and sexual pleasure. The couch became her mental location of sexual union, and her resting in my head the symbol of pregenital harmony and ultimately the location of shared elements and insight. This aspect became even clearer a little later.

Discussion

Comparative evaluation

The claim of this communication was to provide data for a comparative evaluation. In the center of the psychodynamic focus of the two sessions is the process of displacement within the patient's body-image into the transference. The head is used as a transference object. At the same time the patient uses the analyst's thought processes localized in his head as new experience in order to overcome transference repetitions. Insofar, the two sessions contain changes brought about by the offer of the thoughts and feelings of the analyst as a new object (Loewald, 1960). From a microanalytic point of view the verbatim

protocol contains details, which cannot be covered by the molar abstraction of the session.

An alternative conceptualization, based on the Weiss – Sampson plan analysis (1986) of the patient´s material pointed to traumatizing experiences of early upbringing. The analyst, although knowing about these early experiences gave less weight to these early experience in his case conception. He was convinced –whatever the early experiences had been - that the salient impact would had to come from a corrective emotional experience within a new subject-object relationship in order to attain new internalized structures. In this sense we fully agree with Weiss´ ideas about unconscious efforts of patients to disconfirm their unconscious, pathogenic, grim beliefs.

The comparative evaluation of these two case conceptions in the case of the specimen session 152 leads to an interpretation that the patient´s wish to reside peacefully in the analyst´s head not only signifies a phallic intrusion but also could represent the patient´s pregenital wish for reunion with her mother. This unconscious phantasy could reflect the reparation of the early cumulative traumatizing separations experiences. The experimentum crucis consists in identifying behaviors and experiences of the patient that could be weighted for or against these two macro-conceptions. However the psychoanalytic proposition of overdetermination would not rule out that both interpretations have their own justification for which empirical

referents have been identified. Therefore the concept of mini-models (Meyer 1988) in smaller or more extended form linked up to our concept of focal conflicts points (Thomä & Kächele 2003, chap. 9) to a crucial issue: without such signposts marking meso-working models the analyst easily gets lost in almost infinite microscopic states of mind. Taking into accounts the conscious activity has a time window of about three sec it becomes obvious that such models are operating below consciousness and are guiding the analyst´s listening and observational capacities.

Collegial discusssions

As this material was presented at a panel held at the 43rd Congress of the International Psychoanalytical Association, New Orleans, we quote from the final panel report by Wilson (2004):

> The issues were discussed the issues along four dimensions: (1) what made agreement difficult was that everyone defines clinical material from a very different point of view; (2) everyone struggled with how to discuss clinical material in a respectful way and avoid the temptation to 'supervise' the technique of the Ulm-based presenters; (3) an exuberance of theory and scarcity of empirical observations (4) there was a wide consensus throughout the panels, that, no matter what the difference in theoretical perspective, the patient-analyst dyad was proceeding in a way that could be described as characterized by a 'psychoanalytic process' and what was

> interesting was that panellists of different persuasions provided different descriptions of how the sessions were evolving, although all agreed that a psychoanalytic process was present. (Wilson, 2004, p. 1269)

Beyond this friendly bonfire of agreement which was not shared at all by all panelists (Ireland, 2004), we felt that S. Akhtar´s discussion of the technical points of this presentation were quite enlightening:

> 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' 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' 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. 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. 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'. 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 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. (Akhtar, 2007)

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