Comparative Psychoanalysis on the Basis of a New Form of Treatment Report

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> "I get so sick and tired of hearing about the various different schools of psychoanalysis and their great superiority to the other one—whichever it is. The possibility of arguing about their various merits is simply endless—as long as you don't anchor any of it to facts. I don't know of any scientific work that is not based on observation." (W. Bion, 3.7.1978, in 2005 b, p. 39)

In this article, we argue that it is essential to understand how the analyst applies his knowledge in the analytic situation to investigate the analytic process and develop research models to evaluated clinical hypothesis. We accept the premise that the analyst's theory influences technique and that an examination of an analysis involves an interactive process. We ask, "How do we understand the inseparable bound between therapy and research?" We argue that the understanding that develops in psychoanalysis is not research. For research to take place, an exploration of causal connections is necessary that includes the analyst's observations and thinking through out the analysis which can be evaluated by independent observers. We describe and demonstrate a research model based on an audio transcription and annotated comments of the analyst to convey his observations and thinking that can be evaluated by independent observers.

ALTHOUGH MAKING COMPARISONS OF OUR PROFESSIONAL THINKING, the phrase comparative psychoanalysis is new to our vocabulary. To our knowledge, only Scarfone (2002) recently used it as subtitle in the se-

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ries "The analyst at work" in the *International Journal of Psychoanalysis*.[1] In German, the designation *vergleichende Kasuistik* (in English, comparative case study; Jüttemann, 1990) is very often used. It refers to the comparison of psychotherapy. In view of the recognition of psychoanalytic pluralism of Wallerstein (1988, 1990), we compare various psychoanalytic techniques and theoretical assumptions. To make the comparison reasonable, reliable and fruitful, shared criteria are needed. In papers and published case reports criteria are usually only implied, if not totally missing. Eagle's (1984) complaint is still justified: "It seems ironic that psychoanalytic writers attempt to employ clinical data for just about every purpose but the one for which they are most appropriate—an evaluation and understanding of therapeutic change."

A corollary of comparative psychoanalysis is the growing interest in documenting clinical facts. Within the 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).

To make comparative psychoanalysis[2] a fruitful enterprise, it is essential to evaluate how the treating analyst applies his professional knowledge in specific interactions.

To facilitate a critical discussion, we divide this paper into two parts. First, we make some statements about our psychoanalytic thinking under the following headings:

1. How theory shapes technique
2. From case history to treatment report

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[1]R. Wallerstein drew our attention to R. Schafer's (1983) ideas about "Wild Analysis." He suggested to replace "wild" by "comparative" psychoanalysis. Schafer compared the systems of Melanie Klein, Heinz Kohut, and Merton Gill. Of course, nobody would regard the three theories and their considerable merits as wild psychoanalysis. Unfortunately, the criteria, on which Schafers comparison is based, are not specified with regard to their pragmatic truth and their therapeutic qualities.

[2]It is noteworthy that Scarfone's (2002) commentary to the paper of Barros (2002) in the series "The analyst at work" was subtitled "An essay in comparative psychoanalytic practice."

3. Limitations and possibilities of the "inseparable bond" thesis (Junktim thesis)
4. Unconscious schemata and causal dispositions
5. The Ulm Process Model

The second part deals with the case of Amalia under the following headings:

1. Introductory comments to the audio-recording of analytic treatments
2. The importance of annotation
3. Amalia's symptomatology and its history
4. Some principle of treatment reports
5. Transcripts of parts of session 152 and 153
6. Summary

Part I: Psychoanalytic Thinking

How Theory Shapes Technique

The relationship between techniques and underlying theories is a very old problem. Eighty years ago, Ferenczi and Rank (1924) attempted to clarify "the relationship between analytic technique and analytic theory" and to investigate "the extent to which each currently assists or obstructs the other" (Freud, 1922d, pp. 269–271)—Freud's prize question. In spite of Ferenczi's justified hope, the award was not granted and the book of the two authors was heavily criticized by the young Franz Alexander (1925), who expressed the opinion of the majority, including Freud.[3] Many years later, Pulver (1987) aimed at a more justified comparison of different psychoanalytic techniques.

He edited a discussion (1987) under the title *How Theory Shapes Technique: Perspectives on a Clinical Study*. The basis of the discussion is a collection of an analyst's (Silverman) notes, the interpretations he made, and

[3]Still, in 1937, Alexander criticised Ferenczi because of his emphasis on the emotional experiences. Today the "corrective emotional experiences" (without Alexander's role-playing) is recognised in all schools (Marohn, 1990).

the patient's reaction in three sessions. This clinical material was examined by ten prominent representatives of various psychoanalytical schools.

As might be expected, Pulver's comparison demonstrated vast differences in clinical evaluation, depending on the analyst's theoretical orientation. Indeed this study, and a similar one in which Fosshage (1990) volunteered as presenting analyst, undermine the belief that there is a "common ground" (Wallerstein, 1988, 1990) in contemporary clinical psychoanalysis. In view of this pluralism, the importance of research in clarifying the nature of the differences and their effects on the therapeutic process and outcome cannot be overestimated.

A. E. Meyer (1994) called Pulver's (1987) study the "Pulver test." It is a kind of a projective test like the Rorschach. As in similar experiments, like the ones by Streeck (1986, 1995) or Fosshage (1990), the instruction that the analysts should interpret according to their own particular school naturally maximizes divergences and minimizes possible consensual validation. Especially irritating was the claim—tacitly or explicitly made by these participating analysts—that their own particular interpretive bent is the true and, therapeutically, the more successful one. We need remedial strategies, in the sense of Rubovits-Seitz (1992), to minimize such unqualified assertions.

What can be done when experts agree to disagree? There is a wide range of reactions. After many years of dogmatic power games, psychoanalysts are more tolerant of each other today. The pressure from outside furthers the reconciliation amongst the various psychoanalytic groups. Pulver's conciliatory reaction to the serious divergences is typical. He concludes that the differences of opinion between the participants are more apparent than real: "The therapist may be saying essentially the same thing to the patient, but in different words. The patient wants to get used to the therapist's words, in fact to feel understood. For instance, this patient might feel that her ineffable feeling of defectiveness was understood by a Kleinian who spoke of her envy, a self-psychologist who spoke of her sense of fragmentation and a structural theorist who spoke of her sense of castration" (Pulver, 1987, p. 298).

Thus, Pulver assumes that this patient had insights that could have been expressed in different terminology, yet that the latter would simply represent metaphoric variations of the same themes. Joseph (1984) argued in a similar vein by referring to unconscious linkages. For example, an interview covering anxiety and loss touches both on unconscious preoedipal separation anxiety and on castration anxiety. Certainly in response to the

word loss, every individual will recall many experiences that may be interrelated although the losses are of different subtypes. Nevertheless, although such reference to overarching metaphors is an attractive idea, we think that it is misused here as a means of overcoming legitimate controversies instead providing scientific clarification of various theories.

The desire to find harmony in the contemporary psychoanalytic Tower of Babel stimulated a search for common ground at the IPA congress in Rome. As president of the IPA, perhaps for diplomatic reasons Wallerstein underestimated the significance of differences (even contradictions) between various theories and school-related or eclectic techniques in the observation of clinical phenomena. Wallerstein's (1990) great attempt to forge agreement and unity among the schools, at least on the clinical level, was unable to bridge or harmonize true antitheses. He sought a common ground in the clinical theory and in its correspondence to observational data. But the examples cited from the work of S. and E. Fine (1990), as well as from Richards and Richards (1995), support quite a contrary conclusion: Observational data are colored from the onset even by abstract metapsychological point of view, i.e., in the Kleinian School the death drive. In addition, concepts like transference, countertransference, resistance, and the like have very different meanings in various psychoanalytic schools (Richards, 1991). At the congress in Rome, Schafer (1990) seems to have met the zeitgeist of psychoanalytic pluralism. The plurality of orthodoxies (Cooper, 2007) exerts a tremendous pressure to undertake comparative therapy research as the only way to reach "true controversies" (Bernardi, 2002; Eizirik, 2006).

There are many psychoanalyses today. We doubt that the convergence has become greater since the Rome congress (Wallerstein 2002). At any rate, because psychoanalysis is what psychoanalysts do, as Sandler[4] (1982) boldly and briefly put it, the practice of individual analysts has to be investigated to get as close as possible to primary data. It is but metaphorical to claim that we are all doing the same thing. Commonalities are beautifully expressed by metaphors. To be well-contained, to have an analyst who functions as a "container" and "digests" or "metabolizes" unconscious elements are not more than attractive metaphors. "Containment"—the most

[4]In view of the justified critique of the training within the IPA, Sandler's (1982) restriction that his simple definition applies only to those analysts properly trained under the auspices of the IPA, cannot be upheld today (Balint, 1948; Thomä, 1993; Thomä and Kächele, 1999; Kernberg, 2000, 2006, 2007; Kächele and Thomä, 2000; Auchincloss and Michels, 2003).

recent all-embracing and fashionable metaphor—is indeed completely disconnected from Bion's theory and used to designate the supportive and helping function of a therapist. In this sense, every successful analyst is a Bionist. The metaphorical use of "containment" is quite different from the Kleinian–Bionian theory of unconscious fantasies and Bion's hypothesis about alpha- and beta-elements. True followers seem to replace "alphabetization" for analysing (Ferro, 2005), although Bion clearly stated: ". . . there is a lot to be said for considering what I have previously called beta- and alpha-elements, but those are not psychological because I keep them for something I don't know and never will know." (Bion, 2005b, p. 21)

Among the many reasons for unproductive controversies, the following are prominent:

1. The listener or reader of analytic interpretations is at a loss if he or she knows nothing about the cognitive and emotional approach of the treating analyst in general and how it is applied in a concrete situation with a particular patient.
2. Neither of the two participants in the interaction, patient and analyst, are known to the critical listener. All kind of ideas come up in any case discussion. The "personal equation" is very influential: The listener puts himself in the role of the treating analyst; and this is all the more so, the less he knows "how the mind of an analyst works" (Ramzy, 1974).
3. Alternative points of view are then expressed before the ones contained in the original interpretations are discussed in their own right. The lack of consensus between analysts is often a result of the failure to take the colleague's points of view seriously before thinking about alternatives. The negative results of the consensus investigations (Seitz, 1966) have their roots in a design which did not define the frame of reference. When we reduplicated it and gave the investigation a definite frame, we arrived at a fairly reliable consensus among analysts (Thomae et al., 1976; cf. Caston, 1993; Caston & Martin, 1993).

From Case History to Treatment Report

To evaluate therapeutic change, detailed treatment reports have to be made accessible to the professional community. The tradition so far has centered upon the publication of case histories. Freud's main objective was to reconstruct the genesis of psychopathological disturbances; thus the move from

writing case histories to writing detailed treatment reports marks a new era in psychoanalytic practice.

The special tension contained in Freud's case histories results from the fact that all descriptions in them have the goal of making the background of the patient's thoughts and actions plausible in order to be able to present explanatory outlines of their history (Thomä and Kächele, 1992, p. 10ff).

Because the primary purpose of Freud's case histories was to reconstruct psychogenesis, i.e., to demonstrate that symptoms have repressed unconscious causes, the description of therapeutic technique took second place. Freud did not discuss technical rules systematically in his treatment reports. He only mentioned, in a rather fragmentary way, what he felt, thought, interpreted, or otherwise did in a particular session.

Freud distinguished between case histories, which he occasionally referred to as the patient histories (*Krankengeschichten*) and treatment histories. In the Ulm textbook, we have adopted this distinction, except that we prefer the designation treatment reports because of the significance of the different forms of documentation. Freud pointed out in an early publication the difficulties confronting suitable reporting. "My object in this case history was to demonstrate the *intimate structure of a neurotic disorder* and the *determination* of its symptoms; and it would have led to nothing but hopeless confusion if I had tried to complete the other tasks at the same time. Before the technical rules, most of which have been arrived at empirically, could be properly laid down, it would be necessary to collect material from the histories of large number of treatments." And he confessed, "Indeed I have not yet succeeded in solving the problem of how to record for publication the history of a *treatment* of long duration" (Freud 1905e, pp. 9ff, cf. 1912e, p. 114, emphasis added).

The criteria that must be applied to write a convincing case history, i.e., a reconstruction of the conditions of genesis, are different from those for those that apply to description in a treatment report. Treatment reports focus on determining whether change has occurred and what conditions led to the change. Freud could be satisfied with making relatively rough distinctions that left a lot to subsequent research. From today's point of view, however, Freud's case histories are not suited to serve either as a model for a reconstruction of the etiology or as a paradigm for records of psychoanalytic treatment. The task of creating the most favorable conditions for change and of investigating the therapeutic process is a very challenging one. Similarly, research that is designed to provide evidence relevant to the etiological hypotheses demands too much of the individual analyst. Fol-

lowing Grünbaum's (1984) criticism, Edelson (1988) drafted an ideal model according to which a case history and a treatment report would have to be written today to make it possible for hypotheses to be tested.

It is essential that the treatment report contain at least some of the elements of the new genre that Spence (1986) is pleading for.

> What is needed is a new genre and a new mode of clinical reporting and we are reminded of Eissler's prediction that "when a case history has been published of a quality superior to the five pillars on which psychoanalysis now rests (Freud's five case reports), then psychoanalysis will have entered a new phase" (Eissler, 1963, p. 678). We need to have a clean break with what I call the Sherlock Holmes tradition, and to develop methods of presenting our data which will allow the reader to participate in the argument, allow him to evaluate the proposed links between evidence and conclusion, and which open up the possibility of refutation, disconfirmation, and falsification (none of these moves is now possible). The new genre would also provide us with an archive of specimen interpretations, specimen dreams, and specimen cases which would be accessible to other readers, perhaps even from other schools of psychoanalysis, and which could be used in a cumulative manner to combine data from many patients and many analysts [Spence, 1986, p. 14].

The new genre implies a different scientific ideal than the one Freud adhered to. The investigation centers upon therapeutic interventions and their effects on changes.

Plagued by the problem of suggestion, Freud aimed at a pure uncontaminated method—like the philosopher of science and learned physicist Grünbaum. Yet if proof of the causal relationship requires that the data be free of any trace of suggestion to obtain uncontaminated data by means of pure interpretations, then the therapy is ruined.

It is obvious that the analyst offering interpretations influences the patient even if it seems to him that he is only directing his interpretations to the unconscious and has no further aims. This is a self-deception and, instead of unreflected suggestions, it opens the door to hidden manipulation. This dilemma is a consequence of Freud's scientific position, which until recently has severely hampered the development of specific forms of research on psychoanalytic process and outcome. It is ironic that the idea of purity and the search for uncontaminated data could have destroyed re-

search on the home ground of psychoanalysis. Now systematic investigations are examining the question how the psychoanalytic method influences the patient (and vice versa). To objectify the intersubjective process makes it necessary to reflect upon various kinds of suggestion and contamination. Strenger (1991) speaks of a purity myth as Freud's scientific ideal. However, it is obvious that "psychoanalysis is history, but history is never pure ... therefore we must eliminate this pure/impure opposition. Things are always impure, because human beings are impure. In fact, those who strive to avoid influencing others end up doing so in a way that is even more worrying. Because the will to be pure, the will not to influence, is in itself a mighty source of influence. These endeavoring to be pure are those who scare me most! This will to purity can lead us back to the origins of psychoanalysis to Freud's desire to do science in this sense of doing physics, in the classical sense of the word. The wish of Freud's, still present today, is a symptom I want to challenge" (Strenger 1991, p. 106).

We arrive at a very surprising conclusion: Both Freud's and Grünbaum's attempts at purification destroy therapy, as well as appropriate research, in psychoanalysis. The difference between the founder of psychoanalysis and one of its sharpest contemporary critics is that Freud believed that the causal nature of psychoanalytic assumptions can be proven in the therapeutic situation itself, whereas Grünbaum (1984) rejected this opinion with regard to Freud's Tally-argument (Freud, 1917, p. 452). Grünbaum's argument is based on the assumption that the therapeutic application of the psychoanalytic method follows the scientific paradigm of classical physics. To give up the ideal of purity brings Freud's revolutionary ideas to its fulfillment with regard to participating and the constructivist observer.

The contemporary crisis differs from all the previous ones. It depends on the recognition of the intersubjective, relational nature of the psychoanalytic method. The treating analyst, of course, contributes to changes and is capable of observing them. Psychoanalysis is a science based on observation, but for all kinds of practical reasons the participant observer would be overburdened by performing his therapeutic task and, at the same time, being the investigator of the process. 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" (Freud, 1927a, p. 255) thesis, i.e., test the discoveries made single-handedly in the analytic situation. The

psychoanalytic literature abounds in vignettes about new discoveries that often 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 (as Goethe imagined the "Urphaenomene") without further ado, psychoanalysts would be in a unique godlike position. Although we enjoy similar fantasies, we don't think they offer solutions.

Whatever the role of the countertransference may be in the recognition of unconscious conflicts, the assumed connection between them has to be made evident. The contemporary post-Kleinian and wide-spread equation of the countertransference with the unconscious fantasies of the patient would be a wonderful solution of all epistemological problems in psychoanalysis. Bott-Spillius reports (1988) that Melanie Klein gave a candidate in supervision, who ascribed his confusions to the patient's projection, the following warning: "No, dear, *you* are confused" (p. 10, emphasis added). It is more than a funny anecdote! Obviously Melanie Klein was against the equation of processes of projective identification with the countertransference.

Nowadays, this equation lures analysts inside and outside of the Kleinian school into the self-deception, that the countertransference is the new via regia to the unconscious. The "creation" (Heimann, 1950, p. 83) of the patient becomes the third ear and eye, equipped with the unique quality of having a direct and true access to the patient's unconscious. This gives analysts a powerful position, especially as the diagnostic quality of the countertransference is made dependent on a proper post-Kleinian training analysis. Freud's (1912e, p. 116) "telephone-receiver metaphor" was the forerunner of Reik's "third ear" and the post-Kleinian conceptualization of the countertransference. As we do not believe in the magic quality of our countertransference, we are modest with regard to the reliability of diagnostic considerations about unconscious processes. To bring symptomatic changes into correlation with intersubjective processes and, eventually, with unconscious schemata as their conditions are a difficult undertaking. In other words, microanalytic descriptions of intersubjective processes have to be related to the unconscious clichés as typical forms of conflict solutions. We will demonstrate the relationship between assumed unconscious processes and detailed interpretations in the session reports of Amalia.

Limitations and Possibilities of the Inseparable Bond Thesis

The following two questions have been remaining with us for a long time: Who is capable of solving the clinical problems connected with the thesis of the inseparable bond "between cure and research?" And what ways are appropriate to study processes of change?

Strachey translated Freud's original German word *junktim*, which is derived from the Latin *jugum* (yoke), into inseparable bond.

The inseparable bond belongs into the following full quotation:

> "In psychoanalysis there has existed from the very first an *inseparable bond between cure and research.* Knowlegde brought therapeutic success. It was impossible to treat a patient without learning something new; it was impossible to gain fresh insight without perceiving its beneficent results. Our analytic procedure is the only one in which this precious conjunction is assured." [Freud, 1927a, p. 255, emphasis added].

Leaving aside the difference between true discoveries and the subjective learning process of an analyst, we underscore the following: Freud made insight and scientific knowledge dependent on the therapeutic effects by emphasizing that knowledge is connected with therapeutic success and insight is perceived as beneficent. In brief: The *junktim* must be verified by explanations of change-processes eventually leading to cure.

The scientific ramification of the *junktim* is usually overlooked. Many psychoanalysts seem to take it for granted that every therapy is a scientific enterprise (Etchegoyen, 1992). Only a minority is skeptical or opposes it (Meyer, 1998). Shakow (1960) referred to the inseparable bond thesis as a naive misunderstanding of the research process. The treating analyst's personal theories, his truth and its application (efficacy), must be studied by independent judges.

For Stoller (1979), the claim that the psychoanalytic method is scientific remains open to question as long as it lacks one essential element found in all other recognized scientific disciplines: "To the extent that our data are accessible to no one else, our conclusions are not subject to confirmation. This does not mean that analysts cannot make discoveries, for scientific method is only one way to do that. But it does mean that the process of con-

firmation in analysis is ramshackle... I worry that we cannot be taken seriously if we do not reveal ourselves more clearly" (p. XVI). It is a truism, of course, that the transcript "is not a record of what happened but only of what was recorded" (Colby and Stoller, 1988, p. 42). But nonverbal phenomena can be detected. After all, the analyst's interpretations are supposed to refer to those aspects of unconscious affects and feelings not openly and verbally communicated.

Our interpretation of the *junktim* stresses the responsibility of the treating analyst. Clinical research originates in the analytic situation, all depends on the participation of the analyst. In many studies—e.g., those about countertransference—the treating analyst is a most essential part. There is some truth in the inseparable bond thesis, especially if the context of the phrase is taken seriously. As already quoted, the *junktim* is only fulfilled if "beneficent effect (in German, *wohltätige Wirkung*) is proven. Our emphasis that treatment reports have to be centered on processes of change is once more justified. As those processes refer to phenomenon 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, as Ricoeur (1970) did, is from our point of view, unjustified.

Unconscious Schemata as Causal Dispositions

In any clinical research, psychoanalytic and otherwise, the crucial point is that the elimination of an assumed underlying condition as the cause of certain symptoms must change them and eventually bring about their dissolution.

The German philosopher of science, Stegmüller (1969), clearly states, "If we deal with the elimination of certain phenomena or events which only occur if a defined necessary condition is present we tend to declare this special necessary condition as the cause of the phenomenon" (p. 435, our translation).

Freud's conception follows this scientific ideal of a causal therapy. His famous thesis of an inseparable bond (*junktim*) uniting treatment and research fits Grünbaum's requirements as well as the therapeutic expectations of the patient—a wonderful unity if it can be proven. The psychoana-

lytic method becomes therapeutically effective by demonstrating that changing the causative conditions (the unconscious disposition) brings about symptomatic relief. In the German version of our methodological paper (Thomae and Kaechele, 1973; Engl., 1975) we spoke of a possible dissolution of a causal connection by psychoanalytic interpretations. This loose formulation was rightly criticized by Grünbaum (1984). Of course, we had never in mind that causality, as such, was dissolved. Therefore, we gratefully accepted Grünbaum's (1988, p. 33) clarification and he acknowledged that by quoting from our textbook, "In the wake of the resolution resulting from the interpretive work, the conditions maintaining the repression (and thus the symptoms) are changed. Eventually the specific unconscious causes of the repression may become ineffective. This change may resolve the processes determined by the causal nexus but not the nexus itself, as emphasized by Grünbaum (1984), the resolution actually confirms the suspected role of the nexus" (Thomae and Kaechele, 1992, p. 27). Of course, it must become evident that the dissolution has been brought about by psychoanalytic means and not by chance or by nonspecific suggestions. In his later work, Grünbaum (1993) took up the question of dissolution again, this time in a comprehensive sense against Habermas' hermeneutic turn. In our evaluation, the most important point is the following one. If the unconsciously rooted defenses change by psychoanalytic means, a symptomatic relief must be the necessary effect. We are now on empirical grounds and have to face, once more, the problem of suggestion.

Grünbaum's contamination arguments against psychoanalytic observations and interventions are correct, but he draws the wrong consequences. We arrive at a very surprising conclusion: Both Freud's and Grünbaum's attempts at purification destroy therapy as well as appropriate research in psychoanalysis. The difference between the founder of psychoanalysis and one of his sharpest contemporary critics is that Freud believed that the causal nature of psychoanalytic assumptions can be proven by an analyst being an objective, neutral observer, whereas Grünbaum rejected this opinion (Grünbaum's critique of the Tally-argument, a reference to Freud 1917, p. 452). Grünbaum does not even discuss the possibility to differentiate between various forms of suggestion and he underestimates the patients' critical attitudes. Both Grünbaum's Tally-argument and Necessary–Condition–Thesis collapse; it is empirically possible and part and parcel of the therapeutic encounter to discriminate between specific interventions and all kinds of suggestive maneuvers, which Grünbaum uses as the epitome of the scientific ill-foundation of psychoanalysis. This critique of the psycho-

analytic method is based on a physicist's misapprehension of the human sciences, which are, indeed, impure. It is the task of the analyst to differentiate between various suggestions to support the patient's capacities to overcome the unconscious roots of conflicts. Many problems of the philosophy of science, which were produced by the psychoanalytic method, were already discussed at a famous symposium at the New York University (1958) under the aegis of Sidney Hook (1959). On this occasion Adolf Grünbaum, at that time "informally tagged as the 'Mr. Time and Space' of American Philosophy" (Cohen, 1983 p. 12), was born as the sharpest later critic of psychoanalysis. Unfortunately, he did not stay with Hooks' statement: "Nobody has ever denied scientific status to psychoanalysis on the ground that it is not like physics. For we would then have to rule out the whole of biology as a science, which would be absurd" (Hook, 1959, p. 214). As we were well acquainted with possible solutions of the methodological problems discussed at that symposium when Grünbaum turned his passionate spirit towards psychoanalysis, we never have been seriously affected by the "Grünbaum Syndrome" as described by Mitchell.[5] We agree with Mills' convincing argument "that Grünbaum commits a category mistake in comparing psychoanalysis with the physical sciences, thus he upholds a standard of scientific inquiry that cannot be applied to our field" (Mills, 2007, p. 539). We think it is possible to decontaminate psychoanalytic data and to invalidate Grünbaum's critique (Thomä and Kächele, 2006; Kächele, Schachter, Thomä, 2008).

Grünbaum's critique became a source for analysts and philosophers to think about epistemological questions. Fonagy (2003, p. 19) made it quite clear that "most clinical laws are only probabilistic…and therefore they only allow inductive, statistical explanations rather than deductive nomological ones. Every single case is therefore potentially different, which in turn illustrates the necessity of case-studies but also exemplifies the well-known problems of generalization." Very similar points of view made Benjamin Rubinstein (1997) many years ago. It is an ominous sign

[5]According to Mitchell (1998, p. 5), many analysts became afflicted with the "Grünbaum Syndrome" after exposure to his criticism "that there is no way of testing their validity (i.e., of psychoanalytic interpretations) in any independent fashion." The syndrome includes "Several days of guilty anguish for not having involved oneself in analytic research ... And may (also) include actually trying to remember how analysis of variance works, perhaps even pulling a twenty-year-old statistics off the shelf and quickly putting it back. There may also be a sleep disturbance and distractions from work" (Mitchell, 1998, p. 5).

that his work is either forgotten—or even worse—outdated (Strenger, 1991). We are partisans of Rubinstein and believe that, in spite of the so-called hermeneutic turn in psychoanalysis, all analysts think causally. Extreme subjectivism and constructivism can only conceal our dependence on causal thinking and the need for objectivity, even if we fail to comprehend the whole of intersubjective communication. Our emphasis on the relational, intersubjective character of the analytic method is compatible with attempts to objectify change processes. As we are only amateurs in epistemological questions, we refer to the convincing statements of Cavell (1993, 1998).

Single case studies and the uniqueness of every human being are in the center of psychoanalysis (Caws, 2003; Mills, 2007). Inasmuch as unconscious reasons can be taken as (motivating) causes or intentions, psychoanalytic explanations are philosophically sound. Hermeneutic understanding and causal explanation do not oppose, but rather supplement, each other. Freud's discoveries of unconscious reasons in human action created a new method of understanding by explanation. It is no wonder that the philosopher von Wright (1994, p. 177f), among others, finally arrived at the recognition of a type of explanation, which he called "explanatory understanding." The apparently naive conviction of psychoanalysts that the historical dichotomy of *Verstehen* and *Erklären* belong to the past, is well founded. The psychoanalytic method helps to deepen the understanding of human experiences by probabilistic explanations. Psychoanalysts move back and forth between idiographic and nomothetic approaches. For principle reasons, we can only get close to those ideals. To express it by a paradox, the perfect type is the unique single case! We are and remain "idiographic nomotheticists."

To sum up, given that the aim of psychoanalytic therapy is a structural change—i.e., a change in the unconscious conditions—it is essential to make tentative diagnostic assumptions about the unconscious conditions of the patient's experiences and behavior. Microanalytic descriptions of the therapeutic process have to refer to these unconscious schemata. The hypothetical character of such correlations reaches a high degree of probability if changes brought about through the influence of the analyst are made evident beyond any reasonable doubt. It is most regrettable that, in clinical papers, the evidence for unconscious changes are very often missing. Boesky (2002) recently presented a piece of research entitled "Why don't our institutes teach the methodology of clinical psychoanalytic evidence?" At an interval of 10 years Boesky conducted a survey of

recognized American psychoanalytic institutes to discover whether the curriculum includes courses on the presentation of clinical evidence. In nearly all institutes, candidates are not trained to pay attention to evidence criteria in their case reports. So it is no wonder that throughout the psychoanalytical world—whether in vignettes, case histories, membership papers, or clinical discussions—criteria of evidence, implied in Freud's inseparable bond thesis are notoriously neglected. The disappearance of symptoms, alone, does not suffice. Diagnostic considerations are going on all the time with reference to the microanalytic descriptions of the intersubjective process. Therefore, we conceptualize the analytic process as a continuous focal therapy with changing psychodynamic topics and their working through.

The Ulm Process Model

We excerpt from the Ulm textbook some paragraphs (Thomä and Kächele, 1987, pp. 345ff):

> The development of the psychoanalytic technique has from its very beginnings been the object of two antagonistic tendencies, one toward methodological uniformity and the other toward syndrome-specific variation of the technique. On the subject of *therapeutic activity,* for example, Freud mentions technical modifications for phobias and compulsion neuroses: "another quite different kind of activity is necessitated by the gradually growing appreciation that the various forms of disease treated by us cannot all be dealt with by the same technique" (1919a, p. 165). In the general and specific theories of neurosis, hypotheses of the genesis of psychiatric and psychosomatic illnesses have been developed which are empirically more or less well founded. By making diagnoses and prognoses we apply our imprecise knowledge of what would have to happen in the psychoanalysis of anxiety neurosis, anorexia nervosa, or depressive reaction, to name just a few examples, in order to achieve an improvement in the symptoms or a cure.
>
> A serviceable process model must therefore combine flexibility in approaching the individual patient with regularity structured around the therapeutic task. In trying to do justice to this requirement, we base our process model on the following set of axioms:

1. The patient's free association does not lead by itself to the discovery of the unconscious portions of conflicts.
2. The psychoanalyst makes a selection according to his tactical (immediate) and strategic (long-term) goals.
3. Psychoanalytic theories serve to generate hypotheses, which must constantly be tested by trial and error.
4. The utility of therapeutic instruments can be judged by whether the desired change is achieved, if the change fails to occur, the treatment must be varied.
5. Myths of uniformity in psychoanalysis and psychotherapy lead to self-deceptions.

This list clearly outlines our conception of psychoanalytic therapy as a process of treatment regulated according to strategic considerations. This point of view is definitely unusual inasmuch as our call for *evenly suspended attention* on the one hand and for *free association* on the other seems to express just the opposite of a plan of treatment. In order not to create an objectively unnecessary contradiction it is advisable to refer to Freud's justification for his recommendation on evenly suspended attention: it is an excellent means for correcting theoretical prejudices and for more easily discovering the origin (focus) of complementary functions: the functional state of gaining a maximal amount of information (the evenly suspended attention) and the organization of this information according to the most significant points of view (the focusing) alternate at the forefront of the analyst's mind.

We have now introduced a central concept of the Ulm process model: the focus.

After reviewing the literature on the focus concept we arrived at the following summary: We consider the interactionally formed focus to be the axis of the analytic process, and thus conceptualize psychoanalytic therapy as an *ongoing, temporally unlimited focal therapy with a changing focus* [Thomae and Kaechele, 1987, p. 347, emphasis in original].

It is essential to take very serious the notion that a focus is used as a hypothesis and not as a rigid prescription. It is our conviction that all analysts unknowingly and intuitively direct their interpretations toward

unconscious dispositions, therefore the idea of an aimless nontendentious analysis is a self-deception. This fact has only recently been acknowledged by Sandler and Dreher (1996). Patients begin a treatment with conscious and unconscious aims. Analysts also have aims even when they practice a mystical emptying of the mind (Bion, 1967; Bion, 1988).

Against the aimlessness of just analyzing, Sandler and Dreher (1996) emphasize that: "those who believe that the aim of the psychoanalytic method be nothing more than to analyse do deceive themselves... all analysts are influenced during the session knowingly or unknowingly by therapeutic aims" (p. 1). The reproach that they deceive themselves and their patients would be invalid only if it could be demonstrated that just analyzing"is the optimal way to reach the best possible aims. Such evidence is missing.

Analysts influence their patients even in the evenly-hovering attention. Conflicts inside the analyst can play a role only when choosing between different forms of intervention. We think that Freud's (1919) recommendation asks analysts to continuously free themselves from theoretical prejudices for the sake of their patients. Bion, however, has not only required mystical contemplation but also left pseudomathematical formulae that now influence the hermetic thinking of many analysts. No other analyst has moved back and forth between such extremes.

As becomes obvious from a panel on the goals of psychoanalysis that Bartlett (2002) reported on, the Kleinian school seems to be the only one that still sticks to the idea of non-directionality, paying only lip-service to Sandler's and Dreher's (1996) critique. Bott Spillius, for example, emphasizes that the conflict between a strict and pure psychoanalysis that follows the slogan of just analyzing cannot be eliminated. To get closer to Bion's ideal of no memory and no desire Bott Spillius (1996) recommends becoming aware of one's aims to be able to effectively ignore them. Most Kleinian analysts are said to be opposed to the conceptual discussion of goals because they think that the aim of analysis is just analyzing. The leading idea is, thus, that aims come about all by themselves, i.e., by strict analysis in the Kleinian sense.

Through our interventions, whether based on intuition or reason, we are knowingly or unknowingly causal agents with intentions. Upon reflection, it should be possible for us to recollect the intentional background of our interpretations.

In the reconstruction of case histories, one can dispense with the recounting of aims. For treatment reports, however, it is decisive which aims are followed by the patient and by the analyst and what interactional conditions facilitate change and which ones stand in the way.

Part II: The Case of Amalia[6]

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. My very idiosyncratic style of interpreting[7] makes some editing of the original text necessary. My involvement has the peculiar consequence that I am often seeking the most appropriate words and start sentences anew.

The tape recorder is, without a doubt, a neutral receiver that cannot miss something or be selective. I owe a debt of gratitude to Kubie (1958, pp. 233–234), who based his supervision (in 1955–1956) on tape recorded sessions at the Yale Psychiatric Institute, where I was a resident on a Fulbright stipend at that time.

Transcripts often seem paltry in comparison to the recollections that the analyst has of the session and that are revitalized when he reads the text. It is the rich cognitive and emotional context that adds vitality to the sentences expressed by the patient and the analyst. This context and the multifacetted background, which are revitalized when the treating analyst reads a transcript, can only be assumed by the reader who did not participate in the interview; it may be possible for the latter to fill in the gaps with the aid of his imagination and his own experience. 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

[6]In the second part, we change the style of our text. Helmut Thomä, as the treating analyst, speaks now in the first person singular.

[7]Among the many scholars who worked on those transcripts, Jimenez (2004) description of my personal style is to the point.

the use of generalizations, i.e., 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 to 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.

Sandler and Sandler (1984, p. 396) refer to the "major task for future researchers to discover why it is that the transcribed material of other analyst's sessions so often makes one feel that they are very bad analysts indeed." They qualify this by adding that "this reacting 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. My somehow ironic interpretation to this observation is the following one: Both of the Sandlers would belong to those bad analysts, if they had presented audio-taped dialogues without giving their thoughts and feelings as the flesh to the verbal skeleton. In other words, our oral report conveys some of the emotional climate of the analytic situation to the audience. Without an additional editing and an augmentation of the transcribed material by the treating analyst the pure 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. This simple technical tool was, and still is today, an object of controversy among psychoanalysts. The IPA is very reluctant to support experimentation with tape recordings, as the report by Freedman, Lasky, and Hurvich (2000) points out. All French analysts of Perron's group refuse this dogmatically.

As head of the department of psychotherapy at the Ulm University, and director of the newly-founded psychoanalytical institute under one roof with the university department, I started tape recording psychoanalytic treatments in 1968. As a clinician, I exposed myself to the critique of my coworkers and young candidates, and learned a great deal from their evaluation. I mention with some pride that, already in 1968 at a meeting of the German Psychoanalytic Association in Ulm, I presented in the presence of Paula Heimann a psychoanalytic investigation based on tape-recorded sessions. Twelve completely audio-taped analyses and analytic therapies of mine are now stored in the Ulm Text Bank as part of the section for informatic in psychotherapy (Prof. Dr. E. Mergenthaler, Prof. Dr. H. Kächele).

The introduction of research into the psychoanalytic situation is of immediate benefit to the patient because it enables the analyst to draw many stimuli from the scientific issues that are raised.

I add some warnings. 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. It is our experience that isolated microanalytic descriptions of reports about sessions—even if they are audio-taped and not annotated—do not lead to very fruitful discussions. Microanalytic descriptions of transference-counter-transference-processes must be referred to macro processes of prognosticated changes. It is remarkable that Isaacs' (1939) fundamental paper on "Criteria for Interpretation" seems to be almost completely forgotten. It contains not only criteria for interpretations. Isaacs stresses the importance of tentative predictions. Fifty years before Renik she made it quite clear that the therapeutic outcome is the "primary dependent variable when testing psychoanalytic hypothesis" (Renik, 1998, p. 495). We want to emphasize that the most essential aspects of the new form of describing the analytic process are the analyst's annotations to the interventions. Under Isaacs influence, Thomä (1967) and Thomä & Houben (1967) introduced this simple clinical technique more than 40 years ago. It is independent from the scientific advantage of tape recording.

The Need for Annotation

To enhance the understanding of the dialogue, it is essential to make comments about the background of given interpretations.

These "considerations" are subsequently added to the interpretations and the patient's responses when I was writing this report. It is obvious that I was led not only by the ideas described here when I arrived at my interpretations. However interpretations may be created, any interpretation actually made to the patient must be aligned along cognitive criteria, as demanded by Arlow (1979). My comments refer to the cognitively- and rationally-based end products—my interpretations—and neglect the intuitive, unconscious components in their development. Therefore, I rarely refer to my countertransference. I am an eclectic psychoanalyst and an intersubjectivist (cf. Pulver, 1993). With regard to the countertransference, I am as old-fashioned as Melanie Klein (cf. the anecdote mentioned previ-

ously). There might be typical interactional patterns of transference and countertransference, but I think it is the responsibility of the analyst to make the best for the patient of his emotional reactions.

The source of each of my analytic thoughts remains open. If we assume that the analyst's perceptive apparatus is steered by his theoretical knowledge, which may have become preconscious, then it is very difficult to trace the genesis of interpretations back to their beginnings. 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 my second thoughts. For all clinical and naturally controversial discussions, I recommend taking the background information as the starting point of our exchange. In other words, I hope that my considerations are coherent enough to be critically discussed. Such a coherence is important because it supports my hypotheses about the unconscious patterns of the patient.

Amalia's Symptomatology and Its History[8]

Amalia X (born 1939) was in analytic treatment (517 sessions) during the 1970s, with good results. Some years later, she returned to her former therapist for a short period of analytic psychotherapy because of problems with her lover, many years her junior. At a recent follow up (with a different analyst), it turned out that the final separation from this friend had caused unbearable difficulties and she asked for further help.

Amalia X came to psychoanalysis because the severe restrictions she felt on her self-esteem had made her vulnerable to depression in the last few years. Her entire life history since puberty and her social role as a woman had suffered from the severe strain resulting from her hirsutism. Although it had been possible for her to hide her stigma—the virile growth of hair all over her body—from others, the cosmetic aids she used had not raised her self-esteem or eliminated her extreme social insecurity (Goffman, 1974). Her feeling of being stigmatized and her neurotic symptoms, which had already been manifest before puberty, strengthened each other in a vicious circle; scruples from compulsion neurosis and different symptoms of anxiety neurosis impeded her personal relationships and,

[8]Amalia is the German speciman case investigated very thoroughly from many perspectives (Kächele, Schachter, and Thomä, 2008).

most important, kept the patient from forming closer heterosexual friendships.

The analyst offered to treat this woman, who was hard-working in her career, cultivated, single, and quite feminine despite her stigma, because he was relatively sure and confident that it would be possible to change the significations she attributed to her stigma. In general terms, he proceeded from the position that one's body is not one's only destiny and that the attitude that significant others and oneself have to the body can also be decisive. Freud's (1912) paraphrase of Napoleon's expression to the effect that our anatomy is our destiny must be modified as a consequence of psychoanalytic insights into the psychogenesis of sexual identity. Sexual role and core identity originate under the influence of psychosocial factors on the basis of one's somatic sex (see Lichtenstein, 1961; Stoller, 1968; Kubie 1974).

Clinical experience justified the following assumptions. A virile stigma strengthens penis envy and reactivates oedipal conflicts. If the patient's wish to be a man had materialized, her hermaphroditic body scheme would have become free of conflict. The question "Am I a man or a woman?" would then have been answered; her insecurity regarding her identity, which was continuously reinforced by her stigma, would have been eliminated; her self-image and physical reality would then have been in agreement. It was impossible for her to maintain her unconscious fantasy, however, in view of physical reality. A virile stigma does not make a man of a woman. Regressive solutions, such as reaching an inner security despite her masculine stigma by identifying herself with her mother, revitalized old mother–daughter conflicts and led to a variety of defensive processes. All of her affective and cognitive processes were marked by ambivalence, so that she had difficulty, for example, deciding between different colors when shopping because she linked them with masculine or feminine qualities.

General Treatment Report

When structuring the psychoanalytic situation and dealing with problems of the described type, the analyst must pay extra attention to not letting the asymmetry of the relationship excessively strengthen the patient's feeling of being different. This is important because the idea of being different—that is, the question of similarity and difference, of identity and non-

identity—forms the general framework within which unconscious problems appear. In this case, the analyst and patient succeeded relatively quickly in establishing a good working relationship, creating the preconditions for recognizing the internalization of earlier forms of interaction with primary reference persons—parents and teachers—during the development of the transference. The correction that was achieved can be seen in the changes in her self-esteem, in her increased security, and in the disappearance of her symptoms (see Neudert, Grünzig, & Thomä, 1987).

In retrospect, some 30 years later, I have the following after-thoughts about my personal understanding of the psychoanalytic method at the time. I think I was quite successful in establishing a helping alliance, which made it possible to make transference interpretations with regard to processes of displacement and condensation: the head as the symbol for understanding and communication and as a symbolic expression of the penis and the phallus in the sense of Lacan.

The two excerpts of treatment given 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 on the object, which is simultaneously 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 closeness and distance. This example clearly demonstrates the therapeutic effect that insight into the connections between the analyst's perceptions and thoughts can have.

We have selected this case because, in our opinion, it is suited to provide several lines of support to our 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 intellectual communication between the patient and the analyst about what was sought hidden inside the 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 rediscovery of displacement brought something to light that was new to the patient.

The patient suffered from severe feelings of guilt, which were actualized in her relationship to me. The Biblical law of an eye for an eye and a tooth for a tooth was reinforced in her experience because of her sexual desires. Her life historical role model for the contents of her transference

was a fantasized incestuous relationship with her brother. The increase in inner tension led the patient to reconsider the idea of dedicating her life to the church as a missionary or to contemplate committing suicide. (As a young girl she had wanted to become a nun and nurse, but given up this idea after a trial period because the pious confinement became too much for her. Leaving also helped her establish some distance to the strict Biblical commandments.) Now she wielded her old Bible against me 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 my interpretations, and she had the feeling that I 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 me and to live in me; she thought about giving me an old, lovely, and wonderful clock that would strike every hour for me (and for her).

What had she learned from measuring my head? In a similar situation, Amalia X had once said that for a long time she had thought that I was looking for confirmation of what was already there—in books, in my thoughts, in my head. She wished that something completely new would come out. She, herself, looked for interpretations and made an effort to understand my ideas.

Transcripts of Parts of Sessions 152 and 153

The patient mentioned her strict boss, who had unjustly criticized her and for whom she was no match. 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 me as a young man with a head symbolizing a phallus. Her momentary forgetting is a beautiful example of Luborsky's (1967–2001) de-

scription of small parapraxes as symptoms. 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 me a "superego function." This interpretation took the burden off her and gave her the courage to rebel (the patient had recognized long before that I was different and would not criticize her, but she was not sure and could not believe it because she still had considerable unconscious aggressions against old objects). I assumed that she had much more intense transference feelings and that both the patient and I could tolerate an increase in tension. I repeated her concern that I 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). I meant for this allusion to phallic symbolism to stimulate her unconscious desires. It was an overdose! The patient reacted by withdrawing. Assumption: 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 take 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 stepped, 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.

We continued on the topic of what I can take and whether I let myself 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. I 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. 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 I did not even understand "get inside" at first, mistaking it for "put inside." The patient corrected me 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.

I 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 rejection 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 we exchanged a few more thoughts, I gave an explanation, saying that there was something very concrete behind our 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"[9] for nothing.

P: That's just the reason I broke off this line of thought. [For about ten minutes the patient had switched to a completely different subject.]

[9]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 killed enemies.

After expressing her insight into her resistance to an intensification of transference, she again evaded the topic. She 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. I first mentioned the shrunken heads because I 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 me 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 my 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 my assumption as to

what the envy might refer to. In this case I 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 I 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 me to recognize another aspect of this fight. It was also an expression of how important it was to me that she remain 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, I had attempted to relieve her intense feelings of guilt with regard to her destructiveness. I picked up the idea once again that her thoughts about my 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 my 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.

My 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 me, to have a bench in my head. Very peacefully she mentioned that I could say, when looking back on my life when I die, that I had had a lovely, quiet, and peaceful place to work. (My 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 motherhouse 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 my head and measuring it and to the fact that it had disturbed her that I 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 my security and my dogmatism, and it was clear that the patient had taken a comment I had once completely undogmatically made about Freud and Jung (I have forgotten what it was) 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 my 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.

The claim of this presentation 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 represents a transference object. At the same time the patient uses the analyst's thoughts 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; Gabbard and Westen, 2003). From a microanalytic point of view the verbatim protocol contains details, which might get lost by a molar abstraction of the session.

An alternative conceptualization, based on the Weiss–Sampson plan analysis of the patient's material pointed to traumatizing experiences early upbringing. The analyst, although knowing about these early experiences gave less weight to them 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 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 patient's wish to reside peacefully in the analyst's head not only signified 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 in smaller or more extended form linked up to our concept of focal conflicts points to a crucial issue: without such signposts marking working models the analyst easily gets lost in almost infinite microscopic states of mind.

The head is the location of the individual mind and in so far the organ of individual perspective on transferences and countertransferences. At the same time, the head can be used by mechanisms of displacements to differentiate various aspects of the intersubjective processes in the psychoana-

lytic situation. These sessions are good examples for displacements within the body image and a demonstration of beneficial therapeutic action in the psychoanalytic encounter. This is proven by more than thirty years of follow-ups (Kächele, Schachter, and Thomä 2008).

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