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The treating analyst as promoter, participant observer and object of empirical research - *a personal view*

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Preface

Only a very few parts of this paper were read at the George Klein Research Forum devoted to the topic „Amalia X. A German specimen case of a psychoanalytic therapy„. Amalia X is the pseudonym of one of the well studied, audiotaped psychoanalyses which provided the basis of the volume 2 of our textbook on psychoanalysis (Thomä and Kächele, 1988, first English edition, 1992, paperback by Aronson, 1994) The various process and outcome studies done on this analysis fulfill, I hope, the characteristics of a „Specimen Case„. At any rate we, H. Kächele, E. Mergenthaler and myself, present our attempts to solve problems of empirical research in psychoanalysis by centering upon Amalia‘s psychoanalysis, as it is documented in transcripts and clinical summaries.

This foreword is intended to inform the reader in on two points which will facilitate his/her orientation. On the last page of this paper the program of the George Klein Forum 1997, set up by its coordinator, Hartvig Dahl, is reprinted. It is an informative introduction and an initial reading is highly recommended before proceeding since I use this occasion to describe how and why I have become (all too slowly) a research-minded psychoanalyst, - as I call the critical attitude I eventually achieved. Thus the larger context of this paper is my

professional life with its detours, ups and downs. For this reason I am choosing the subtitle „a personal view„.
My attempts to promote process- and outcome studies, as we would say today, are parts of a intensive struggle with widespread psychoanalytic attitudes not congenial to research, to say the least. I somehow misused this occasion to refer again to some of the problems which have negative consequences for the future of psychoanalysis, such as the one sided training; but these points are now put into an Appendix referred to in the main body of the paper.

Being the treating analyst, I felt a strong obligation to integrate the empirical findings presented by Horst Kächele and Erhard Mergenthaler. In fact the therapeutic cycle described by Mergenthaler refers to session 152 which I regarded as an example of „the patient‘s identification with the function of the analyst„. It is obvious that such an integration is a difficult task ahead of us, so the detailed clinical data are put into the Appendix in order to make the reading of the main body of the paper easier.

The investigation of the therapeutic process both by analytic colleagues and by researchers from other disciplines open new avenues. Unavoidably, they lead in all kinds of directions and move away from clinical problems, although they start with clinical questions: in our case, queations about Amalia‘s analysis. What then is the relevance of linguistic, content-analytic and other findings for the theory and practice of psychoanalysis? Which of the many studies based on the therapeutic dialogue with Amalia had the greatest influence on myself? For the time being I prefer to give a general answer, although the distance of the various papers to their clinical relevance certainly varies greatly. It is the research culture as such created by interdisciplinary exchange, which had the greatest impact on myself as the treating analyst.

As promoter, participant-observer and research-object of the Ulm process and outcome studies, I shall try to put them into the context of contemporary psychoanalysis.

Being primarily a devoted clinician, I will describe here my slow conversion to research-minded analyst. As indicate, the chronological order is left when I deal with problems of modern psychoanalysis without discussing their relation to my professional curriculum the following topics:

_ The Beginning
_ A new model of reporting (1963)

- How theory shapes technique - common ground-pluralism

_ Unconscious schemata (CCRT-FRAMES)
_ From the „case history„ to the „treatment report„
_ Amalia and the Here and Now
_ An example of therapy research
_ The treating analyst - promoter and objekt of research ---
Interdisciplinary studies
- obstructing educational structures

The Beginning

At Mitscherlich‘s Psychosomatic Hospital of Heidelberg University psychoanalysis found an academic place for the first time in the history of German universities (1950). It was a very complicated birth, even the name itself being a compromise. The philosopher and former psychiatrist Jaspers campaigned against psychoanalysis; and the chairman of the psychiatric Department, Kurt Schneider, claimed that psychotherapy belonged to his kingdom. Eventually the Faculty could not refuse a donation from the Rockefeller Foundation, and the university gave Mitscherlich‘s Psychosomatic Hospital a strucure independent of psychiatry.

While investigating cases of Anorexia nervosa in the fifties, I was impressed by the discoveries made possible by the psychoanalytic method. Psychoanalysis had become broadly unknown during the twelve years of Nazi regime.

Today it is unbelievable that, at that time, anorexia nervosa was diagnosed in German medicine as a psychotic syndrome of unknown origin or as an endocrinological disease . Thus it was easy for me to demonstrate the unique value of the psychoanalytic method (Thomä, 1961, 1967).

The syndrome was known to Freud but had not been thoroughly studied later on, and was wrongly explained as a defense against oral impregnation phantasies. My contributions in the late fifties and early sixties imply that even a poorly trained analyst - by IPA standards - might be capable of making new findings under favorable conditions. All members of the first postwar generation of German analysts were insufficiently trained. Obviously a „New Beginning„ under a helpful tutorage is even possible in countries where psychoanalysis had disappeared for some or many years under totalitarian regimes (Germany, UDSSR). I hope that the IPA realizes the present chances in the East as well as certain prominent analysts did in West-Germany after the second world war.
By a combination of chance and (personal) determination, my tenure opened a career at German universities as I was the first Privatdozent for psychosomatic medicine and psychoanalysis. From early on I was method-conscious. So far so good, but where is the research-promoter? Not born yet, - although his position as a university teacher obliged him to carry oout research. Being a clinician, I was more and more dissatisfied with the usual case- reports as being attempts at etiological reconstructions instead of research into the processes and outcomes of therapy. I did not know better in the fifties. In retrospect, I can even feel some pride about my published case reports on Anorexia nervosa (1961, 1967, 1977), peptic ulcer (1954), and transsexualism (1957/58).

Mitscherlich introduced a model in order to make systematic studies possible. This model was of great didactic value, because it facilitated a comparison of cases during the phase in which Franz Alexander‘s „specificity hypothesis“ was dominant in psychosomatic medicine. Attempts at reconstruction were in the center of my clinical interest. Accordingly, I described the course of an analysis mainly by reference to

the assumed psychogenic roots of the psycho-pathology (Thomä, 1978). The „specificity hypothesis“ had to be given up, as the title of a paper written retrospectively, about the non-specificity of psychosomatic diseases indicates (Thomä, 1989, s. Thomä and Kächele vol.2)

In the analytic situation, I took the basic rules for granted and oriented myself by collecting psychogenic connections, which I memorized and wrote down afterwards as the patient‘s narrative. Most case-histories were (and still are) narratives of that kind, although today short stories called 'vignettes' predominate; Webster defines this genre as compositions "characterized by compactness, subtlety, and delicacy". Even if they reach Webster‘s qualification, the scientific value of psychoanalytic short stories is very limited.

A new model for reporting the psychoanalytic dialogue (1963)

A postgraduate year (1962) in London, made possible by a stipend of the Foundations‘ Fund for Research in Psychiatry, brought about a new direction. Balint‘s emphasis on the contribution of the analyst to the process of change fascinated me. In order to study this interaction I later on introduced a schema in Heidelberg, which facilitates the evaluation of interactions reported by other analysts. The very ambitious aim of validating hypotheses by reference to the effectiveness of interpretations was, of course, beyond the reach of that somehow naive and pretentious project. Nevertheless it was a beginning toward treatment-reports and from then on, I have been volunteering myself as an object of research.

We attempted - by examining interpretations - to identify the important aspects of an analyst‘s technique and its theoretical foundation, and - by studying patients' reactions - to estimate its therapeutic effectiveness.

In order to study interpretations systematically , we (Thomä and Houben 1967, Thomä 1967) followed a recommendation made by Isaacs (1939) and designed a report scheme. It required the psychoanalyst who was preparing the protocol to locate interpretations between observation and theory and to describe the patient‘s reactions. Sessions were described according to the following points:

1. Associations, forms of behavior, and the patient‘s dreams that led the analyst to focus on a specific topic in one period for working through (psychodynamic hypotheses)
2. The analyst‘s thoughts, based on the theory of neuroses and his technique, that preceded individual interpretations
3. The goal of the interpretation
4. The formulation of the interpretation
5. The patient‘s immediate reaction
6. All the rest of the analyst‘s interpretations and the patient‘s reactions (associations, forms of behavior, dreams, changes in mood and affective state, etc.) that appear to be relevant for the topic to be worked through
7. Was the goal achieved?
8. Reference to material that does not match with the hypotheses

Under point (2), you probably miss „countertransference„. We were not concerned with the question of „how the mind of the analyst works„ (Ramzy 1974, Meyer 1988) at that time, but with its product. Today it is a widespread and fashionable trend, originally Kleinian, to describe the countertransference as if this would be the key to the core of everything psychoanalytic. Now treatment reports contain often intimate admissions about countertransferences as if they had without further ado diagnostic and therapeutic value. A far cry from scientific standards! (see Appendix III)

One of the cases studied was a young married woman suffering from a hysterical body-image disturbance (suffocation). A deep-seated birth anxiety about going - partition meaning death - brought about strict contraception and all kind of conscions control leading to fridigity.

Any investigation of the process of change on the homeground (Mutterboden) of psychoanalysis, makes it necessary that the clinician clarifies theoretical assumptions underlying his/her thinking and doing. In the case mentioned (Beatrice), the theory of conversion (or certain

parts of it) were at stake and were duly operationalized (Thomä 1967, Thomä and Kächele 1992).

From my earliest experiences onward, I remained convinced that it is necessary to clarify the general theoretical assumptions which have a bearing on an individual case. This conviction has several consequences. The clinician is obliged to work through again and again all relevant aspects of his personal psychoanalytic theory and practice, and to compare them with other psychoanalytic points of view. Beatrice's analysis confronted me with all manner of unsolved problems in the theory of conversion. A short example (Appendix I) refers to one of these aspects of the theory.

The Heidelberg reporting scheme, introduced 1963, is still a suitable means for providing important information for clinical discussion, as Pulver (1987) demonstrated much later. It is enormously productive for the analyst to prepare protocols of his feelings - partly countertransferences -, thoughts, and interventions in a way that enables a third party to develop alternative perspectives.

How therapy shapes technique

Pulver's study aimed at a comparison of different psychoanalytic techniques. It implied problems of "common ground" versus "pluralism" as they are manifest since the Montreal congress of the IPA (1987). Therefore I put Pulver's investigation into historical context.

The relationship beetween techniques and underlying theories is a very old problem. Sixty years ago Ferenczi and Rank (1924) attempted to clarify "the relationship between analytic technique and analytic theory" and to investigate "the extent to which the technique has influenced theory and the extent to which each currently assists or obstructs the other" - Freud's prize question (1922d, pp. 267-270).

At first a few words about Pulver's study. 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 the patient‘s reactions in three sessions. This clinical material was examined by ten analysts who are prominent representatives of various psychoanalytic schools.

As might be expected Pulver's comparison demonstrates vast differences between the clinical evaluation due to the theoretical orientation of the analysts. Indeed this study and a similar one by S. and E. Fine (1990,1991) undermine the belief that there is a "common ground" in contemporary clinical psychoanalysis. In view of the "pluralism" if not chaotic subjectivism the role of research to clarify the nature of the differences and their consequence for process and outcome cannot be overstimated.

Pulver enthusiastically welcomed the frankness of the reporting analyst. It is remarkable, in fact, that analysts still deserve our special praise when they attempt to record precisely in a protocol - prepared during or after the session - what the patient said and what they themselves felt, thought, or said; and when they do this being fully aware that their protocol will form the basis for a discussion with colleagues from other psychoanalytic schools. The fact that such praise is appropriate even today shows that attempt at 'objective' research, and even the idea of 'peer rewiev' , are still regarded as dangerous in our discipline.

Shane (1987) and Pulver (1987) summarized the results of the discussion, in which each of the analysts naturally started from his own personal point of view. Silverman, the treating analyst, is known as an adherent of structural theory.

After an evaluation of the material by Brenner (structural theory), Burland (Mahler's school), Goldberg (self psychology), and Mason (Kleinian perspective), Shane concluded in resignation:

"First, we cannot help observing that each panelist found in the patient important diagnostic features best explained by his particular frame of

reference... In summary, I would say that the diversity of opinions regarding the diagnosis and dynamics of Silverman's patient would suggest that one's theoretical stance takes precedence over other considerations. The presentations amply demonstrate that each theory can sound highly convincing, which makes absolute judgement almost impossible and personal choice inevitable." (Shane 1987,pp. 199, 205)

Schwaber (1987, p.262) also showed convincingly that the models employed by the participants in this discussion frequently habe a distorting effect even on the gathering of data. For this reason she argues that theoretical models should be used in a more appropriate manner. These critical insights into an on-going treatment illuminate the numerous problems that the participation of third parties, whether they be specialists, scientists from other disciplines, or lay people, can make apparent.

A.E.Meyer called this study the "Pulver-test". It is a kind of a projective test like the Rorschach or the TAT: all participants receive the same but multifarious information which makes many interpretations possible. In Pulver's study, Silverman's protocols were offered to schoolbound analysts to be interpreted from their points of view. This instruction maximizes of course divergencies and it minimizes possible arguments or "consensual validation", (s. Thomä et. al. 1976). Still the divergencies between the experts from different psychoanalytic orientations and their intervention strategies are high, even contradictory. It is especially irritatig that each evaluation -modestly or openly expressed- claims that his, her vision be the true and the more sucessful one. 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 to each other today. The pressure from outside furthers the reconciliation amongst the various psychoanalytic groups. Pulver's reconciliatory reaction to the seroius divergencies is typical. He said that the differences of opinion between the participants in the discussion are more apparent than real:

"The therapists may be saying essentially the same thing to the patient, but in different words. The patients, once they get used to the therapist's words, in fact *do feel understood*. For instance, this patient might feel that her ineffable feeling of defectiveness was inderstood 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 assumed that this patient could have had insights that could have been expressed in different sets of terminology,yet that the latter would simply represent metaphoric variations of the same processes. 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. Every individual does in fact recall many experiences in response to the word "loss" that may be interrelated but that belong to separate subgroups.

The desire to find harmony in the contemporary psychoanalytic tower of Bable stimulated the "search for common ground" at the congress of the IPA in Rome (1989). In his role as president of the IPA Wallerstein underestimated - perhaps on account of diplomatic reasons - the influence of different and even contradictory theories on the observation of clinical phenomena and school-bound or eclectic techniques.

Wallerstein's (1990, 1991a) great attempt to reach agreement und unity among the schools, at least on the level of observations was unable do bridge over or harmonize fundamental antithesis. Although he sought a common ground in the observational data of the analytic interaction, the cited examples and quotations from the works of S. und E. Fine (1990, 1991) as well as Arlow and Brenner (1988) give voice to quite a contrary opinion: observational data are colored from the outset according to the metaphors and theories in each case, and such terms as "transference", "countertransference", "resistance", and the like have differing meanings in the various psychoanalytic schools (Richard, 1991). Schafer (1990) seems to have met at that congress in Rome the Zeitgeist of psycho-

analytic pluralism. It goes without saying that this pluralism does not remove the obligation to undertake comparative therapy research among the schools and orientations.

Schafers appeal to tolerance and to pluralism as the ferment of creativity was greeted with cheers in Rome. Indeed it is the result of a simple reality testing to accept that there are "many analyses" today (Wallerstein 19...). The question is whether more tolerance for different opinions is a virtue in itself and an indication for the creative vitality in the psychoanalytic movement. Unfortunately the contrary seems to be true: fundamental differences in the theory and practice are smoothed over by the harmonizing idea that on a methaphoric level we all do the same. Indeed it is very likely that successfull therapists have much in common. Commonalities are beautifully expressed by metaphores. To by well"contained", to have an analyst who functions as a "container" and "digests" or "metabolizes" bad unconscious elements, of course is the desire of every human being. "Containment" - as the most recent all-embracing and fashionable metaphor - for instance is disconnected from Bion's theory and used as a denominator for the holding and helpful function of an therapist. Whether the theory behind the metaphor is valid at all belongs to another level of discourse. Fortunately good therapy is possible even with poor or wrong theories! I myself remember very well that with some cases I was a successful therapist at the beginning of my career when my psychoanalytic knowledge was very limited.

Unconscious schemata

In retrospect, the Heidelberg studies were very rewarding. Interpretations are our mediators. They have a microdiagnostic function, and connect our ideas with the assumed affective and cognitive schemata of the patient. It is as a function of unconscious clichés that human beings contruct their world. For all practical and scientific reasons it is sufficient to arrive at a reliable diagnosis of the central schemata, operationalized for instance as Core Conflictual Relationship Themes (CCRT, Luborsky), Unconscious Plans (Weiss and Sampson), FRAMES (Acronym for Fundamental Repetitive And Maladaptive Emotional

Structures, Dahl) or person schema (Horowitz, 1993). I regard myself as a research-minded clinician when a cliché is at first diagnosed, then operationalized in terms of 'if - then' clauses, whose interruption leads eventually toward change. Even Grünbaum accepts the ensuing change as probative for the hypothetical causal assumption (s. Thomä and Kächele 1985). Where the disposition, the unconscious reaction-basis of a patient comes from, raises further causal questions and possibly even leads to neurophysiological answers.

The foundation of psychoanalytic therapy lies in the reliable diagnosis of unconscious schemata and their effects on the patient's experience. Those diagnostic assumptions have a somehow hypothetical character. The supposed correlations reach a high degree of probability, even validity if changes brought about by the influence of the analyst are made evident beyond any reasonable doubt. The disappearence of symptoms alone does not suffice. They are dependent on the diagnosed disposition (unconscious schema). Therefore we speak of structural changes as the aim of psychoanalytic therapy. As in correlation, the cause-effect relation may alternate or may go on in a self-perpetuating circle: symptoms in turn may corroborate an underlying disposition. Panic attacks, for instance, bring not only a trait anxiety to the fore but make it worse. Self-perpetuating circles allow for an interruption at various points of a circular process. Still it has nodal points, and it is possible to diagnose linear stretches and causal chains. How and where to interrupt them, possibly and hopefully for good, is of course therapeutically the most important question; a question which refers to the problem of symptom substitution, which we have discussed thourougly elsewhere (Thomä, Kächele, vol. 2, p. 420 ff.).

The concept of disposition and dispositional explanation diserves further discussion.
Statements such as "the glass breaks because it has quality X" are dispositional explanations. Because the dispositional quality of an object or individual has consequences in the nature of a law, Ryle (1965) classifies such explanations as "lawlike" statements. Dispositional explanations concern that "category of cases in which the activity of the

acting persons should be explained with the help of character traits, convictions, goal projections, and other dispositional factors" (Stegmüller, 1969, p.120).

The patient brings to treatment certain modes of behavior and certain qualities based on unconscious conflict constellations, which we explain by dispositions. Since the patient unconsciously seeks a repetition of his infantile traumata, he constructs the transference situation in an analogous manner. The formation of the transference can be interpreted as the transposition of such dispositions in object relationships that are experiences anew. The overcoming of the transference neurosis will then lead to the dissolution of the unconscious conflicts that previously determined his behaviour,and, with it, of the disposition of those conflicts as a lawful way of reacting.
The German philosopher of science, W. Stegmüller, (1969) states clearly: "If we deal with the eliminaion 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 that phenomenon" (p. 435, my translation) . In medical research, Stegmüller continues, 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. Freud's conception follows this scientific ideal of a causal therapy. His famous "inseparable bondage" (Junktim) of the coincidence of treatment and research fits Grünbaum's and Stegmüller's scientific requirements as well as the theraputic expectations of the patient - a wonderful unity, if the coincidence is proven. The psychoanalytic method were epistemo-logically valid by discovering causal connections and theraputically effective by demonstrating that the change of the causal dependence of symptoms of the diagnosed unconscious disposition (schema) must eventuate in their dissolution. Of course it must be made evident that the dissolution is brought about by psychoanalytic means and not by chance. Suggestions are psychoanalytic means. They are, of course, primarily contaminated. Grünbaum's contamination - argument against the explanatory value of the psychoanalytic method is based on a classical physicist's misapprehension of human sciences. It is the task of the

analyst to make helpful suggestions in order to support the patients capacities to overcome inner conflicts. To reflect upon the given suggestions is part and parcel of the method! The dissolution of causal connection has a probative quality for Grünbaum as he made clear in a commentary to an inexact argumentation in our methodological paper (Thomä u. Kächele, 1975).

The empirical question remains: who is capable of solving the clinical problems connected with the Junktim-thesis and which scientific methods are appropiate to study processes of change. A "naive" misunderstanding (Shakow, ...) of research originated in Freud's thesis. Freud himself expressed doubts about the viability of the Junktim. In fact a thorough reading of relevant passages (1912b, p.106; 1916/17 p.356; 1927a, p 254) makes it obvious that Freud separated research from therapy. Contrary to the Junktim-thesis runs his other saying that therapy destroys the science (Freud 1927a, p. 254, C. Holzman, 1985). Plagued by the problem of suggestion, Freud aimed at a pure "uncontaminated" method - like the learned physicist Grünbaum. Yet if proof of the causal relationship requires that the data be independent of suggestion by the therapist, then therapy destroys the science. If the analyst, on the other hand, believes that it is possible to refrain from making any suggestion whatsoever, in order to obtain uncontaminated data by means of pure interpretations, then he ruins the theapy without coming closer to a causal explanation if *independence* from the observer is required.

It is obvious that the analyst offering interpretations influences the patient even if he apparently only directs his interpretations to the unconscious and without any further-reaching aims, which is a self-deception as it is impossible. Instead of eliminating manipulations it opens the door to hidden manipulations. This dilemma is the consequence of Freud's scientific position. It severely hampered the development of therapy research until recently. It is ironical that the ideal of purity and the search for uncontaminated data destroyed research on the homeground of psychoanalysis. Now systematic investigations are based upon the question how the psychoanalytic method influences the patient (and vice versa). To objectify the intersubjective processes makes

it necessary to reflect upon various kinds of suggestions and "contaminations". Stengers (1995, p. 106) speaks of a *purity myth* as Freud's scientific idea. 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 the sense of doing physics, in the classical sense of the word. This wish of Freud's,still present today, is a symptom I want to challenge." (Strenger, 1995, p. 106)

I arrive at a very surprising conclusion: Both Freud's and Grünbaum's attempts at purification destroy therapy as well as the appropriate research in psychoanalysis. The difference between the founder of psychoanalysis and one of its sharpest contemporary critics is that Freud ambigously believed in a "scientific" method applied in therapy whereas Grünbaum rejected this opinion. The therapeutic application of the psychoanalytic method cannot follow the scientific paradigm of classical physics. To give up Freud's ideal invalidates the foundation of Grünbaum's critique and fulfills Freud's copernicanian revolution by introducing the analyst as "participant observer" (Sullivan). The treating analyst is even a privileges position to make unique experiences and observations with regard to change processes. At the same time this singularity is beset with all the problems of subjectivity. Furthermore for all kind of practical reasons the participant observer is overburdened by the task to initiate change processes and at the same time to investigate them. Therapy research in psychoanalysis is a most complex endeavour far beyond the capacity of the treating clinician working in isolation. Only a well trained team can do the job implied in Freud's junktim, i.e. test the discoveries made single-handed in the analytic situation.

In order to qualify the conditions for cure (i.e. change) it is necessary that the treating analyst documents the interaction by writing treatment

reports. Furthermore analysts and scholars from other fields have to study at least the verbal exchange between patient and analyst by reading transcripts of audiotaped session.

From the „case history„ to the „treatment report„
(s. Vol. 2, ch 1.2; 1.3)

While working on the Heidelberg project during the mid-sixties, it became clear to me that the question of validation can only be answered within the complex field of process and outcome research. This was far beyond our possibilities at that time. If anything has changed the possibilities, it is the fact that some courageous analysts have tape-recorded some therapies and subjected them to systematic research studies by others.

After becoming chairman of the Department of Psychotherapy and after the etablishment of a small psychoanalytic institute in Ulm in 1967, I initiated tape-recording of psychoanalytic therapies. Eleven of my psychoanalytic therapies have been audiorecorded and some of them have been partially transcribed, amongst them Amalia. It took years before we learned to appreciate sufficiently the enormously profitable effects of listening to dialogues and reading verbatim transcripts of our own clinical work; sufficiently, that is, for us to overcome all of our earlier reservations.

I extract from my own experience some features which, I think, are typical for a group of research-minded analysts who have the following in common: They do not believe that the treating analyst is per se a researcher. Shakow (1960) referred to this predominant conviction, derived from Freud‘s assertion of an „inseparable bond between treatment and research„(„Junktim„in the German original, Freud 1927a), as a naive misunderstanding of the „research process„. The treating analyst's personal theories, their „truth„ and their application („efficacy„) must be studied by independent judges.

For Stoller the claim that the psychoanalytic method is scientific was open to question as long as one essential element is missing that can be found in other disciplines acknowledged to be sciences:
„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 process of confirmation in analysis is ramshackle ... I worry that we cannot be taken seriously if we do not reveal ourselves more clearly„. (Stoller 1979, 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 expressions not openly and verbally communicated. The treating analyst is for many studies - e. g. about countertransference - a most essential part.

Stoller seems to refer here to the problem of the different contexts of discovery and justification, a distinction introduced by Reichenbach (1938) and emphasized by Popper. We have, no doubt, an almost unbearable overload of hypotheses in Psychoanalysis. This abundance is inherited. The testing of numerous hypotheses could
keep many generations busy. Who wants to do the hard and dry work "from discovery to validation" and meet "a basic challenge to psychoanalysis"(Kaplan 1981). To create new ideas is much more pleasurable than to „test„ the theories invented by others, usually by members of former generations! For various reasons, I am one of those research-minded clinicians not equipped to do such sytematic hypothis testing himself: I depended all through my career on well trained co-workers.

Although it is my personal view, I rely upon a kind of consensual validation about the need to find new ways of investigating and describing analytic therapies. Psychoanalysts do not arrive at a consensus very easily, and representatives of different schools rarely agree about relevant matters. Therefore it is highly significant if you find a „common

ground„ between prominent analysts of different persuasion. I offer six witnesses who testify that the psychoanalytic dialogue needs another kind of documentation than the old-fashioned case-histories or modish vignettes. My witnesses are in alphabetical order: Arlow (1982), Eagle (1988), Edelson (1988), Eissler (1963), Meyer (1992), Thomä (1996) Spence (1986),. Two quotations from Spence‘s work must suffice here: „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 make a clean break with what I call the Sherlock Homes tradion, 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)

„We shall begin to see for the first time how the narrative account has blinded everyone to the inherent randomness of the data and to the weakness in our explanatory theory. Seen in this light, the narrative approach becomes a serious obstacle to both the understanding and the preservation of our clinical wisdom, and we should hasten to put it behind us - the sooner the better„. (Spence, 1986, p 21).
I arrived at the same postion primarily on clinical grounds. Much later did I realize that research in psychoanalysis as a therapy depends on a fundamental change in methods of data-collection and documentation. Or rather: If psychoanalysts try to understand and evaluate the process of change, they must give account for all clinical data. The phenomena that occur in analytic treatment can, as Eagle (1988) has convincingly demonstrated, make a special contribution „to a theory of therapy, that is,

an understanding of the relationship between certain kinds of operations and interventions and the occurrence of failure of occurrence of certain kinds of specific changes. It seems to me 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“ (Eagle 1988, p. 163).

Freud‘s case histories are reconstructions that proceed from the combination of an individual‘s present situation and an attempt to find the roots of his symptoms and the determinants of their particular type, in the individual‘s past. With regard to the symptoms of psychic and psychosomatic illnesses, time does appear to stand still: the past is present. The phobic is just as afraid of a completely harmless object today as he was 10 or 20 years ago, and compulsive thoughts and actions are repeated ritually in the same way for years.

Neurotic symptoms are so embedded in the patient‘s life history that knowledge of it is essential for comprehending the specific pathogenesis. „Case histories of this kind are intended to be judged like psychiatric ones; they have, however, one advantage over the latter, namely an intimate connection between the story of the patient‘s sufferings and the smptoms of his illness„ (Freud 1895d, p. 161).

In order to evaluate therapeutic change detailed treatment reports have to made accessible to the professional community. The tradition so far is centered upon the publication of case histories. Freud‘s main objective had been to reconstruct the genesis of psychopathological disturbances; the move from the writing of case histories to the study of treatment reports in great detail indicates a new era in psychoanalytic research. The following quotations are taken from the Ulm textbook (vol.2).

„The special tension contained in Freud‘s case histories results, from the fact that all the descriptions in them have the goal of making the background of the patients‘ thoughts and actions plausible in order to be able to present explanatory outlines of their history". (p. 13)

"Since the primary purpose of Freud‘s case histories was to reconstruct the 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" (Thomä and Kächele, vol. 2, p. 14).

Freud distinguished between case histories, which he occasionally referred to as the histories of illnesses, and treatment histories. We have adopted his distinction, except that we prefer the designation 'treatment reports' because of the significance of the different forms of documention. Freud pointed out in an early publication the difficulties confronting suitable reporting:
„The difficulties are very considerable when the physician has to conduct six or eight psychotherapeutic treatments of the sort in a day, and cannot make notes during the actual session with the patient for fear of shaking the patient‘s confidence and of disturbing his own view of the material under observation. 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. 9-10, emphasis added).

„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 task 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*“ (Freud 1905e, pp. 12-13, emphasis added).

The criteria that must be applied in order 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 protocols 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, etiological research that is designed to provide evidence relevant to the hypotheses demands too much of the individual analyst. Following Grünbaum‘s (1984) criticism, Edelson (1986) drafted an ideal model according to which a case history and a treatment report would have to be written today in order to make it possible for hypotheses to be tested.

Greenson (1973, p. 15) has also criticized older textbooks, including those by Sharpe 1930), Fenichel (1941), Glover (1955), and Menninger and Holzman (1977), for hardly describing how the analyst actually works, or what he feels, thinks, and does.

Thus we are justified in joining Spillius (1983) in complaining - as she did in her critical survey of new developments in the Kleinian therapeutic technique - about the lack of availability of representative treatment reports prepared by leading analysts.

According to Freud (1937c, p. 250), „the business of analysis is to secure the best possible psychological conditions for the functions of the ego; with that it has discharged its task.„ If we relate this statement to the treatment situation and not only to the patient‘s ultimate ability to master the difficulties of everyday life without developing symptoms, then it is possible to formulate the following general thesis: Favorable conditions for the resolution of conflicts in the treatment situation are those that make it possible for the patient to transform the passive suffering from the original pathogenic traumas into independent action. This is a generalization of Freud‘s trauma theory; at its center is helplessness, at least since Freud‘s article „Inhibitions, Symptoms, and Anxiety„ (1926d). We agree with Freud (1926d, p. 167) that „the ego, which experienced the trauma passively, now repeats it actively in a weakened version, in the hope of being able itself to direct ist course, It is certain that children behave in this fashion towards every distressing impression

they receive, by reproducing it in their play. In thus changing from passivity to activity they attempt to master their experiences psychically.„ This thesis can be generalized even further: „Through this means of going from passivity to activity (man) seeks to master psychically his life‘s impressions„ (G. Klein 1976), pp. 256 ff.). Klein has shown convincingly that the neurotic and psychotic repetition compulsion described by Freud takes place for psychological reasons, both affective and cognitive. This exacerbates the patient‘s feeling of passive helplessness, which continuously makes it more difficult for him to overcome past conditions of anxiety. Such unconscious expectations have the function of filtering perception in the sense of a negative self-fulfilling prophecy, so that the patient either does not have positive experiences or brackets out pleasant experiences and empties them of meaning. Sacrifices, punishments, and hurt feelings in the distant past - in short, all traumatic experiences - are not only conserved in this way, but increase cumulatively in everyday life and even in therapy if the course is unfavorable.

Amalia and the Here and Now

Obviously our German specimen case is the outcome of a very long professional endeavour. As far as my attidude and technique is concerned, the patient given the pseudonym Amalia X in our Textbook was one of the first to profit from my new understanding of the transference interpreted from the perspective of „plausibility„ in the here and now. In fact Merton Gill supervised a session on the basis of a transcribed audiotaped session in 1976 when the PERT (Patient Experience of the Relationship to the Therapist) was in the making.

He convinced me easily that I had missed a transference interpretation about a day-residue of a dream. Amalia had picked up my idiosyncratic speech acts, which were far from being as clear, distinct and short as an interpretation should be! Quite often I look for the most fitting words, starting anew, changing sentences halfway etc. In Amalia‘s dream, a drunken man was stammering and expressed himself in a strange way. Nothing new for me so far: Because of overdetermination there are

always additional, complementary, alternative, contradictory interpretations possible.

As an anecdote, my experience with Merton Gill goes a long way toward illustrating a fundamental change in my understanding and handling of Freud‘s grand concept: transference. The controversy about „plausiblity„ versus „distortion„ of transferences ended, I think, in favor of the recognition that the patient‘s experience in the Here and Now are „plausible„, insofar as her/his perceptions are quite realistic. But what about the drunken man/analyst? For my part, I was never drunk as therapist. Amalia's dream-image is clearly a distortion due to unconscious schemata which Freud called transference-clichés. Do we therefore end up with the solution that both theses are valid and true? Indeed if we look at the intersubjective exchange, we need many points of view: The patient and the analyst have very many conscious and unconscious world-views. Some of them match, others are antagonistic to each other and some seem „distorted„. If we take all clinical wisdom together, research into the transferences could be very meaningful if it is clear what is measured. For instance: With regard to the findings of Piper et. al (1986, 1991) and Henry et. al. (1994), to the effect that transference interpretations in brief psychodynamic therapies are negatively correlated with outcome, I would ask first: How was what concept of transference applied and evaluated in those studies? (s. Mertens, 1997). Malan (1976) would claim to have shown the opposite!

An example of therapy research

I turn now to a brief clinical report about an essential topic in therapy research, namely the "Identification with the Analyst‘s Functions". It marks the subjectivity of the exchange on the basis of tentatviely diagnosed underlying unconscious schemata and processes.

Freud‘s demand that „the patient should be educated to liberate and fulfil his own nature, not to resemble ourselves„ (1919a, p. 165) seems to contradict the large, decisive therapeutic significance of the patient‘s identification with the analyst. At a symposium on the termination of

analyses, Hoffer (1950) declared the patient‘s capacity to identify with the psychoanalyst‘s functions to be the essential component of the therapeutic process and its success. This topic is thus of fundamental importance for an understanding of the therapeutic process, and for the tension between the poles characterized in the following quotations:
„We serve the patient in various functions, as an authority and as substitute for his parents, as a teacher and educator ... . However much that analyst may be tempted to become a teacher, model and ideal for other people and to create man in his own image, he should not forget that is not his task in the analytic relationship, and indeed that he will be disloyal to his task if he allows himself to be led on by his inclincations (Freud 1940a, pp. 175, 181).

Yet this raises a number of questions. What does the patient identify with? What are the consequences of the psychoanalytic theory of identification for the optimization of therapy in the sense of facilitating the patient‘s experiencing, to distinguish the functions from the person embodying them?

Altough transference-based neurotic repetition - itself strongly dependent on the situational conditions created by the psychoanalyst - determines the form and content of observable phenomena, the identification with the psychoanalyst‘s functions provides insight into previously unknown, unconscious connections and new experiences. Sterba (1940, originally published in 1929) emphasized the therapeutic significance of identification in an early article which, in contrast to his later publication (1934) on therapeutic ego-splitting, has remained relatively unknown. He writes:

„The invitation to this identification comes from the analyst. From the beginning of treatment, comments are made by the analyst about the work they will have to accomplish in common during the cure. Many phrases such as, „Let us recall what you dreamed, or thought, or did there„, used by the analyst contain this invitation to identification with him as it is implied every time the analyst uses „we„ to refer to the patient and himself. This identification with the analyst is based first on

the patient‘s wish for recovery and second on the positive transference ... . This identification is based finally on a narcissistic satisfaction resulting from *his participation in the intellectual work of gaining insight during the analysis.* (Sterba 1940, p. 371, emphasis added).

In this passage Sterba came close to recognizing the important fact that the identification can also be directed at the joint work and not just at an object. Thus the form of communication that can lead the patient out of the neurosis is itself one of the major issues.

The example indicates my turn towards theapy-research. Session 152 investigated by Mergenthaler (s. Preface) belongs to this phase of the treatment (s. Appendix II).

The treating analyst - promoter and object of research

A few final words about my role as a participant observer in the local scientific enterprise. I hope that my colleagues here and at home agree with the following subjective, nonscientific self-evaluation.

For all kinds of reasons, in psychoanalytic practice too much has been taken for granted for too long a time. Therefore it was very easy for me to provide a model of a critical clinician. As teacher I exposed myself to an evaluation of my work by candidates, colleagues and scientists from many academic disciplines (Psychology, Sociology, Linguistic, Mathematics, Philosophy, Theology). The very simple first step towards research is that experienced psychoanalysts present paradigmatic treatment phases in a way that facilitates a critical evaluation of the interpersonal exchange. The contributions of the analyst and all rules should be studied from the perspective of their change facilitating function.

What about the overall gain? The research atmosphere created by Horst Kächele and myself prevented the well known tensions in psychoanalytic institutions brought about by dogmatism. Is it presumptuous that we contributed to the „research culture„ emerging now in the IPA (Emde

and Fonagy 1997)? No. Our initiative to organize an international conference on empirical research before the Hamburg IPA Congress (1985) alarmed the Executive Council. A standing conference on Research was instituted. Now, in the form of a Research Training Program, the IPA offers for the first time in its history a summer school to teach analysts who are in charge of projects.

As too many functions were represented in one person, (being myself training analyst, chairman of a University Department and head of a small, though growing Psychoanalytic Institute), a balance came about by my serving as the object of many studies. It needs some stamina to survive as a guinea-pig! To expose one‘s „psychoanalytic spirit„ (Green, 1996) in all details may also serve as cure against that kind of narcissism connected with psychoanalytic belief systems and the „spirit„ itself. Though I agree with Green that any analyst understands what he is alluding to „spirit of psychoanalysis„ in a opaque way the, nevertheless, I prefer with Wallerstein to have the spirit brought down to earth and liberated from its holy connotation. The controversy between Green and Wallerstein, publisched in the IPA newsletter 1996 (vol. 5, p. 10ff) is highlighted by the use of the metaphor "The proof of the pudding will be in the eating" by the two authors. Wallertstein had emphasised, that Green's posoition about the "spirit of psychoanalysis" is itself an empirical Question - to be proven by eating. Green expressed his strong distaste for such an imposition and replied by a sarcastic elaboration of the metaphor: if the proof of the pudding is in the eating an "*even stronger evidence is in its indigestion*". (Green, 1996, p.21) In plain language psychoanalytic research makes the very prominent French analyst Green "sick". I admit freely that I get even nauseated about the fact that therapy research is scorned especially by analysts like Green who praise the psychoanalytic spirit as if it were a self- fulfilling quality. Is it enough to describe what "takes place in the mind of the analyst in his consulting room? No other research Green (p. 20) continues, was set up by Bion when he had discovered the concept of container in the treatment of psychotic patients". How valid is this discovery? Where are thorough case histories, going beyond small vignettes of psychotic patients treated by Kleinian - Bionian analysts? And are such

descriptions on a clinical level - not to speak of research - convincing for adherence only or for other analysts as well, not to forget the patients themselves, their family, general practitioners and psychiatries? Green avoids such issues.

I did not enjoy being a guinea pig as such, but arrived on the fruitful cooperation and mutuality of interests. There is not one masochist who draws pleasure from suffering as such. I found satisfaction from gaining knowledge which I could use in my day-to-day professional and private life. As psychoanalysis has been my-love object now for about fifty years, its growth enhances the lover and its decline hurts him.

Interdisciplinary studies

For the small psychoanalytic community in Ulm, it was very beneficial that the course of some analytic treatments could be studied in detail by candidates, faculty and independent scholars.Transcripts of the dialogue make interdisciplinary studies on the homeground of psychoanalysis possible. The pretension of psychoanalysis to be an interdisciplinary science is truly fulfilled if academics and - for certain projects even lay people - have access to the material, which allows to study the psychoanalytic dialogue from their specific method. Many theses in various faculties originated from the Ulm textbank to the enrichment of both sides.

What type of basic research is most relevant for psychoanalytic practice? Probably that is not a meaningful question, since there is no basic science for mankind. A fruitful approach would be to examine the current kinds of research into the psychoanalytic process as far as it is concerned with structures and their changes.

Even if researchers and clinicians work under one roof and in the same Department, it seems unavoidable that many roads branch off from a

round-about: in our case, from Amalie. Who has the capacity to integrate many different findings?

For the time being, it seems to be a fruitful step to base interdisciplinary research on the homeground of psychoanalysis, on the data of process and outcome. The exchange between analysts and scholars from many other disciplines yields a rich harvest, even if the pretentions of one or the other (e. g. the cognitive sciences) to being the basic science cannot be realized. We have much to learn from disciplines that deal with structures. Practising Psychoanalysts are not used to the cooperation necessary to the scientific study of the psychoanalytic process. In Germany universities are responsible for research. Indeed all German universities have independent Departments of Psychotherapy and Psychosomatic Medicine, many of them chaired by psychoanalysts.

Unfortunately growing tensions between „university analysts„ and prominent members of the 13 Institutes of the German Psychoanalytic Association are a bad omen for the future. This estrangement is brought about worldwide by the structure and function of the psychoanalytic institutes. In the typical psychoanalytic „evening schools„ and their „tripartite„ curriculum (Training analysis, theoretical and practical courses plus supervision), there is a deplorable lack of research. As university psychoanalysts are supposed to devote at least part of their time to scientific work, a fruitful cooperation would be quite natural. It is a pity that it rarely functions very well, although there are still a few places in Germany where some hope for the future is justified. The membership is aware of the shortcomings and has endorsed a comprehensive, multicentered project chaired by three psychoanalysts working in universities (M. Leuzinger-Bohleber, M. Beutel, U. Stuhr).

It is not a special virtue, and not more than a precondition for a scientist to be as critical and self-critical as possible. At the same time practitioners have to take some principles for granted, at least temporarily. Bowlby described the tension between practitioners and scientists very succinctly.

„In his day work it is necessary for a scientist to exercise a high degree of criticism and selfcriticism: and in the world he inhabits neither the data nor the theories of a leader, however admired personally he may be, are exempt from challenge and criticism. There is no place for authority. The same is not true in the practice of a profession. If he is to be effective a practitioner must be prepared to act as though certain principles and certain theories were valid; and in deciding which to adopt he is likely to be guided by those with experience from whom he learns. Since, moreover, there is a tendency in all of us to be impressed whenever the application of a theory appears to have been successful, practitioners are at special risk of placing greater confidence in a theory than the evidence available may justify. (Bowlby 1979, p. 4)

Obstructing educational structures

Whether new discoveries, even if they are reliable and valid, are taken up by the psychoanalytic community depends on very many conditions beyond the validitiy of the research findings themselves. A restrictive factor is the nature of psychoanalytic training. Therefore, I have to make some critical remarks about it, even if they are somewhat out of place at this occasion (The address being the IPA). Therefore I refer the reader to my "Proposals for Reform of Training Analysis and Psychoanalytic Education" (published in English 1993 and the insuing controversy between Beland (1992) and Thomä (1992).
It is a tragedy that a critical attitude as fons et origo of research is not fostered during the training in the IPA Institutes. Or rather: that such an attitude is often perverted to a campaign against other schools or against prominent representatives within the wide spectrum of psychoanalytic pluralism. It is not my task here to discuss in detail the negative consequences of the one-sided curricula. But if Sandler‘s (1983) and Kernberg‘s (1984, 1996) critique is correct, properly trained analysts still need too long a time before they overcome the „wrong„ theories they have learnt. (s. Appendix IV)

Is there any hope today? I try to be optimistic inspite of all kinds of negative experiences with regard to the structure and function of

psychoanalytic institutions. I even invented a new content for Hartwig Dahl's acronym FRAMES, namely "Fundamental Repetitive And Maladaptive (or maladjusted) **Educational** Structures". Not an ironical joke: it is a very saddening story that the academic triad - teaching, treatment, research - was reduced to the tripartite model without research. Therefore, introducing research seminars might be a first step.

I am torn back and forth between wishful thinking, the knowledge about the power of self-fulfilling prophecies and a skeptical attitude as expressed in the title of Shakespeare's play "Love's Labour's Lost" (German translation: "Verlorne Liebesmüh").

Appendix I

At first a short history of Beatrice‘s symptoms

At the beginning of treatment Beatrice X was 24 years old, had been married for 2 years, and did not habe any children. For some 8 years she had been suffering from cramped breathing accompanied by a feeling of constriction and severe distress. These symptoms appeared for the first time in the year of her father's death, who died from a chronic cardiac disorder accompanied by difficulties in breathing. Her condition, which was diagnosed by an internist as a nervous breathing disorder, had worsened for about 2 years, making her fear that she would suffocate. She incessantly coughed and cleared her throat throughout the entire day (nervous cough). During her honeymoon her anxiety increased so much, particularly while eating in the company of her husband and then also in the presence of others, that the patient had had to eat her meals alone ever since. Her symptoms were accompanied by abstruse fantasies about her body: terrible experiences of emptiness; she thought her thorax was empty and no air went into it; thought she was too weak to breathe and that the air escaped as it does from a porous ball. Then she would feel as if she were a steel pipe. Coitus was impossible due to vaginismus.

Beatrice started the session by reporting a dream:

Dream. She entered a room. A man was setting up spotlights and film equipment and did not have any time for her. She was disappointed.
After describing the dream, the patient repeated her feelings toward attending the building party.
Consideration. The session began five miuntes late. I wanted to draw the patient‘s attention to her - presumed - disappointment and asked her a suggestive question: „The man did not have enough tim for you?„
Reaction. The patient did not respond to it, but mentioned her desires instead, saying how nice it would be to be at the center of things at the party. Then she gave mi precise details about her sex life. She said she did not use to have an orgasm because she had restrained herself and had not actively participated when she became more excited. Then somehow she had become anxious that she could be injured if she were very active. She also said it was not right for her husband to have so little time for her. She added that it was her fault because she would do trivial things in the evening instead of enjoying a quiet evening talking to her husband.
Consideration. Unconsciously the patient wanted to exhibit herself, be at the center of attention, and have a particularly satisfying orgasm. She was anxious about injuring herself. To keep from exhibiting herself, in her dream she picured the man as not having any time for her. Then it was the man who disappointed her, and she could complain about him. This enabled her to maintain her repression of her sexual desires.
Interpretation. In accordance with my consideration, I referred to an older dream in which she had seen a woman dancing and exhibiting herself, and told the patient that she would like to show herself in a state of sexual excitement but that she reckoned with disappointment because she feared too much intensity. Then she would complain to me about my not having enough time for her.
Reaction. This was 100% right, and there were no buts. She added that she thought about a dream and her anxiety about giving birth.
Dream. She saw a pale child, the baby of a girlfriend from school who had always looked bad. (In the dream it was clear that the woman hat too often hat intercourse during pregnancy, injuring the child.) A man put a small boy on a elephant, between its ears, and she was very afraid that something would happen to him.

Associations. She said she knew that a woman should not have any intercourse the last few weeks before giving birth. The elephant‘s ears made her think of a woman‘s labia. There was something to her anxiety regarding pregnancy and giving birth, namely about losing something.
Consideration. The familiar topic of injury and loss returned again. I thought about the fantasies the patient had during defloration and about her fear that her vagina would tear further and further open. She did not experience anything new in a child; it did not provide any new experiences. She thought most of all that something fell off (the body between the ears/ the labia). I puzzled about the equating of child and penis. The child does not augment her self-image, but it falls off. Why?
Interpretation. She had the impression that she would be injured while giving birth and would lose something. The small boy was where the elephant‘s trunk is, i. e., it was as if the boy would lose his trunk/penis. She had the impression that she had lost something compared to her brother, namely a penis, and she feared the injury could increase by giving birth.
Reaction. She could not recall such in idea with regard to her brother, but said that it was clear to her how much she was preoccupied by the thought of being injured while giving birth and of losing something. She was disturbed that she still had such thoughts and dreams despite the fact that she knew better.

Appendix II

Amalie X came to psychoanalysis because the severe restrictions she felt on her self-esteem had reached the level of 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 fo 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; scrupels from compulsion

neurosis and different symptoms of anxiety neurosis impeded her personal relationships and, most importantly, kept the patient from forming closer heterosexual friendships.

Thr analyst offered this woman, who was hard working in her career, cultivated, single, and quite feminine despite her stigma, treatment 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 our body is not our only destiny and that the attitude which significant others and we ourselves have to our bodies can also be decisive. Freud's (1912d, p.189) paraphrase of Napoleans'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 1968,1975; 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; and 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 identifiying 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 the qualitites of masculine or feminine.

In this phase of the treatment one topic took on special significance and intensity; this was her interest for my head. What had she learned from measuring my head? In a similar situation Amalie 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.

Although the head acquired sexual connotation as a result of the process of unconscious displacement, this displacement did not alter anything regarding the primacy of the 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 experiencing because of her sexual desires. Her life historical role model for the contents of her transference neurosis was a fantasized incestuous relationship to 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.

Session 152 - report on the basis of the transcription

The patient mentioned her strict boss, who had unjustly criticized her and for whom she was no match.

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 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 sasumed 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 nek, 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.
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 objet.
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 wehter 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 withyour head.
A: Does it stay on ? You‘re often preocupied 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 mor 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 parial withdrawal of the object increased her unconscious phallic aggressiveness.
The patient spoke so softly that I didnot 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 alaogy to head hunter jargon as „head shrining.„ 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 sycle. The

rejectionof her sexual and erotic desires that now occurred unconsciously strenghened 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 conrete behind our concern withthe 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 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.)
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 shringing are now ...
She laughed, immediately expressed her regret, and was silent. I attemted 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 replaces 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 gain became the focus of attention in a general sense.
A: By thinging about the head you‘re attempting to find out what wour are and waht 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 when she had seen my picture printed somewhere.

P: I disovered 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 towhat 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 fscinated 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 culd never take anything. You wouldn‘t believe how bland I think my father is. He couldn‘t take anythin.
Consideration. A surprising turn. The patient‘s insecurity and her anxiety about taking hild 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.
Consideration. An objectivistic image of „intellectual„ exchange as a displacement?
The patient‘s idea abut the two-sided nature of the exchange led me to recornize another aspect of this fight. It was also an expresison 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 tome 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 before the session, wether she shouldn‘t withdraw in some way or other and put an end to it all.
At the beginning I had attemted to relieve her intense feelings of guilt with regard to her destructiveness. I picked up the idea one 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 stron, unshakable stability. The topic of dogmatism probable belonged in this context. Although she criticized it - both her own Bible and my presumend belief in the Freud bible - it also provided her security, and for this reason the dogmatism could not be too rigorous of 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 attemt 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 inmy 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.
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 tured 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 stuggle 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, the patient returned to my head and measureing 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„ It is highly relevant if and when an interrupted association is taken up again. It indicates that a „psychic act„ is brought to a couclusion and this often goes together with unconscious changes. (The derogatory colloquial „headshrinker„ = psychiatrist has no German counterpart and is unknown to Amalie).

Appendix III

Countertransference
The countertransference certainly influences the analytic attitude in general and inference processes leading to interpretations in particular. It is widely accepted that an analyst's countertransference can serve as a source of information about the patient. But only if the countertransference would be the „creation„ of the patient and mirror

his/her uncouscions phantasies - by projective identification - could we ascribe to it (to the countertransference) a reliable diagnostic function. At any rate the usage of countertransference has to be „controlled„, what ever that may mean (P. Heimann, Thomä and Kächele). Paula Heimann's warnings are completely forgotten. The very subjective countertranferences are taken as reliable and valid diagnostic indications: Gabbbard (1995) regards the modern understanding of the countertransference as further area of "common ground". It is true that analyst of all schools have a new understanding of the countertranference in common. They would certainly agree, as Gabbard (1995, P 475) put it "that an analyst's countertransference can be a crucial source of information about the patient...". However, are very subjective countertransferances - usually not even closely examined by the treating analyst regarding their diagnostic reliability - stable pillars for a common ground? They are rather the opposite. The countertransference is the most subjective part of the so called "analyzing instrument" (Balter et. al. 1980). It does determine the present extreme pluralisme in psychoanalysis. The search for common ground leads into a dead-end-road if the concepts of a theory are so embracing, that they mean all kind of things for clinicians. For instance the "unconscious" has lost its unifying power because of its infinite extension on the one hand and its school-bound restrictive usage on the other hand. In the latter case it is the common denominator only for a subgroup. The consequence is that the subgroups disagree with each other.

Bouchard et. Al. (1995) tried to develop a rating procedure in order to systematically describe countertransference and finished their clarification of the concept by saying: „Throughout our history, attitudes about countertransference have shown us that it is vital to set a course that seeks to avoid twon pitfalls: on the one hand, the myth of our unattainable ideal of total objectivity and detachment, which is nothing but the result of denial and repression of our subjectivity and our limitations; on the other, a sort of fascination leading us to be so caught up in our own subjectivity and self-anaysis that we are in danger of being engulfed in contemplations on countertransference that may swallow up the whole analysis„. Indeed, oral case reports, membership-papers and publications in all psychoanalytic journals prove that the

„countertransferences„ ar „swallowing up the whole analysis„. Attempts at a comprehensive clinical evaluation are replaced by an extreme subjectivism,euphemistically called „psychoanalytic pluralism„. There have been always fashions in the history of psychoanalytisis. Insofar the swing towards the „total" understanding of the countertransference is a reaction against the ideal of the detached, „totally objective„ analyst. But I am afraid that the turn towards the present extreme subjectivism is more than a fashion and rather a symptom of the disintegration of Psychoanalysis.

Appendix IV

Psychoanalytic Training
Unfortunately it is now evident that for decades the apprenticeship model of psychoanalytic training has been lacking a most essential part: The masters‘ exemplary demonstration of a psychoanalytic treatment from start to finish.

Among the „least expected findings„ from Morris‘ (1992) recent survey on „psychoanalytic training today„ is the following: „In none of the 28 institutes of the American Psychoanalytic Association is it the practice to have training analysts or even junior faculty ever present in continuous case conferences, though faculty may present brief vignettes of clinical material in their other courses. Rather it is always the practice that candidates present recent or current material in such conferences, and no institute reported having the goal of following a single case from start to finish. Thus, the only completed analysis that a candidate experiences longitudinally is his or her own„. Loewald's similar statements forty years ago and his encouragement for experienced faculty to present their case material were without consequences.

The deficiencies typical of most institutes can not be made up for by certain improvements of the „core curriculum„ on which Morris seems to base his optimistic judgement that „psychoanalytic education is alive and well„ (p. 1207). Of course it is alive since it exists. But is it well? If a healthy life means progress and change and not stagnation or even

regress, psychoanalytic education is not well at all. In fact there has been a conspicious decrease in the average number of candidates from 60 to 24 per institute between 1960 and 1990, although the number of institutes of the American has doubled during this timespan (from 14 to 28). The total number of candidates has not grown in proportion. There were 888 candidates (all Mds.) in 1960 and 1051 (17% non-medical)candidates in 1990.

It is also striking that the tripartite psychoanalytic curriculum - personal analysis, seminars, supervision - is far removed from the triad of research, training, and treatment which Freud favored in the classic academic tradition. Forty years ago Knight (1953) in his paper on „the present status of organized psychoanalysis in the United States„ complained about the consequences of certain training regulations of the American. He says bluntly: „... our regulations may have the effect of drying up the supply of research psychoanalysts„ (p. 215). This evaluation is still valid and true for almost all institutes of the IPA. In fact Morris‘ survey confirms once more that the tripartite psychoanalytic curriculum does not include research.