Lecture Programme
CAIXAFORUM MADRID

70 YEARS WITHOUT FREUD
New perspectives

(Possible) Develoments of Psychoanalytic Therapy

Horst Kächele, Ulm

Since its inception psychoanalysis has spread throughout the world as a scientific discipline and as a mode of treatment. Starting in the Western hemisphere it soon travelled from Vienna to the European capitals like Berlin, Budapest, London, Paris; surprisingly soon Moscow (Luria 1924; see Etkind 2000) and even more surprising to Calcutta (Bose 1921; see Vaidyanathan & Kripal 1999; Kakar 2000). After Freuds visit psychoanalytic ideas jumped over the atlantic ocean conquering North America by people trained by Freud himself (Shakow & Rapaport 1964). Already in 1911 Freud reviewed a paper by Greve, a Chilean physician, which contains the first reference to psychoanalysis in Latin America, but it was the achievement of the psychiatrist Matte Blanco´s to institutionalize psychoanalytic training since the forties (see Jiménez 2002, p. 83).

The real introductor on psychoanalysis is the Spanish Philosopher José Ortega y Gasset, who publish two papers on psychoanalysis (1911, “Psicoanálisis: ciencia problemática” and “Nueva medicina espiritual”). Ortega was the mentor that encourages to Luis López Ballesteros (The translator of Complete Works of Freud from German to Spanish, published 1922), with the aid of some neuropsychiatrist.

Already in the fifties of the last century the Japanese psychiatrist Takeo Doi developed his ideas on the exquite concept of amae’ dealing with „the anatomy of dependence“ as a cornerstone of japanese psychoanalytic developmental thinking (Doi 1971). After the downfall of the iron curtain Russian psychologists and psychiatrists remembered the early achievements in psychoanalytic thinking (Etkind 2000) and were quick to accept the missionaries of various psychoanalytic

backgrounds. However they also devise an own brand supported by president Yeltzin, who in 1993 signed an official document for the re-installation of „Russian psychoanalysis“ (Reshetnikov 1996). Presently we witness the implantation of psychoanalysis in China promoted by various psychoanalytic groups that have been teaching in China for a number of years (Gerlach 2005; Varvin 2008).

Given these developments it seems fair to speak of a process of globalization of psychoanalysis. At a closer view one cannot avoid to note quite a diversity of what is covered by the term psychoanalysis in respect to treatment practice. Should we work with the most minimal assumption that Freud once proposed that everybody who uses the notions of transference and resistance could be called a psychoanalytic therapist or should we continue – as many do - to insist on a sharp distinction between psychoanalysis proper and psychoanalytic informed treatments. I shall argue in my lecture that for the common public the commonalities of the psychoanalytic treatments are much more evident than any distinctions based on small insider group needs for difference?

Differences and similarities between psychoanalysis and potential offsprings have been discussed since Freud’s times. On the one hand Freud spoke of „analyses which lead to a favourable conclusion in a short time“ enhance the therapist's self-esteem. These shorter treatments – loosely called psychoanalytically informed or psychodynamic - have substantiated the medical impact of psychoanalysis, as they dominate the psychoanalytic therapies of today. To denounce them as „insignificant as regards the advancement of scientific knowledge“ does not do justice to the importance of a scientific foundation of psychoanalytic treatment principles (Galatzer-Levi et al. 2001; Kächele 2001). Many empirical studies on these shorter treatments have contributed to a theory of therapy (Fonagy & Kächele 2009); they can further the understanding of the relationship between interventions and the outcome of treatment. In contrast to such a medical, treatment oriented model Freud wanted ‚true analysis’ to succeed „in descending into the deepest and most primitive strata of mental development and in gaining from there solutions for the problems of the later formations“ (Freud 1918b, p. 10).

Freud maintained the same dichotomy – therapeutics versus truth - still years later: "I have told you that psycho-analysis began as a method of treatment; but I did not want to commend it to your interest as a method of treatment but on account of the truths it contains, on account of the information it gives us about what concerns human beings most of all — their own nature — and on account of the connections it discloses between the most different of their activities" (Freud 1933a, p. 156).

His lifelong concern, that "the therapy will...destroy the science" (1927a, p. 254), led him to the (now rejected) assumption that strict, objective rules of investigation produce the best scientific conditions for the reconstruction of the patient's earliest memories, and that uncovering the amnesia created the optimal conditions for therapy (1919e, p. 183). However in another context Freud recommended the creation of the most favorable circumstances for change in each individual analytic situation, i.e., he recognized the need for patient-oriented flexibility (1910d, p. 145).

The creation of a therapeutic situation is a prerequisite for gaining insight into unconscious psychic processes. Freud underestimated the scientific challenges for demonstrating therapeutic change and clarifying the curative factors. At one point he wrote: "A psycho-analysis is not an impartial scientific investigation, but a therapeutic measure. Its essence is not to prove anything, but merely to alter something" (1909b, p. 104). Opposing these two aspects – psychoanalysis cares for truth and psychotherapy for therapeutics - is questionable. Too many questions regarding the development of a disorder (etiology) cannot be clarified by analyzing patients in whatever frequency or setting. This does not reject the notion that clarification of biographical connections may be therapeutic; in the process of reviewing past experiences and exploring the patient´s unconscious, mental models of intersubjective experience are modified (Fonagy 1999a, p. 1011).

The main concern of modern research into therapy is to show whether therapeutic changes occur in the course of psychoanalytic treatments and to clarify the relationship between these changes and the theories adhered to by the analyst as the well-known British psychoanalyst and Sigmund-Freud Professor at the London University College, Joseph Sandler had pointed out long ago (1983).

The general public might not be aware how elaborate this discussion has been

and still is: the discussions revolve around theoretical, practical, and political issues. Are the differences in indications, technique and processes mainly a matter of ‚degree' or is it a matter of ‚quality', the latter being a stricter distinction? This constitutes an important empirical issue; can they be empirically distinguished? The process of attempting to delineate (proper) psychoanalysis from (psychoanalytic) psychotherapy has taken up considerable amounts of energy and ink (Kächele 1994). Many discussions point to two options: One option votes for a categorical approach that holds psychoanalysis as different from psychoanalytic psychotherapy (as Kernberg (1999) carefully spells out); the other option prefers a dimensional approach that identifies empirical dimensions of clinical work (Wallerstein 1995). In this view, any practice fulfiling such criteria as discussed below may qualify as psychoanalytic to the degree to which the core concepts of the psychoanalytic theory of technique are realized.

Ever since the British psychoanalyst Edward Glover investigated the technique of psychoanalysts by distributing a simple questionaire among the members of the British Society (Glover & Brierley 1940), all empirical approaches lead to little systematic evidence for a strict distinction between psychoanalysis and analytic psychotherapy. In the mid-fifties of the last century Gill (1954) had suggested a definition of psychoanalysis distinguishing intrinsic and extrinsic criteria, which he revised in 1984. As "intrinsic criteria" he had postulated: the analysis of transference, a neutral analyst, the induction of a regressive transference neurosis and the resolution of this artifical neurosis by interpretation; as „extrinsic criteria" he mentioned "frequency of sessions, the use of the couch, a relatively well integrated (analysable) patient/…/, and a fully trained psychoanalyst". However in my view these distinctions do not hold up under empirical scrutiny. The analysis of transference f.e. has been a major object of studies on psychoanalytic psychotherapies of all kind (Luborsky & Crits-Christoph 1998; Hoeglund 2004). Furthermore the concept itself of transference neurosis has been questioned (Cooper 1987) and the issue of a resolution of the transference neurosis has been questioned by careful follow-up studies (Schlessinger & Robbins 1983). The concept of neutrality

is debated intensely (Schachter & Kächele 2007). Likewise the so-called extrinsic criteria have melted in the fire of debates among various groups. Frequency of sessions too often are dictated by economic or cultural factors; the use of the couch as an indispensible criterion also is put into question (Schachter & Kächele 2010).

For example the most ambitious project making a relevant comparison - the Psychotherapy Research Project (PRP) of the Menninger Foundation – led to a conclusion in favour of blurring the boundaries between modalities of treatment:

> "The therapeutic modalities of psychoanalysis, expressive psychotherapy, and supportive psychotherapy hardly exist in ideal or pure form in the real world of actual practice. /…/ (treatments) are intermingled blends of expressive-interpretative and supportive-stabilising elements…. and /…/ the overall outcomes achieved by more analytic and more supportive treatments converge more than our usual expectations for those differing modalities would portend; and the kinds of changes achieved in treatment from the two end of this spectrum are less different in nature and in permanence than is usually expected." (Wallerstein 1989, p. 205).

Thus, contrary to what was expected, there were no overwhelming differences in outcomes after supportive-expressive, analytic psychotherapy and psychoanalysis; and alas the mean effects of either treatment were quite modest; supportive techniques were as powerful as more interpretative ones; and psychoanalysts used supportive techniques to a larger extent than what was usually assumed. Even if one would criticize these findings as ecological unvalid – as the kind of patients do not correspond to the usual case load of analysts in private practice – the results came as a surprise and led to secondary evaluations searching for moderating factors. Besides personality dispositions benevolent interpersonal schemas also faciltated therapeutic change in these patients (Blatt 1992; Sharar & Blatt 2005).

The point that quantitative, not categorical distinctions may be useful for differentiation has also been recently demonstrated (Ablon & Jones 2005). Using an operational description of psychoanalytic process one finds that it does take place in analytic psychotherapy, although significantly more in psychoanalytic treatment. Therefore some researchers hold the opinion that findings of the treatment studies

have been vitalising to the discussion on the psychotherapy versus psychoanalysis issue by putting some empirical facts in focus. „There is a need for more such empirical data“ (Grant & Sandell 2004, p. 83).

So what I am really talking about is the impact of treatment research on the headquarters of organized psychoanalysis. This has been the most powerful development in my view. Some years ago, Prof. Fonagy from London remarked at a meeting: „For long time we research-minded psychoanalysts have been a minority; now are are a significant minority“. Psychoanalytic treatment research a still a rather young field. It goes back to the first investigation on therapeutic effectiveness at the Berlin Psychoanalytic Institute in 1930 (Fenichel 1930). It was shortly awakened by the fulminant critique of Prof. Eysenck in the early fifties and it was finally established as a scientific field on its own with the establishment of the Society for Psychotherapy Research in the early seventies. From this time on we may speak of a science of psychoanalytic treatment which has increasingly generated rich and suprising findings.

Since there is no consensually agreed definition of psychoanalysis that has been generally accepted, we end up defining psychoanalytic therapies by what psychoanalysts do in practice (Sandler 1982, p. 44). Thomä & Kächele (1989) conceived ‚Psychoanalytic Practice’ (pratica del psicoanalisis) as a task using agreed upon technical recommendations in a variety of settings. Each of the recommendations leave ample space for patient-oriented modifications. This leads to the position that psychoanalytic practice covers a range of instantiations with no clear default value. Each of the instantiations may be more or less close to an ideal prototype of analytic work (Ablon &Jones 2005); alas any prototype construction is based on a selection of analysts working in different conceptual frames. So most likely we are going to have an ego-psychological prototype, a Kohutian prototype, a Kleinian, or even a Lacanian. The real question is to what extent the representatives of the various protypes share a minimum of basic notions of psychoanalytic therapy? The core concepts of clinical psychoanalysis – e.g. therapeutic relationship, transference, countertransference, resistance, insight, defense mechanisms – and the rules of the game – like inviting the patient to free association, inviting dream

materials and focusing on the here-and-now interaction supplemented by an attentive attitude, reasonable neutrality of the analyst etc. – render it feasible that the argument can be reversed. Every therapist using these core concepts -- to whatever degree of perfection or intensity -- should be called a psychoanalytic therapist.

That those psychoanalytic therapists who have mainly worked in the intense mode have shaped the theoretical edifice, written the books and papers that most of us have studied carefully does not come as a surprise. But the reluctant attitude of those ‚true' masters of psychoanalysis – as we may respectfully call them - towards empirical research – on the other hands – is responsible for a gap between two kinds of scientific cultures (Luyten et al. 2006). This gap results partially from a mixing of what is appropriate for understanding the process with the clinical work and and what approproate for understanding the process for the formal evaluation. No doubt the clinician in his daily work has to operate on the assumption - if he is to be effective - 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. This wrote the by-now-famous British psychoanalyst and inventor of attachment theory John Bowlby 1979 in a paper on art and science in psychoanalysis (p. 4). The proper understanding and appreciation of what clinicians must do, is one thing. For the researcher on treatment process and outcome these are just the facts of life he or she has to study: „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" (p.4).

So the big problem that has hindered psychoanalysis to develop into a rather sound profession is not the nature of its data; its problem has been the perennial limited access to its data. When the German professors Grimm started to study fairy tales based on oral accounts of old women, these data were indeed very soft. However the nature of the research program they and others then developed secured the evaluation of science that since long bears the hallmark of a sound edifice (Propp 1928).

So you may ask: what are the data of psychoanalyic therapies? Well there are at least three sources of data to take into account: The patient´s view, the analyst´s view and the external observer´s view. Two of these data sources are principally first-persons statements which no one from outside can critizise; you have to take them as they are. Traditionally the field took Freuds words, or M.Kleins words or the thousands of other analysts´case reports for the primary data. In other words, in my words, this were the fairy tales told to us by our teachers. They did their best and we believed them. Transmission of knowledge was by oral or written media but there was no way of checking what the masters said. The most recent illustration of this rather specific problem of the psychoanalytic epistemic culture is the report by Heinz Kohut of a patient of his, Mr. Z. (Kohut 1979). In it the course of two psychoanalytic treatments is presented, one differing considerably in technical approach from the other.

Recently a biography on Kohut (Strozier 2001) clarified that the second analysis of Mr. Z is an artful invention intended to make up for his rather negative experience with Ms. Ruth Eissler in a first analysis. In 1984 Kohut reinforced his satisfaction with the first fictive psychoanalysis worldwide. In his own appreciation he glorifies the changes by the self-psychological theory. Nothing else Kohut did, illustrates more clearly his heroic sense of himself. Even in his last work “How does analysis cure?” (1984) in a final debate with his critics he wrote:

> „The lessons to be learned from the two analyses of Mr. Z is the following: The case illustrates not only the way how theoretical changes render the analyst capable. To perceive new clinical configuration, bit also shows, how the analysts´ understanding of the self-object transference impacts on his handling of clinical material influenced by the enlarged empathy that results from the new theoretical frame” (Kohut 1984).

The two analyses of Mr. Z are also a telling demonstration that even distinguished journal editors are unable to differentiate valid clinical dynamics from theoretical, hypothetical dynamics; how can an analyst determine whether the dynamics developed with a patient are valid or theoretical?

Referring to the title of my lecture „(possible) developments in psychoanalysis“ I hope to have clarified by this example that story telling as important as it may be in everyday life (Ehlich 1980) hardly leads to new developments for psychoanalysis.

Psychoanalysts telling stories had a long time to convince the world; they have only partially succeeded. Their voices are many and they are culturally highly embedded. So the many cultures in psychoanalysis are a product of the multilingualism in psychoanalysts telling their stories. Recently there is growing awareness that this leads to a babelisation of psychoanalysis (Jiménez 2009).

What about the voices of the consumers of psychoanalysis, where are they to be found? To be honest, we do not have many of such voices. The famous Consumer Reports study in the US did not expect psychoanalytic patients to respond and so they didn´t (Seligman 1995). The reports of analytic patients we have, - they are mainly quite critical (f.e. Drigalski 1980). There are but a few reports of patients that give a grateful account on how psychoanalytic therapy has changed their lifes (Schachter 2005). This could be an interesting phenomenon to investigate: why do people with satisfying experiences due to psychoanalytic therapy seldom find a pen to write down what has been their perspective on the change processes. We as analysts might learn a lot about this other perspective and it may enrich our understanding, but also may even reduce the importance of some of our (untested) assumptions about how treatment works. The endless debates on the correct interpretation or the fitting theory, do they really matter in the patients´view? We do not know and my hope this that we see a development in psychoanalysis that encourages patients to write about psychoanalysis.

Remember I said there are three sources of psychoanalytic relevant data and the third source is of a qualitative different nature. The external observer´s view is a third person´s view on the therapeutic process and it has been the very last to make its appearance on the psychoanalytic stage. Until today there are reknowned analysts that would disqualify this perspective and declare the analyst to be the sole psychoanalytically reliable source of knowing (Tuckett 1994). It may be obvious that I do not at all agree with this restricted view. If we would have Freud´s daily case notes we would be better of, if we would have audio-recordings of his dialogues the better. To dream of video recordings would something only poets could think of as fictionalized psychoanalytic materials have long been in the mainstream of modern theatre.

Seen from outside the psychoanalytic business in each session has obvious similarities to a mini-drama; therefore the Gerrman philosopher Habermas (1968) rightfully spoke of the stage model of psychoanalysis. From the outside there are distinct features of the transactions there can be identified with any number of qualitative or social science technology. To list psychoanalysis under the natural sciences is completely misleading, but to count it to the group of nomothetic sciences is most apt. To reduce it to hermeneutics does not do justice to the interactive nature of the processes.

It is here that I see the potential for development in psychoanalysis. By recording the sessions we get access to the micro-world of intersubjective exchange on the linguistic and para-linguistic levels. It is there where we better unterstand what´s going on in a good analysis and what is going wrong in a bad analysis (Fonagy 1999b). It is like the invention of the microscope in medicine enlarging our view. This methodology brings researcher into the field of psychoanalysis that by their own methodology enrich our understanding. The famous philosopher Adolf Grünbaum (1982) insisted on extra-clinical testing; there are however any number of phenomena which exist only inside the therapeutic frame. And for these phenomena we need intra-clinical yet robust research designs that do not depend on the analyst as participant observer.

The battle of what constitutes a psychoanalysis has to be fought on empirical grounds not in heated debates without arguments that do not have facts to support them.

It is interesting to note that seen from outside the diverse groups of our profession are lumped together as all constituting psychodynamic-psychoanalytic practice. A conceptual tool formulated by Ford & Urban (1963), „systems of psychotherapy“, could be utilized to identify the major systems as psychoanalytic, cognitive-behavioral, systemic etc. This conceptual distinction has guided the famous meta-analysis by Grawe et al. (1994) on the outcome of treatments. Short, middle range and longer psychoanalytic therapies belong for the open-minded spectator to the same system of psychotherapy. Is there a need to maintain differences among the various psychoanalytic worlds? As far as we can tell, these differences do not play a major role in patients´views and as far we can tell from research evidence on

shorter treatments, the role of the specific technique, excluding the analyst´s personality and style, is not likely to play a substantial role for outcome (Wampold 2001).

For any critical observer the present situation of psychoanalysis as therapy is marked by "the failure of practice to inform theory" (Fonagy 2006) which logically leads to the most recent call of "studying practice in its own right" (Jiménez 2009). But which practice are we talking of? The multiplicity of versions of psychoanalytic practice across continents, countries and even cities makes it abundantly clear that such a move to practice requires an open-minded psychoanalytic world allowing for theoretical and technical diversity. There is no longer one bible at hand and there are many prophets promoting one or the other version of psychoanalysis whether or not these claims are supported by evidence – and too often they are not. The history of psychoanalysis is rich on claims and poor on data.

Mapping out the global field of psychoanalytic practice by agreeing to basic assumptions seems to be timely. Instead of separating entities that hardly exist in real practice, we might better talk about conceptual families or at least close neighbours (Wallerstein 1995; Grant & Sandell 2004).

Therefore psychoanalytic work as a therapeutic enterprise should be covered by the term “psychoanalytic therapy” including a host of variations in setting and intensity; the boundaries of this inclusive term are loose stretching across numerous variations of psychoanalytic practice. The decisive criteria reside in the patient´s welfare by the convincing empirical demonstration that this treatment works (Fonagy et al. 2002). To overcome the dichotomy of the clinical application of psychoanalysis and its derivate forms of psychoanalytic psychotherapy by applying such a generic term would re-center the efforts of the psychoanalytic community.

From the diverse, heterogenic kaleidoscope of psychoanalytic theories and practices, one conclusion emerges with reasonable certainty. All psychoanalytic therapists are urged to approach their work with a deep sense of humility. Weakly-based convictions about a particular analytic view may impede the monumental

empirical assessment that lies before us.

Ablon JS, Jones EE (2005). On analytic process. J Am Psychoanal Assn 53: 541-568.

Bateman AW, Fonagy P (2004). Psychotherapy for borderline personality disorder. Mentalisation-based treatment. Oxford: Oxford University Press.

Blatt SJ (1992). The differential effect of psychotherapy and psychoanalysis with anaclitic and introjective patients: The Menninger Psychotherapy Research Project revisited. J Am Psychoanal Assn 40: 691-724

Bose G (1921). Concept of repression. Calcutta: Parsi Bagan.

Bowlby J (1979) Psychoanalysis as art and science. Int Rev Psychoanal 6: 3-14

Clarkin JF, Kernberg OF, Yeomans FE (1999). Transference-Focused Psychotherapy for Borderline Personality Disorder Patients. New York: Guilford Press,

Cooper AM (1987). Changes in psychoanalytic ideas: transference interpretation. J Am Psychoanal Assn 35: 77-98.

Doi T (1971). The Anatomy of Dependence (Amae no Kouzou). Kodansha International, Tokyo

Drigalski D, von (1980) Blumen auf Granit. Eine Irr- und Lehrfahrt durch die deutsche Psychoanalyse. Ullstein, Frankfurt am Main Berlin Wien (Aktualisierte Neuausgabe im Antipsychiatrie Verlag Berlin 2003)

Ehlich K (1980) Der Alltag des Erzählens. In: Ehlich K (Hrsg) Erzählen im Alltag. Suhrkamp, Frankfurt, S 11-27

Etkind A (2000). The eros of the impossible. Yale University Press, New Haven

Fenichel O (1930) Statistischer Bericht über die therapeutische Tätigkeit 1920-1930. In: Radó S, Fenichel O, Müller-Braunschweig C (Hrsg) Zehn Jahre Berliner Psychoanalytisches Institut. Poliklinik und Lehranstalt. International Psychoanalytischer Verlag, Wien, S 13-19

Fonagy P (1999a). Response. Int J Psychoanal 80: 1011-1013

Fonagy P (1999b) The process of change and the change of processes: what can change in a 'good' analysis. Keynote address to the Spring Meeting of Division 39 of the American Psychological Association. New York.

Fonagy P (2006). The failure of practice to inform theory and the role of implicit theory in bridging the transmission gap. In: Canestri J Psychoanalysis from practice to theory. Editor. 69-86. West Sussex: Wiley.

Fonagy P, Jones EE, Kächele H, Clarkin JF, Krause R, Perron R, Gerber AJ, Allison L (Eds.) (2002). An open door review of the outcome of psychoanalysis. London: International Psychoanalytic Association

Fonagy P, Kächele H (2009). Psychoanalysis and other long term dynamic psychotherapies. In MG Gelder, JJ Lopez-Ibor, N Andreasen (Eds.) New Oxford Textbook of Psychiatry (2 ed.) 1337-1350. Oxford: Oxford University Press.

Ford D, Urban H (1963). Systems of psychotherapy. A comparative study. New York: Wiley & Sons.

Freud S (1909b). Analysis of a phobia in a five-year-old boy. SE 10 : 1-149

Freud S (1910d). The future prospects of psychoanalytic therapy. SE 11: 139-151

Freud S (1918b). From the history on an infantile neurosis. SE 17: 1-122

Freud S (1919e). 'A child is being beaten'. SE 17: 175-204

Freud S (1927a). Postscript to the question of lay analysis. SE 20: 251-258

Freud S (1933a). New introductory lectures on psycho-analysis. SE 22: 5-182

Gabbard GO, Westen D (2003). Rethinking therapeutic action. Int J Psychoanal 84: 823–842

Galatzer-Levi RM, Bachrach H, Skolnikoff A, Waldron W (2001). Does psychoanalysis work? New Haven: Yale University Press.

Gerlach A (2005). Psychoanalysis - an inspiration for Chinese culture? Taiwan Center for the Development of Psychoanalysis May 3rd.

Gill MM (1954). Psychoanalysis and exploratory psychotherapy. J Am Psychoanal Assn 2: 771-797.

Gill MM (1984). Psychoanalysis and psychotherapy: A revision. Int Rev Psychoanal 11:161-179.

Glover E, Brierley M (1940). An investigation of the technique of psycho-analysis. London: Baillière, Tindall & Cox.

Grant J, Sandell R (2004).Close family or mere neighbours? Some empirical data on the differences between psychoanalysis and psychotherapy. In: Research on Psychoanalytic Psychotherapy with Adults. Richardson P, Kächele H, Rendlund C. editors. 81-108. London: Karnac.

Grawe K, Donati R, Bernauer F (1994). Psychotherapie im Wandel. Von der Konfession zur Profession., Göttingen: Hogrefe - Verlag für Psychologie.

Grünbaum A (1982) Can psychoanalytic theory be cogently tested "on the couch"? Psychoanal Contemp Thought 5: 155-255;311-436

Habermas J (1968). Erkenntnis und Interesse. Suhrkamp, Frankfurt am Main

Hoegland P (2004). Analysis of transference in psychodynamic psychotherapy: a review of empirical research. Can J Psychoanal 12: 279–300.

Jiménez JP (2002). Chile, and psychoanalysis. In: Erwin E (Ed.) The FREUD Encyclopedia. Theory, therapy, and culture. 83-84. New York: Routledge.

Jiménez JP (2009). Grasping psychoanalysts' practice in its own merits. Int J Psychoanal 90: 231-248.

Kächele H (1994). Book Review: "Interaction and interpretation: Psychoanalysis or psychotherapy?" By J. Oremland, with a critical evaluation by M. M. Gill. Hillsdale, NJ: Analytic Press, 1991. J Am Psychoanal Assn 42: 919-925.

Kächele H (2001). Book Review: Does psychoanalysis work? By Robert M. Galatzer-Levi, Henry Bachrach, Alan Skolnikoff, and Sherwood Waldron. New Haven: Yale University Press. J Am Psychoanal Assn 49: 1041-1047.

Kakar S (1997). Culture and psyche. Oxford University Press, Delhi

Kernberg OF (1999). Psychoanalysis, psychoanalytic therapy and supportive psychotherapy: Contemporary controversies. Int J Psychoanal 80: 1075-1091.

Kohut H (1979). The two analyses of Mr. Z. Int J Psychoanal 60: 3-27

Kohut H (1984). How does analysis cure? Univ Chicago Press, Chicago London

Luborsky L, Crits-Christoph P (1998). Understanding transference. 2nd ed. New York: Basic Books.

Luria A (1924). Russian Psycho-Analytical Society. Bull Int Psychoanal Assn 5: 258-261.

Luyten P, Blatt SJ, Corveleyn J (2006). Minding the gap between positivism and hermeneutics in psychoanalytic research. J Am Psychoanal Ass 54: 571-610

Propp WJ (1928). Morfologia delle fiabe. Einandi, Torino

Reshetnikow M (1996). The first hundred years of psychoanalysis: It´s Russian roots, repression and Russia´s return to the world´s psychoanalytic community. East-European Institute of Psychoanalysis. St. Petersburg

Sandler J (1983). Reflections on some relations between psychoanalytic concepts and psychoanalytic practice. Int J Psychoanal 64: 35-45.

Schachter J (Ed) (2005) Transforming lives. Analyst and patient view the power of psychoanalytic treatment. Rowman and Littlefield, Lanham, MD

Schachter J, Kächele H (2007). The analyst's role in healing: Psychoanalysis-PLUS. Psychoanal Psychol 34: 429-444.

Schachter J, Kächele H (2010). The couch in psychoanalysis. Contem Psychoanal in press.

Schlessinger N, Robbins FP (1983) A developmental view of the psychoanalytic process. Follow-up studies and their consequences. New York: International Universities Press.

Seligman MEP (1995) The effectiveness of psychotherapy. The Consumer Reports Study. Am Psychol 50: 965-974

Shahar G, Blatt SJ (2005). Benevolent interpersonal schemas faciltate therapeutic change: Further analysis of the Menninger Psychotherapy Research Project. Psychother Res 15: 1-4

Shakow D, Rapaport D (1964). The influence of Freud on American psychology. International University Press, New York

Strozier CB (2001) Heinz Kohut. The making of a psychoanalyst. Farrar, Strauss and Giroux, New York

Thomä H, Kächele H (1989a) Teoria y Practica del Psicoanalisis. 1 Fundamentos, Bd: Fundamentos. Editorial Herder, Barcelona

Thomä H, Kächele H (1989) Teoria y Practica del Psicoanalisis. 2 Estudios clinicos. Editorial Herder, Barcelona.

Tuckett D (1994) The conceptualization and communication of clinical facts in psychoanalysis. Int J Psychoanal 75: 865-870

Vaidyanathan T, Kripal J (Eds.) (1999). Vishnu on Freud´s desk. A reader in psychoanalysis and hinduism. Oxford: Oxford University Press.

Varvin S (2008). What do we know about what works in psychoanalysis and psychoanalytic psychotherapy: Research findings, clinical experience and experience from psychotherapy in China. 5th World Congress for Psychotherapy, Beijing Oct 12-15.

Wallerstein RS (1989). The psychotherapy research project of the Menninger Foundation: An overview. J Consult Clin Psychol 57: 195-205.

Wallerstein RS (1995) The talking cures. The psychoanalyses and the psychotherapies. New Haven: Yale University Press.

Wampold B (2001). The great psychotherapy debate. Models, methods and findings. Mahwah, NJ: Lawrence Erlbaum.

Prof. Dr. med. Dr. phil. Horst Kächele
Klinik Psychosomatische Medizin und Psychotherapie
UniversitätUlm
Am Hochstraess 8
89081 Ulm / FRG
horst.kaechele@uni-ulm.de
www.horstkaechele.de