

PALACI

quiring structure building, rather than uncovering of unconscious conflicts. At the same time, some analysts introduced "parameters" into standard technique in order to meet these special needs. Still others regarded any deviation from standard technique with more disturbed patients as especially harmful (e.g., the Kleinians, Giovacchini).

Among many analysts, there was a growing feeling that drive theory did not adequately accommodate clinical observations on this subgroup of patients. A number of analysts (Hartmann, Winnicott, Khan) had attempted to utilize the concept of self, but without precise definition. Kohut initially proposed to use the concept of self within the framework of structural theory as part of the "contents of the mental apparatus." In Palaci's view, Kohut's greatest merit lay in his subsequently being able to break out of the structural framework; he then (1977) proposed a theory where the self became a supraordinate concept; within this new framework, oedipal drive theory has a delimited sphere of application. From the new vantage point, the analysis of transference should encompass not only oedipal conflicts, but also tensions resulting from unresolved preoedipal development and object relations; e.g., problems of inadequate separation, or unstable self-structures. The concept of transference to a self-object is seen as a major clinical contribution here.

Generally, Palaci sees Kohut's restructuring of theory as a "unique and boundary-breaking contribution." It places at the center of the work with a large group of patients "the threat of temporary fragmentation of the self and intrusion of grandiose archaic narcissistic structures and archaic self-object relations with the danger of dedifferentiation." This is seen as not just a matter of a new terminology and definitions, but rather as a distinct and novel approach to the issues. It has generated a number of useful new concepts; e.g., the bipolarity of the self, vertical and horizontal splits, in addition to the above-mentioned self-object transferences, fragmentation, and reactivation of archaic structures.

Returning to his theme of the application of psychoanalysis as against psychoanalytic psychotherapy, Dr. Palaci expressed the view that Kohut's contribution to the psychoanalysis of the self may necessitate a through rethinking of the traditional definitions and recommendations in this area.



PERSPECTIVES ON TECHNIQUE*

By Gerald J. Gargiulo

I would like to continue my discussion of analytic neutrality, not merely because the previous column was somewhat short, but mainly because neutrality is, I believe, one of the major concepts of psychoanalysis. All too frequently, the point bears repeating, neutrality is confused with some type of studied blandness towards the patient, or is articulated in terms of an intellectual construct implying that we, as analysts, are exclusively transference-objects for our patients and thus not real persons. I hope my previous column clarified some of the difficulties with such an approach. The question is not whether we are real persons to our patients; obviously, our clothes, office, speech and, most importantly, our professional mores all manifest the latent person, so to speak. The question is how we, as analysts, can be personally present to our patients and yet not intrusively intimate; how we can achieve the needed empathic responsiveness which involves a certain identifying with and even, perhaps, a temporary merging with a patient, and yet avoid a narcissistic counter-transferential involvement. These are not facile issues to resolve, nor do they lend themselves to easy explication since they reflect a paradox within analytic practice. And it is a paradox that we have been slow to discuss in our literature.

TECHNIQUE*

Before discussing this further, let me mention why the use of neutrality is so distinctive to psychoanalysis. Certainly, other mental health practitioners, or teachers, and sometimes even weary parents will resort to analysing resistances or defenses. (Such has even been known to be indulged in by new analysts on the first available object they encounter when leaving a session.) In addition, the content of what analysis has uncovered has, by now, been disseminated into many fields. Thus oedipal constellations or discussions about pre-oedipal rapprochement meanderings are certainly not the exclusive domain, nor should they be, of psychoanalysis. Nor is the clinical setting in itself, as we know from all the variety of therapeutic modalities available, distinctively psychoanalytic. But what is particularly noteworthy about psychoanalysis is, I believe, the neutrality the analyst is expected to bring to himself. In this vein Kohut speaks of an analyst's empathic identification with the patient as well as a simultaneous self-observing awareness--that is, a personal receptivity to whatever the patient may say and a capacity to reflect to the patient the import of what he says, not only in view of his total situation but also in view of its reverberations in the analyst. We must, therefore, correspondingly match the patient's free associations with our free associations. All of this must be done with as little narcissistic self-preoccupation as an analyst can allow himself, given the fact that he is using himself so extensively in hearing what the patient is saying. The response we, as analysts, bring to the analytic-play-space-between-us is shaped by our personal but disciplined subjectivity. And such discipline is necessary since there are few professions where one must so minutely be sensitive to what is being created between two people. Neutrality is an aspect of that disciplined subjectivity.

If the relationship between patient and analyst evokes an intrusive intimacy (narcissistic self-preoccupation) on the part of the analyst, then we have a loss of disciplined subjectivity; we have, to follow Winnicott's use of the term, the loss of professional barriers, the presence of countertransference. Such countertransference is presumptively present when there is sexual contact between a patient and analyst, but it is not limited to this. If a patient is expected, quite unconsciously on the part of the analyst, to compensate for the analyst's own narcissistic wounds by making the analyst a hero-savior by, for example, remaining in treatment for fourteen or sixteen years; or if the analyst is not only a training analyst but also takes over the function of being a control analyst for an analytic candidate, then in such situations as these we have cause for concern. It is also possible that an analyst's own competitive aggression can burden the patient with becoming noticeably better before, perhaps, the necessity for the patient to get noticeably worse. Nor, as we know today, is the presence of sexual oedipal fantasies the sure sign of lifting of repression: it may very well be produced in response to the analyst's expectations. Finally, by way of example, if an analyst hears his own recent divorce decision echoed in a patient's associations about his own marital status, we have the probability of personal intrusiveness. Of course, the difference between being personally present to patients and being narcissistically intrusive can be understood in terms other than these; it must be understood, to follow Winnicott again, in terms of the overall tone the analytic process reflects.

Our distinctively analytic contribution to the interface between us and our patients is our neutrality. It is this disciplined subjectivity, what I have called the analyst's neutrality toward himself, that enables him to contribute, in a way that aids the innate developmental growth processes, to what is happening between him and the patient. As we match the patient's free associations, so do they also match our self-neutrality. Their contribution is an internal openness or honesty, as it were. This does not imply the absence of defenses, but rather a willingness to bring those defenses and, most importantly, the developmental injuries which are their root to this place where therapy is occurring. And a positive prognosis in analytic treatment is closely related to a patient's capacity to bring his or her own developmental injuries to the fore. Of course, this is no easy task for the patient--nor for the analyst; and thus the flight into neutrality, understood as some kind of expressionless mask we don for our patients, is understandable. To bring neutrality to ourselves, however, is much more of an open-ended process, for it robs us of the consolation of interpreting the patient's pathological processes without simultaneously understanding our own.

*copyright 1979