

## **Clinical Comparative Method, A New Way of Studying Psychoanalysis**

In recent years, psychoanalysis has fragmented into a number of competing theories and techniques about understanding and working with the dynamic unconscious. Many of us have welcomed such differences as a creative way forward. But for real development to proceed, we need to develop a means of evaluation of these differences as they evolve. The usual academic way of resolving innovative differences is to subject the collected data to scrutiny and debate, leading to an eventual consensus about what is most useful. This has not happened in psychoanalysis. Analysts have not systematically collected the raw data of recorded clinical hours. On the one hand, there are concerns about confidentiality and disturbing the delicate balance in the consulting room by recording. On the other hand, there is a suspicion of clinical material as being too subjective and the difficulty in recording many of the non-verbal processes. Equally stifling is the experience of presenting clinical material in a group setting. The usual practice is to “supervise”, that is, each group member interprets the material according to their own personal theory, effectively talking past each other. Most clinical discussions regress into theoretical struggles. There is the need to prove the superiority of one’s own beliefs and the need to compete successfully in the group. Thus, there is no way to meaningfully evaluate the clinical data (Tuckett, 2007). What are often missing in these types of discussions is how individual analysts think about their work and how that thinking informs their technique. Only then would it be possible to start to compare and contrast differences.

David Tuckett and his European colleagues (2008) have been trying to develop a method of examining an individual analyst’s theories and working practices in a systematic examination of what the analyst actually does. This has come to be called the Comparative Clinical Method. This project started in Prague in 2002; groups of 10-14 analysts were invited to an extended discussion of case material from one analyst. At the beginning, 5 hours was devoted to two cases. This has evolved to a study of one case for 11 hours. The prime assumption is that each presenter is considered a psychoanalyst and this fact is not to be debated. The working task of the CCM group is to understand (a) how this analyst works with this patient at this time, and (b) to place that work within a range of practices, to flesh out convergences and difference. Free discussion did not work well; it tends to quickly evolve into basic assumption groups and power struggles. What has evolved over time is what is called the Two Step method.

The overall focus is the explanatory models of the analyst, both those that he or she can articulate consciously and those which are implicit, deriving from both training and personal experience. Actual knowledge of the rules followed in conduct may not be explicitly available to the working analyst and is often only seen in the practice itself. Thus it is not helpful to ask the analyst what they do. Observers must construct what is normative conduct that is implicit in the clinical material of actual work.

In presenting clinical work, the presenting analyst has both to present his or her own views and to be open to hearing of blind spots and new ideas. Group members may have

access to information that the presenter does not have, being outside the dyad, but can easily be pulled into judgments and/or parallel process enactments. The goal, then, of such discussions should be to allow for unconscious and implicit ideas to emerge in both the presenter and the group members. If the group members are diverse, a number of explanatory models will be present in the room that will allow the group as a whole to usefully enquire into the particular explanatory model that the presenter is using, both consciously and unconsciously. The moderator of such groups is critical to maintaining the frame and creating a working group. The moderator works with the presenter to select appropriate clinical material. The moderator in the group tries to continuously inject curiosity into the group, bring out difference among the group members and get them to play with disagreements.

The Two Step Method currently works as follows. 8-12 group members, ideally of diverse psychoanalytic backgrounds, are invited to participate. The presenter prepares 2-3 hours of written case material with as much detail as possible in the interchanges between the dyad. The group spends an hour in free discussion of the material provided to get to know the case and the different viewpoints in the room. In Step One, each intervention of the presenter is considered in depth. What was the purpose of the intervention in the analyst's mind? The group is asked to classify each intervention into 6 possible categories:

1. Maintaining the basic setting and frame
2. Brief and ambiguous comments aimed at the unconscious
3. Linking at a conscious level
4. Here and now fantasy
5. Elaborated or constructed meanings
6. Mistakes

This classification is mostly a means to an end. What is important is not the classification itself, but a deep discussion focusing on what the analyst is explicitly and implicitly trying to do. Having categories keeps the discussion more rigorous. The goal is to bring out and defend multiple points of view, hoping to expose hidden aspects of the analyst's intentions. This process will take 3-4 hours.

In Step Two, we take what we learned of what the analyst does to construct an explanatory model of linked beliefs about a psychoanalytic view of this patient:

1. What's Wrong and a psychoanalytic explanation of pathology
2. The Analytic Situation – a theory of transference
3. Listening to the Unconscious
4. Furthering the Process
5. How Analysis Works

These categories are designed to be relatively clear and to explore major psychoanalytic concepts 'in situ'. We try to avoid language associated with various schools. Each group members brings their own point of view, but which we then focus on the presenter's way of working. The presenter is asked to remain in the background but we check back from time to time about agreement. Our "constructed" models must be consistent with the presenter's way of working or we have failed in our task. We hope to

discover aspects of the model that have not been thought through by the presenter but make sense to the presenter and the group members. This process will take 4 hours.

In North America, a group of us have been working with Abbot Bronstein and David Tuckett to learn the method and form CCM groups here. Our first set of CCM groups was in June, 2008 in Atlanta. I participated as a group member with a European moderator and a South American presenter. Our second set of CCM groups was in January, 2009 in New York. I presented in a group with a Canadian moderator. Our third set of CCM groups was just completed in Chicago. I moderated a diverse group of European, American and South American group members with an Argentinean presenter.

Almost without exception, those who have taken part in these groups leave feeling excited and stimulated by the experience. It is truly a unique way to listen to clinical material and to gain an in-depth understanding of how an analyst works. We hope that each participant will be able to see more clearly their own explanatory models of how they work. Our next set of CCM groups will be at the National Meeting in New York in January. I invite all members to consider participating. I am also interested in thinking how this experience could be transformed into a teaching tool in the Institute.

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Tuckett, D. (2007). On the problem of comparing and discussing clinical material in psychoanalysis: implications for future standards of clinical work. *Psyche*.

Tuckett, D. et. al. (2008). *Psychoanalysis Compatible and Incompatible*. London: Routledge.