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ON THE THERAPEUTIC POTENCY OF KAISER'S TECHNIQUES: SOME MISUNDERSTANDINGS?

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Recent publications have stressed the absence of specific technique in Hellmuth Kaiser's writings on psychotherapy, suggesting that his approach consists of a mere humanistic, nondirective stance. The author demonstrates that this position is a skewed representation of Kaiser's views on psychotherapy. After a short historical perspective, the six most important principles of technique, which can be found throughout Kaiser's writings, are discussed. Finally it is shown how Kaiser himself may have originated some of these misunderstandings about his technique.

In two recent publications Kaiser's recommendations about psychotherapy have been characterized as "therapy without technique" (Paltin, 1993, p. 432) and "nontechnique-oriented" (Fierman, 1997, p. 6). If technique is meant here in a narrow sense as a specific, well-defined procedure such as transference interpretation in psychoanalysis or as following an A-B-C sequence as in cognitive therapy, such statements about Kaiser may be warranted. However, what the authors suggest is that, according to Kaiser, the therapist has no specific tools or goals other than establishing a genuine and nondirective relationship with the patient. Fierman remarked in this respect: "The single, concentrated task of the therapist is to offer the patient a relationship of nondirective communicative intimacy. Such a relationship would require that the therapist is authentic, egalitarian, nonavuncular [*sic*], nonpedagogic, spontaneous, and sharing" (1997, p. 10). Paltin states: "Therapy now became more of an attitude on the part of the therapist than a technique" (1993, p. 430). Though these statements are in themselves justified, they are not an adequate description and may be misleading by neglecting the technique in a more ample sense present in Kaiser's approach.

Through an analysis of Kaiser's writings on neurosis, psychotherapy, and technique, I will try to show that the task of the therapist, according to Kaiser, is a very specific one, though technique in the narrow sense cannot be predefined because it depends on the communicative act of the patient at each particular moment.

Before addressing the central issue of this article, a short summary of the evolution of Kaiser's views on psychotherapy is given.

A Short Historical Perspective

Kaiser finished his training as a psychoanalyst in Berlin in 1929, after having previously obtained his Ph.D. in Philosophy and Mathematics. From his first two articles, though they comprise a sharp psychoanalytic literary analysis, no specific guidelines for psychotherapy can be deduced (Kaiser, 1930, 1931). In 1934 he published a controversial article on problems in psychoanalytic technique, advocating "consistent resistance analysis," as opposed to the traditional "content-analysis," which consists of interpreting the patient's repressed affect and the childhood situation to which this affect belongs.

The idea of the analysis of resistance was first mentioned by Freud (1914/1957), who stated that

An English translation of Kaiser (1934) and also Reich (1933), Alexander (1935), and Fenichel (1935) can be found together in M. S. Bergmann and F. R. Hartman (Eds.), *The evolution of psychoanalytic technique*. New York (1990): Columbia University Press.

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it is important to make the patient acquainted with his resistance. Freud was not very specific on how or when these resistance interpretations should be applied, limiting himself to stating only that the patient should "work through" the resistance.

In 1933 Reich further elaborated this idea in what he called "character analysis." Reich argued that character resistance can hinder the classic content analysis, as every content interpretation is distorted by the typical rigid cognitive functioning of the patient's character structure. In tune with the concern of ego analysts in that period regarding premature interpretations, Reich showed that content interpretation could even be counterproductive, because the uncovered content may be distorted in a way to strengthen the character structure, creating new and even more sophisticated resistance. So he concluded that "It is not only what the patient says but how he says it that has to be interpreted" (1933, p. 49).

Reich was not entirely complete in his reasoning when distinguishing between character neurosis and symptom neurosis. He argued that character resistance is a special kind of resistance and the result of character neurosis. About its counterpart, symptom neurosis, he then confusingly remarked, "the more deeply we penetrate into its reasons, the more we move away from the actual compass of the symptom and the more clearly we perceive its basis in the character" (p. 47). What remains unclear is what type of "normal" resistance is left, once this character resistance is cleared. Reich avoided this delicate point and just argued that first character resistance has to be cleared by means of interpreting the patient's attitude, and "the analyst then takes up the analysis of content" (p. 56).

Kaiser tapped into this incomplete reasoning when in 1934, apart from discussing various crucial issues on technique, he put forth his more radical view. He basically subscribed to the view of Reich about the importance of the analysis of (character) resistance, but argued that content analysis is unproductive and unnecessary altogether, since removing resistance will automatically lead to the repressed content entering into consciousness (compare with Menninger, 1958, pp. 119–120). He did not state it in so many words but it would be warranted to say that for Kaiser it follows that all neurosis is, in fact, character neurosis.

Though receiving some support from Searl (1936), Kaiser's view that repressed material should not be interpreted was severely criticized by the influential Alexander (1935) and Fenichel (1935), who accused Kaiser of neglecting the unconscious and its specific characteristics. This article caused Kaiser to be marginalized from the psychoanalytic community because it implied a dissent from psychoanalytic drive theory in two basic aspects. First, he abandoned the primacy of the unconscious, putting it side by side with the manifestations of the ego. Fenichel sharply demonstrated the difference: "psychoanalysis must explain the phenomena [of the ego] too as arising from an interplay between unconscious—and in final analysis, biolgical—instinctual tendencies, and influences of the external world" (1935, p. 348). Second, Kaiser downplayed the importance of infantile object relations that Freud defined as an essential characteristic of psychoanalysis: "It consists of tracing back one psychological structure to another which preceded it in time and out of which it developed" (1913/1955, pp. 182–183). This is most clear in Kaiser's position with respect to transference; it is only relevant for analysis when accompanied by resistance. It should be dealt with not by tracing back its roots, but rather by maintaining a here-and-now orientation, pointing out the patient's rationalizations at that moment (compare with Paltin, 1993, p. 429).

Because Kaiser had to flee from Nazi Germany he did not practice as a psychoanalyst until 1949 when he was invited to work at the Topeka Institute. In this period Kaiser identified himself less and less with psychoanalytic theory, and an article written in 1955 represents his break with the psychoanalytic community. In "The Problem of Responsibility in Psychotherapy" he distanced himself even more from the genetic point of view, arguing that the origin of neurotic personality derives from the desire for closeness, in a regressive sense, which is attained through the mechanism of fusion or identification. The neurotic is not able to form meaningful relationships on the basis of equality or symmetry, each respecting the other's individuality and differences in personality. The patient will thus either annihilate his or her own personality, limiting awareness of parts of the inner experience and of his or her motivations, or annihilate the personality of the other, in order to maintain the illusion of closeness.

This conception of neurosis does not constitute a true theory, but an isolated assumption. The idea of resistance is maintained, now in the form of "maneuvers" to keep out certain content from

consciousness, most notably the motivation that leads to the patient's acts. These maneuvers may include inconsistent or incomplete reasoning, turning blank, or changing the subject. As a result, the patients do not see themselves as fully responsible for their actions; they experience their actions as not being really their own, or do not "feel at one" with their actions and words. The patients' actions are justified as being compelled by outer circumstances or "force majeur," though the possibility of a different course of action is obvious. Patients feel that they have no choice, feel compelled to act, know they have to act like this, fate decided for them, something in them made them do it. Or a patient may believe that he or she did it but did not want to do it, or he or she wanted but could not.

The task of the therapist thus is to "induce in the patient a sense of responsibility for what he says and does" (p. 206). Cure is the process in which the patients increasingly feel that words and actions are really and wholly their own. This concept can be found more recently in Shapiro's "autonomy" (1981) and Shafer's "action language" (1976).

In his posthumously published work "The Universal Symptom of the Psychoneuroses" (1965), Kaiser maintained the fusion hypothesis as the causative explanation for neurosis, but did not elaborate on it further. Resistance can be found in the form of character resistance that resides in the general communicative attitude of the patient. This resistance may be very faint and only reveal itself over many sessions. Kaiser referred in this respect to a shift in the gestalt perception of the patient by the therapist. After an initial phase of the patient making perfect sense in what he or she is saying, the therapist starts to feel estranged by certain aspects of the patient's communication, as if two messages are being sent at the same time. The patient is not talking "straight"; the words are somehow not fully convincing because they lack the adequate emotional coloring or represent a logical fallacy. The hearer experiences the words as distant, indirect, or artificial and not as a straightforward self-expression from the patient.

Kaiser concluded that this "duplicity" represents a universal symptom that can be found in all neurotic patients. Responsibility is incorporated in the concept of duplicity and has become one of the aspects of duplicity. The therapist has to provide a consistently straight communication, with the objective of exposing the patient's duplicity. Progress can be detected as the patient displays a straight communication, diminishing his or her duplicity.

Kaiser Recommendations on Technique

In Kaiser's writings between 1934 and 1965, changes in his theory of neurosis also changed the rationale for his therapeutic interventions. In 1934 the interventions were directed at eliminating resistance, in 1955 at increasing the sense of responsibility, and in 1965 at diminishing duplicity.

The technique itself, illustrated in numerous vignettes, which constitute a kind of ideal intervention. Clarified by Kaiser's explicit considerations about technique, it has remained surprisingly constant, in spite of the broad theoretical shifts. A discussion of the characteristics of technique that can be found throughout his writings follows.

1. *The importance of "inner experience."* In all his writings the object of the therapeutic intervention has remained the same: the patient's inner attitude toward his or her own actions and words and the way the patient experiences his or her inner situation. Shapiro (1989) elaborated on this concept and called it "subjective experience."

The therapist tries to draw the attention of the patient to aspects of the inner experience that are not recognized by the patient. The patient's awareness of inner experience brings about a "reordering of the concept of his inner situation" (Kaiser, 1955, p. 209).

Kaiser remarked about the process of change that is brought about in the awareness of the inner experience: "He is not lying, neither does it represent a conscious effort on the part of the patient. He is not dishonest in the beginning and later abandons his lies, for at every stage he expresses his conviction as best as he can" (1955, p. 210).

Some examples of Kaiser's interventions that draw attention to these unrecognized parts of the inner experience include the following:

Patient: "I have a question to ask and I wish you would give me a straight answer."
Therapist: "You think your question is such that I would feel inclined to dodge it?" (Kaiser, 1955, p. 207)

Patient: "You are asking many questions."
Therapist: "And you think that that is wrong?"
(compare with Kaiser, 1962, p. 112)

The patient is silent for a long time in the beginning of a session.

Therapist: "You indicate that you are immersed in thought and almost not aware that you are here."
(Kaiser, 1965, p. 91)

Therapist: "You say things are black when you feel grey."
(Kaiser, 1965, p. 80)

2. *Duplicity as a focus of therapy.* A second characteristic of Kaiser's interventions is that they point out some kind of inconsistency, which exists in the construct the patient draws up from himself or herself and his or her experience. In 1934 he referred to these inconsistencies as "erroneous thoughts," faulty thinking that remains intact by a lack of attention: "if this highly intelligent person had focused his attention on these thoughts, he could hardly have maintained his conviction" (p. 495). In 1955 these inconsistencies were described as the artifacts that the patient draws up, especially with respect to the motivational responsibility for his or her actions. Flaws in reasoning and sloppy logic permit that the patient does not feel his or her actions as coming from self-motivation, and does not seem to be "behind" or "present" in his or her words. In 1965 Kaiser introduced the term duplicity and the concept that the inconsistency resides in the general attitude of the patient. The patient is not "talking straight"; the patient claims certain feelings or opinions but somehow the general attitude with which this is communicated is at odds with the verbal message. Through their communications, the neurotic patients want (us) to believe something about themselves, which is not consistent with reality. They claim to be something they are not, to feel things they do not really feel, to have opinions that are not really theirs. Similar ideas can be found in the concept of "double bind communication" (Bateson, Jackson, Haley, & Weakland, 1956), "incongruence" (Rogers, 1959), and more recently the concept of "split" by the experientialists (Greenberg & Pavio, 1997; Greenberg, Rice, & Elliot, 1993).

Examples of interventions, which point out these inconsistencies, are:

A patient stated he wanted to meet his brother-in-law and is sorry he could not make it. The therapist asked the reasons for his angry mood, which is inconsistent with the patient's statement affirmation. (Kaiser, 1934, pp. 494–495)

A patient stated in a rather triumphant manner that he would like to talk about certain things with the therapist, but that he could not. Kaiser pointed out to him that if this were entirely true he would feel sad, which he does not. (Kaiser, 1955, p. 209)

A patient stated that he was beyond hope and that the therapy could not help him. Kaiser confronted the patient with the idea that if he were fully convinced of this he would not come to the therapy sessions at all. (Kaiser, 1965, p. 88)

3. *The experiential detection of duplicity.* It is possible to give examples of duplicity but it is not possible to describe duplicity exhaustively because the inconsistencies can take innumerous forms. Kaiser described an experiential process through which the therapist could detect duplicity: after an initial phase in which the patient seemed to make perfect sense (compare with Reik, 1948, p. 129), a new or second gestalt came up where the therapist started experiencing the patient's communication as not being straight. It may take many sessions for this second gestalt to appear. The advantage of this experiential definition of duplicity is that it provides a valuable heuristic that allows for the detection of all forms of duplicity, especially atypical or subtle ones. A contemporary version of the principle of the therapist's feelings as a diagnostic tool can be found in the work of Safran (Safran, 1998; Safran & Segal, 1990).

Kaiser's examples of this experiential detection of duplicity follow:

A woman who came to therapy because she lost her interest in sex after her child was born, seemed very worried with the correctness of her representation of the facts, constantly correcting herself and apologizing. The therapist felt confused, since the interest in the subject disappeared as soon as the report was finished, suddenly switching to completely unrelated subjects. (Kaiser, 1965, pp. 48–50)

A man claimed his life was meaningless to him, though he was successful in every area of his life. When he told of dramatic experiences from his childhood, this seemed not intended to provoke sympathy for his misery. Instead, he told his story in such a determined way that the therapist felt kept under a spell, feeling "assaulted, struck by a blow." (Kaiser, 1965, pp. 51–52)

A patient who came to therapy to "understand himself better" talked about himself in an apparently open and civilized way. The therapist had the odd feeling that the patient was talking "in front" of him instead of to him, as if he showed himself to the therapist so that the therapist could treat him. (Kaiser, 1965, pp. 52–53)

4. *Avoiding content analysis.* Throughout his writings Kaiser remained faithful to the principle formulated in 1934 that content analysis should be avoided and that the proper technique is the consistent analysis of resistance.

As previously pointed out, Kaiser was inspired by Reich in this respect. However, it has gone somewhat unnoticed that there is a marked difference between Reich and Kaiser regarding their understanding of the actual technique of resist-

ance analysis. Reich stated in this respect: "we endeavor to arouse his interest in the particularities of his character in order to elucidate, with his help, their meaning and origin through analysis" (1933, p. 54). Reich thus may have offered tentative interpretations of certain aspects of the patient's character or talked with the patient about their meaning. For Kaiser, such an approach implied the same risk as content interpretation, meaning that the patient is still in a position where he can deny and draw up an even firmer resistance. Though Kaiser never referred specifically to this difference in technique in relation to Reich, he was quite clear about this point: the therapist should refrain from such interpretations but consistently draw the attention to faulty thinking itself.

Some examples of avoiding content interpretation include these:

A patient argued that not making it to a meeting with his brother-in-law, was not his fault, although he was very eager to see him. From his irritated mood it was clear from the beginning, that he did not like his brother-in-law. Kaiser did not give this interpretation, but instead confronted him with not taking into account the obvious alternative course of action, like not answering an unexpected phone call or taking a cab, which would have made the encounter possible. (Kaiser, 1934, p. 499)

A patient stated that he did not want to tell his secrets to the therapist. Kaiser argued that explaining to the patient that he in fact wished to tell his secrets would gear up new and more sophisticated resistance in the patient. (Kaiser, 1955, p. 208)

5. *The "correct" use of language.* Kaiser used language in an extremely careful and precise way. He contended that many communications of patients are not what they seem to be; questions are not real questions intended to obtain information, but to obtain effect. Words are not used in the correct context, many things are assumed but remain unsaid, and sentences and questions are grammatically incomplete and therefore dubious. Kaiser was a real linguistic detective at finding the intricacies and duplicity in the patient's use of language and skillfully pointed out how the "incorrect" choice of words by the patient implies subtle differences in meaning, and does not correctly describe his or her subjective experience.

The following are examples of "correcting" the choice of words:

Patient: "I know I should tell my thoughts in therapy, but I simply don't want to."
Therapist: "You feel that you should tell them, but you don't want to?" (1955, p. 207)

Patient: "I can't tell you that."
Therapist: "You don't wish to tell me that." (compare 1955, p. 207)

Patient: "I do not understand."
Therapist: "I think you understand what I said but you can't quite believe it." (1965, p. 72)

Patient: "No, that's not what I wanted to say. I'm sorry."
Therapist: "Are you sure? I rather got the impression that that was exactly what you felt like saying, while at the same time you seemed to feel you shouldn't." (1962, p. 116)

Ambiguity in questions is demonstrated as follows:

Patient: "Would you think it helpful if I told you my secret thoughts?"
Therapist: "Helpful for what, for whom?" (1955, p. 207)

Patient: "Should I start now?"
Therapist: "With what?" (1965, p. 46)

These are examples pointing out the implicit meaning:

Patient: "If I wished to, I could."
Therapist: "But it seems you cannot wish to." (1955, p. 207)

The patient does not finish his sentence.
Therapist: "And you think the rest is obvious." (1955, p. 207)

Patient: "I do not believe in self-deception."
Therapist: "And your coming here for the purpose of getting help, as you say, comes dangerously close to self-deception?" (1965, p. 93)

6. *A stepwise method.* When reading the vignettes of Kaiser it can be seen that he applied a stepwise and carefully dosed method to demonstrate the duplicious aspects of the communication to the patient, again, in order to avoid new resistance.

It is therefore important that the aspects pointed out by the therapist, which are not fully noted by the patient, should be experientially accessible or directly perceivable by the patient. In 1934 Kaiser remarked in this respect that it is important to focus on the preconscious aspects of the patient's experience and that primacy should be given to the most recent utterance of the patient, since this one has the most affective meaning. In leading the patient step-by-step, he or she cannot resist or deny and will be brought to a point where the content enters into consciousness. The patient feels his or her wish or urge but cannot go back anymore, and thus has to change the conception of self.

It is difficult to illustrate his stepwise method with examples because it depends on the therapist's evaluation of what can be recognized by

the patient, or in other words, what is preconscious. For one patient it may be possible to draw direct attention saying, "Why do you sound so angry?" and leading the patient to acknowledge the unrecognized emotion, while in another case the therapist feels that the patient may resist this intervention. The therapist then will choose to call attention to the patient's stuttering and getting red as a secure partial step to the same aim.

Conclusions

As can be seen from the above-mentioned characteristics, Kaiser clearly established guidelines for the therapist's intervention in the therapeutic process. As such it would be too skewed a view to think of Kaiser's approach as being without technique.

Kaiser is generally thought of as an experiential therapist (e.g., Fierman, 1997; Paltin, 1993). This is warranted, as demonstrated by the previously noted characteristics, because the inner experience of the client is central to Kaiser's approach. However, elements can be found in the work of Kaiser that are forerunners of an interpersonal approach: resistance as a communicative maneuver, the detection of duplicity through its effect on the therapist, and the curative power of a nonduplicitous communication. Keeping these interpersonal elements in mind may result in a more complete conceptualization of Kaiser's approach (compare with Safran, 1999, p. 14).

The misconceptions, that surround the interpretation of Kaiser's ideas may partly stem from the last section of his 1965 publication, in which he discussed the difficulty in conveying correctly the concept of straight communication. He stated that any technical recommendation might introduce duplicity on the part of the therapist by the mere effort of the therapist to comply with this recommendation, trying to do the right thing (p. 162). It is there that he mentioned desirable attitudes of the therapist, such as being genuine, communicative, respectful, and supportive. But again he warned: "whenever you feel the need to do something, or to refrain from doing something for the purpose of showing concern, you can be certain that your concern is lacking" (p. 170). Confronted with this paradox, he then desperately concluded that it was impossible to recommend anything at all, since one can never be sure that the reader has the same inner experience needed to understand the idea Kaiser wanted to transmit. Any such recommendation runs the risk of contradicting itself.

Kaiser chose not to resolve this paradox, which has an obvious solution in stating that the therapist should try to be straight as best as he or she can. It seems that he preferred to maintain this philosophical doubt in order to alert others to the risks inherent in communication and the difficulty of avoiding duplicity. He thus also touched once more on the central issue of his thesis, the primacy of the inner experience, this time also for the therapist. It is not words that are important—these are often unclear and ambiguous—but the inner experience that is transmitted through them. This must be understood as a philosophical exercise to get a point across, not as a summative definition of his ideas about therapy.

Another point that may have fostered misunderstanding is that Kaiser suggested that all that might be needed to be effective is "to be with the patient" (Kaiser, 1965, pp. 157–159). With this pronouncement, all technical aspects of the intervention seem to have disappeared. All earlier recommendations about the therapist's being straightforward in his or her communication, pointing out duplicity and noncommunicative elements in the patient's behavior, and avoiding new resistance by being selective seem irrelevant in this light.

Of course the statement should not be taken literally. It is reminiscent of the phrase "All you need is love." Though valid, it is not a true statement in a strict sense. With love, but without food or water, we die. We may understand these as the words of an older person who, having experienced the ups and downs of life, summarizes in this way the essence of what he or she has learned. In order to truly understand what this conclusion means, one would need to have experienced all that has led to this conclusion; otherwise the statement is nothing but empty words. Without taking the technical background into consideration, the words "to be with the patient" are equally empty. Clearly the statement should be understood as a conclusion, summarizing the essence of what Kaiser discovered after years of struggling with therapeutic technique.

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