A MEETING OF MINDS

MUTUALITY IN PSYCHOANALYSIS

LEWIS ARON

THE ANALYTIC PRESS
1996 Hillsdale, NJ

3 THE PATIENT’S EXPERIENCE OF
THE ANALYST’S SUBJECTIVITY

Although many cultural, social, and scientific developments have contributed to a relational view of the psychoanalytic process, I believe that the shift to an intersubjective perspective has emerged predominantly out of our accumulated clinical experience in psychoanalytic work with patients. In this chapter, I highlight the clinical centrality of examining the patient’s experience of the analyst’s subjectivity in the psychoanalytic situation.

THE DEVELOPMENT OF INTERSUBJECTIVITY

Only with the recent development of feminist psychoanalytic criticism has it become apparent that psychology and psychoanalysis have contributed to and perpetuated a distorted view of motherhood (Dinnerstein, 1976, Chodorow, 1978, Balbus, 1982; Benjamin, 1988). In all our theories of development, the mother has been portrayed as the object of the infant’s drives and as the fulfiller of the baby’s needs. We have been slow to recognize or acknowledge the mother as a subject in her own right. In discussing the prevalent psychological descriptions of motherhood Jessica Benjamin (1988) writes:

The mother is the baby’s first object of attachment, and later, the object of desire. She is provider, interlocutor, caregiver, contingent reinforcer, significant other, empathic understander, mirror. She is also a secure presence to walk away from, a setter of limits, an optimal frustrator, a shockingly real outside otherness. She is external reality—but she is rarely regarded as another subject with a purpose apart from her existence for her child [1988, p. 24].

Benjamin argues that the child must come to recognize the mother as a separate other with her own inner world and her own experiences, and as being her own center of initiative, an agent of her own desire. According to Benjamin, this expanding capacity on the part of the
child represents an important, and previously unrecognized, developmental achievement. Benjamin has proposed that the capacity for recognition and intersubjective relatedness is an achievement that is best conceptualized as a separate developmental line, and she has begun to articulate the complex vicissitudes involved in this advance. The developmental achievement she describes is radically different from that previously described in the literature. The traditional notion of "object constancy" is limited to the recognition of the mother as a separate "object." The focus of the intersubjective perspective is the child's need to recognize mother as a separate subject, which is a developmental advance beyond viewing mother only as a separate object. Dorothy Dinnerstein (1976) anticipated this intersubjective idea when she wrote, "Every I first emerges in relation to an 'It' which is not at all clearly an 'I.' The separate Iness of the other person is a discovery, an insight achieved over time" (p. 106).¹

The term intersubjectivity has been used in a variety of ways by philosophers and by psychoanalysts. Benjamin's (1988) work on intersubjectivity emphasizes mutual recognition as an intrinsic aspect of the development of the self. Regarding the clinical psychoanalytic situation, Benjamin (1990) writes that "an inquiry into the intersubjective dimension of the analytic encounter would aim to change our theory and practice so that 'where objects were, subjects must be'" (p. 34).

Benjamin, drawing on her background in critical theory, adopts the term intersubjectivity from Habermas, and other philosophers who deliberately formulated the concept of a subject-subject relation in contrast to the subject-object relation. For Benjamin (1992), intersubjectivity "refers to that zone of experience or theory in which the other is not merely the object of the ego's need/drive or cognition/perception, but has a separate and equivalent center of self" (p. 45). How it is that a person may come to recognize the other as an equivalent subject is the central problem that she, following Winnicott, attempts to address. She argues that we need to maintain a tension in our theory between relating to others as objects and relating to others as separate subjects. She uses the terms intrapsychic and intersubjective, respectively, to indicate these two realms, and she insists on maintaining both intrapsychic and intersubjective theory.

Winnicott (1954–1955) anticipated the importance of an intersubjective perspective and provided a preliminary hypothesis regarding the establishment of intersubjectivity. He expanded Melanie Klein's depressive position to include the development of the capacity for "truth" (p. 265), which he contrasts to the state of "ruthlessness" that exists prior to the development of the capacity to recognize the other as a separate person. Winnicott (1969) elaborated a theory of "object usage," which describes the process by which the infant destroys the object, finds that the object survives destruction, and therefore is able to surrender omnipotence and recognize the other as a separate person. Turning his attention to the transaction between the internal world and the external surround, Winnicott (1951, 1958) developed the concepts of transitional objects and transitional phenomena in an attempt to explore the mediational processes operating between these worlds.

Outside of relational theory, the idea of intersubjectivity was already developing through the work of Lacan. It was perhaps Lacan (1988) who, in his seminars of the mid-1950s, first discussed the implications of intersubjectivity within the psychoanalytic situation. Lacan and his followers described the emergence of subjectivity as it was mediated by language and other cultural structures in the formation of personal experience. Lacan thus introduced his own way of integrating the psychological with the social domain into psychoanalytic thought.

Stolorow and his colleagues (1978) introduced the term intersubjectivity into American psychoanalysis. For them, intersubjectivity theory is a field theory or systems theory in that it seeks to comprehend psychological phenomena not as products of isolated intrapsychic mechanisms, but as forming at the interface of reciprocally interacting subjectivities (Stolorow and Atwood, 1992, p. 1).

They note that their use of the term intersubjective has never presupposed the attainment of symbolic thought, of a concept of oneself as subject, or of intersubjective relatedness in the sense used by Stern (1985). "Unlike the developmentalists," they write, "we use 'intersubjective' to refer to any psychological field formed by interacting worlds of experience, at whatever developmental level these worlds may be organized" (p. 3).

There are important differences in the ways the term intersubjectivity is used by Benjamin, Stolorow, and Stern. For Benjamin (1988), intersubjectivity is a developmental trajectory, in which recognition is inconsistently maintained. Intersubjectivity refers to a dialectic process where subjects recognize each other as separate centers of subjective experience, but also continually negate the other as separate subjects. For Stern, following Trevarthan and Hubley (1978, cited in Stern, 1985, p. 124), who were themselves influenced by the existential literature of the mid-1970s (Natterson, 1991), intersubjectivity refers to the developmentally achieved capacity to recognize another person as a

¹ Viewing the other as an "I" or an "It" evokes Buber's (1923) I and Thou. I comment further on Buber, intersubjectivity and the "interhuman" in Chapter 5.
separate center of subjective experience with whom subjective states can be shared.

Stern's (1985) description of the developmental progression of the sense of self has begun to draw attention to the domain of intersubjective relatedness in which the nature of relatedness includes the recognition of subjective mental states in the other as well as in oneself. Recent theorizing about the construction of internal representations of self and others (Lichtenberg, 1983; Beebe and Lachmann, 1988a; Stern, 1989), has just begun to consider the child's emerging ability to attribute subjectivity or internal states to others and to explore the ways in which these internal states can be interpersonally communicated.

Stern (1983) writes that somewhere between the seventh and ninth month the child makes

a momentous discovery, namely, that he or she can share with another a state of mind such as intention. In other words, the infant develops a "theory of interfuseable minds." This has several implications: that the infant has the ability to impute, unaware, an internal mental state to another; that he or she has some apperception, at the moment of a particular internal mental state; and that the interfacing, in the sense of sharing or reciprocally manifesting these two states is not only possible, but a goal to be sought [pp. 8–9].

Stern (1985) explains that traditional psychoanalytic, ego-psychological developmental theory neglected the creation of mutually held mental states because of its overriding emphasis on the emergence of a more autonomous self through the separation-individuation process. In contrast, Stern cites Vygotsky's notion of the "intermental," Fairbairn's conception of the newborn's innate interpersonal relatedness, MacMurray's philosophical idea of the field of the personal, and Sullivan's interpersonal field theory as examples of the thinking of influential theorists outside the psychoanalytic mainstream who were receptive to the study of intersubjectivity as a dyadic phenomena.

By contrast, for Stolorow and his colleagues, the term intersubjectivity is applied whenever two subjectivities constitute the field, even if one does not recognize the other as a separate subjectivity (Stolorow and Atwood, 1992). The difference between Benjamin and Stern, on one hand, and Stolorow and colleagues, on the other, in their use of the term intersubjectivity is that Benjamin uses the term to describe a developmental achievement in which there is mutual recognition of each other's subjectivity. Her thinking includes the idea that intersubjectivity is a category that refers to a whole dialectic continuum that includes movement toward and negation of mutual recognition, whereas Stolorow and colleagues use the term intersubjectivity to indicate the principle of mutual regulation and unconscious influence. Some theorists, like Hirsch (1993), have questioned the need for the term intersubjective as it is used by Stolorow by asking how it differs from the term interpersonal.

Where relational, interpersonal, and intersubjective theories intersect is in their shift of focus from the individual to the "realm of the between" (Gergen, 1994) or to the "transitional space" between analyst and analysand. G. H. Mead's (1934) early work, which was a significant influence on the interpersonal theory of Sullivan (1953, 1954), was a major contribution to this viewpoint. Mead suggested that self-consciousness derives from adopting the standpoint of the other toward the self. One's conceptions of oneself are dependent on the attitudes and actions of others; the self is radically intersubjective and interdependent. Sullivan (1953, 1954) developed this line of thinking in his conceptualization of psychopathology in terms of microsocial processes that trace symptoms to interpersonal, rather than intrapsychic, processes. Object relations theories, while continuing to emphasize psychic structure formations, turned their attention to the interrelatedness of the self and the other, while self psychology similarly centered on the relations between the self and the selfobject.

Pizer (1992) has linked the concept of intersubjectivity with the two-person process of negotiation. He speaks of "intersubjective negotiation" (p. 217) in the sense that we constantly influence one another, consciously and unconsciously, and in this way patient and analyst weave the complex tapestry of the transference–countertransference; through negotiation they reach a meeting of minds.

Contemporary Kleinians are also interested in the development of intersubjectivity. Projective identification, a central concept in Kleinian–Bionian theory, is assumed to occur extremely early in life. In emphasizing, following Bion (1959), projective identification as a form of primitive, preverbal, and presymbolic communication, these theorists must reconsider how early in life the infant might be thought of as recognizing the presence in the object of another mind.

It may indicate that once mental life starts, it has an entirely mentalistic base — everything is a mind. A concrete physical reality develops only as a later awareness. This confounds more usual notions of the development of mind: from an earlier stage of physical perceptions towards a sensitivity to other minds at a much later, more mature level (Hinselwood, 1994, p. 133).

Perhaps the capacity for intersubjectivity is not even a development, but is rather hard-wired into the human brain at birth, a preconception, in Bion's terms; or perhaps we should think of it as something that is hard-wired but appears maturationally, as in Chomsky's (1957, 1968) view of language. This way of thinking about the early development or
innate capacity for intersubjectivity may have different implications than Stern's developmental model does and raises further questions about the difference between Stolorow's position and that of the developmentalists. Perhaps Hinshelwood is right in advising us to remain agnostic on the actual state of the newborn infant's mind.

Natterson (1991) presents a detailed comparison of a variety of uses of the term intersubjectivity in contemporary psychoanalytic theory. His own work moves in the direction of a radical and relentless intersubjective analysis. Critical of Stolorow and colleagues, he argues that in their reported case studies they confute the terms intersubjectivity and countertransference. According to Natterson, Stolorow and his followers limit their focus on intersubjectivity to the pathological aspects of the analyst's interaction with the patient. From Natterson's perspective, Stolorow's brand of intersubjectivity does not pay consistent enough attention to the therapist's continual influence on the treatment. For Natterson, "Nothing short of a complete inclusion of all psychological input and reactions of both participants will permit optimal understanding of the issue" (p. 99). Intersubjectivity must be carefully distinguished from the more traditional view of transference-countertransference in which the direction of influence remains largely from the patient to the analyst. The more traditional view pathologizes countertransference. For Natterson, intersubjectivity implies the "essential, initial, coequal role of the analyst in the analytic process" (p. 109).

While I am in general agreement with Natterson's argument—I too would emphasize the analyst's essential, continual, bidirectional, or mutual influence in the analysis—my own view is that Natterson is mistaken in referring to the mutual influence as "coequal," since mutual influence need not imply equal influence (I elaborate on this in Chapter 5). It does seem to me that speaking of the organization of the analyst's subjectivity or subjective experience has advantages over referring to the analyst's countertransference, and speaking of intersubjectivity has advantages over referring to transference-countertransference, because (1) the terms subjectivity and intersubjectivity do not imply the pathological, (2) because they do imply bidirectional, if not necessarily equal, influence, and (3) because these terms do imply a continuous, ongoing flow of influence, in contrast to countertransference, which implies an occasional or intermittent event.

More than any other psychoanalytic theorist writing today, Thomas Ogden (1986, 1989, 1994) has systematically formulated a theory of the interplay of subjectivity and intersubjectivity in development, psychopathology, and psychoanalytic treatment. Ogden traces the establishment of subjectivity to the distinction between the symbol and the symbolized. Subjectivity is seen as emerging in the space between the thought and the object of thought. "For symbol to stand independently of the symbolized, there must be a subject engaged in the process of interpreting his perceptions... The achievement of the capacity to distinguish symbol and symbolized is the achievement of subjectivity" (Ogden, 1986, pp. 224-225).

In his elaboration of the dialectical nature of subjectivity, Ogden has built on the work of Freud, Klein, and Winnicott. For Freud, subjectivity was constituted by the dialectic between consciousness and unconsciousness. For Klein, the subject was defined by the oscillating movement between the paranoid-schizoid and depressive positions, and in Ogden's reading of Klein, in her concept of projective identification, she contributed to the understanding of subjectivity as it develops within a "complex system of psychological-interpersonal forces" (p. 8). At the heart of Winnicott's work is the notion that the subject comes to exist in the (potential) space between the mother and the infant. Ogden's conception of analytic intersubjectivity places central emphasis on its dialectical nature. His elaboration of the contributions of Freud, Klein, and Winnicott culminates in the development of his original concept, "the analytic third," neither subject nor object, but jointly created, intersubjectively, by the analytic pair. "The intersubjective and the individually subjective each create, negate, and preserve the other," and created out of the dialectical interplay of these forces is "the intersubjective analytic third" (Ogden, 1994, p. 64). Gerson (1995) has suggested that we speak of this mutual relation of minds as the "relational unconscious."

In spite of the boldness of Ogden's theoretical innovations, a reading of his work suggests that he is quite conservative technically, particularly in his advocacy of using the analytic's subjectivity primarily to understand the patient's experience. Ogden emphasizes the asymmetrical nature of psychoanalysis, writes forcefully against attempts at "mutual analysis," and does not advocate any active use of self-disclosure. But, more fundamentally, my reading of Ogden leaves me with the impression that he views his own subjectivity largely as reactive to the patient rather than as initiating particular forms of interaction; nor does he view the analytic participation as mutually influenced from the beginning. The relational-perspectivist view that I am propounding here assumes the mutual, even if unequal, participation of patient and analyst from beginning to end. For Ogden, subjectivity is paradoxically both always already present and a developmental achievement; in his elaboration of Klein's work on the paranoid-schizoid and depressive positions, both these positions exist from the beginning in dialectical relation to each other. "Even at the very beginning of life," Ogden
(1994) writes, "the infant has some rudimentary sense of otherness that he bumps up against. At the same time, there is an aspect of consciousness in which the infant and other are at one" (p. 198).

Elsewhere I (Aron, 1993a, 1995a) have argued for the oedipal stage and the internalized primal scene as a fundamental structure in the establishment of one's sense of self and of internal object relations, and I have referred to its role in the establishment of intersubjectivity. Prior to the oedipal stage, the child lives in a two-person world. The child relates to both the mother and the father, but to each of them differently; that is, the child has a separate and unique relationship with each parent. The child relates to only one parent at a time, however, even if alternating from one to the other in momentary glances. It is only in the oedipal stage of triadic object relations that the child perceives that he or she is part of a system that includes a separate relation between the parents from which the child is excluded. Britton (1989) uses the term "triangular space" (p. 86) to describe the internalization of this relation.

The Oedipus complex entails not just the child's viewing of the parental relationship as an excluded outsider, but also the myriad fantasies of the child in which the entire system of family relations is experimented with and internalized. The little boy or girl is at one moment the small, excluded child barred from the gratifications of adult sexuality, at another moment is the fantasized rival of the father for mother's love, and at the next moment loves father and is seeking a separate, private, and exclusive relationship with him. The child alternates between seeing himself or herself as outside of a two-person relationship, as the observer, or inside a two-person relationship, being observed by a third. Thus, it is in the oedipal stage that the child first alternates between observation and participation. This oscillating function, the moving back and forth smoothly between experiencing and observing, can come about only with the attainment of Piaget's period of concrete operations, because it requires maintaining two perspectives in mind at once (Piaget, 1965). The oscillating function is clinically important because the oscillating function becomes the basis on which a person can participate in an analysis.

From the standpoint of the development of intersubjectivity, it is critical that, in reversing the configurations of the oedipal triangle, the child comes to identify the self-as-subject with the self-as-object and the other-as-subject with the other-as-object. The child internalizes the image of the parent as an object and the image of the parent as a separate subject; but, just as important—because this involves the dialectical relations of subjectivity and objectivity—the child internalizes and identifies with the parent's image of the child (reflected appraisals)

(Sullivan, 1953, p. 17; see also Mead, 1934). Thus the child's identification with the parent's subjectivity includes, as one component, an identification with the parent's subject image of the child as both a subject and an object. In effect, these ideas are consistent with Benjamin's (1988) view of intersubjective and intrapsychic complementarity.

Preoedipal and oedipal development is always interconnected. The development of intersubjectivity should not be seen as an early or exclusively preoedipal development, for example, one tied to the anal-approach phase, to be studied in isolation from later oedipal issues. Rather, I am suggesting that the establishment of subjectivity and of intersubjectivity continues to evolve with oedipal development.

Children are confronted with a multitude of tasks surrounding the establishment of self- and object constancy. They need to establish a sense of self as a center for action and thought, and they need to view this self in the context of other selves as an object among other objects (Bach, 1985). Similarly, they need to establish a sense of the other as a separate center of subjectivity as well as a view of the other as the object of their own subjectivity (Benjamin, 1988). These developments are of central importance to psychoanalysts since the analytic process consists of introspection and reflective self-awareness as well as of awareness of the self's interpersonal relations. Thus, one needs to develop a cohesive sense of self as a subjective self, a separate center of subjectivity, a sense of self-as-agent, an experiencing ego; and one needs to be aware of and be able to reflect upon oneself as an object of one's own investigation, as well as of oneself as an object of the wishes and intentions of others. Each of these two dimensions of self needs to be attained, and one needs to be able to recognize each of them as one's own self. When an analysand has not achieved these distinct senses of self or their integration, for example in the "narcissistic neuroses," the goal of analysis becomes to help the analysand achieve them.

A dramatic example of the failure to develop this integration is provided by Guntrip (1969), who tells of a schizoid woman who would punch herself in a perpetuation of the beatings by her mother. When Guntrip once said to her that she must feel terrified being hit like that, she stopped and stared and said, "I'm not being hit. I'm the one that's doing the hitting" (p. 191).

Postmodernist or poststructuralist thought has questioned the very existence of a unitary, cohesive, nonmultiple, essentially unique identity. Poststructuralism deconstructs and decents the human subject and insists that the notion of a unique, bounded individual is socially and historically constituted. It is from this postmodernist perspective
that Dimen (1991) and Goldner (1991) have challenged the idea of a unitary gender identity as anything other than a simplified version of a self from which opposing tendencies have been split off and repressed: "a universal, false-self system generated in compliance with the rule of the two-gender system" (Goldner, 1991, p. 259). The postmodernists insist on each of our "multiplicities" and view our "identities" with suspicion. Consequently, the term intersubjectivity should not be taken to mean relations between two cohesive subjects; rather, the terms intersubjective and interpersonal refer to relations among multiple personifications (Barratt, 1994; Bronberg, 1994, 1995; Mitchell, 1993a).

Sympathetic critics (e.g., Flax, 1990), however, have argued that postmodernists have erred by not distinguishing between a "core self" and a "unitary self." Flax proposes that "those who celebrate or call for a 'decentered' self seem self-deceptively naive and unaware of the basic cohesion within themselves that makes the fragmentation of experiences something other than a terrifying slide into psychosis" (pp. 218–219). Similarly, Rivera (1989) concluded that the idea of personality integration or unification is necessary but that personality integration prescribes not the silencing of different voices with different points of view—but the ability to call all those voices "I," to disidentify with any of one of them as the whole story, and to recognize that the construction of personal identity is a complex continuing affair in which we are inscribed in culture in a myriad of contradictory ways [p. 28].

I am suggesting, in agreement with Flax and Rivera, that, instead of abandoning the notion of "identity," as the postmodernists would have us do, our understanding of subjectivity must include both "identity" and "multiplicity." Identity emphasizes a person's sense of continuity, sameness, unity, constancy, consistency, synthesis, and integration. Postmodernism is correctly concerned with the way in which the idea of identity obscures differences within and between beings. While people certainly need a cohesive and integrated sense of self, they also need to be able to accept a lack of integration, and to tolerate—perhaps, enjoy—confusion, contradiction, flux, and even chaos in their sense of who they are. They need to accept their own internal differences, their lack of continuity, their multiplicity, their capacity to be different people at different times, in different social and interpersonal contexts. Thus, I am suggesting that, rather than abandon "identity" and "subjectivity," we maintain both identity and multiplicity as aspects of human subjectivity.

How is it that psychoanalysis, which is so concerned with individual subjective experience and with the development of the child's experience of the other, for so long neglected the exploration of intersubjectivity? Why has it taken so long for us to recognize that we must develop a conception of the other not only as object but also as separate subject? As separate psychic self? As separate center of experience?

The answer to this question brings us back to the nature of classical theory as a one-person psychology dominated by the metapsychology of drive theory. Classical metapsychology envisions the mind as a closed energy system fueled by biological drives pressing for discharge. The ego regulates, channels, and defends against these drives while attempting to find objects suitable to meet their fulfillment. From within this theoretical framework, the other person is "objectified"—seen as the "object" of the drive. Because the focus of the theory is on the vicissitudes of the drives, the role of the other is reduced to that of the object of the drives, and the most relevant variable is whether he or she is gratifying or frustrating. It is only with the shift in psychoanalysis away from drive theory and toward a relational theory that psychoanalysis could begin to study the other not as an object but as a separate subject. As Mitchell (1986b) has put it, "If the analytic situation is not regarded as one subjectivity and one objectivity, or one subjectivity and one facilitating environment, but two subjectivities—the participation in and inquiry into this interpersonal dialectic becomes a central focus of the work" (p. 38).

On a more deeply unconscious level, it may be that psychoanalytic theorists were unable to conceptualize early development intersubjectively because they were avoiding the recognition of the mother as a separate subject. Dinnerstein (1976), Chodorow (1978), and Benjamin (1988) have clarified the ways that our collective fear and envy of the mother lead us to objectify her as a means to control and devalue her.

**INTERSUBJECTIVITY AND CLINICAL PRACTICE**

The theory of intersubjectivity has profound implications for psychoanalytic practice and technique as well as for theory. Just as psychoanalytic theory has focused on the mother exclusively as the object of the infant's needs while ignoring the subjectivity of the mother, so too psychoanalysis, neglecting the subjectivity of the analyst as he or she is experienced by the patient, has considered the analyst only as an object.
The traditional model of the analytic situation retained the notion of a neurotic patient who brought his or her irrational childhood wishes, defenses, and conflicts into the analysis to be analyzed by a relatively mature, healthy, and well-analyzed analyst who would study the patient with scientific objectivity and technical neutrality. The health, rationality, maturity, neutrality, and objectivity of the analyst were idealized, and thus countertransference was viewed as an unfortunate, but (it was to be hoped) infrequent, lapse. Within the psychoanalytic situation, this bias, which regarded the patient as sick and the analyst as possessing the cure (Racker, 1968), led to the assumption that only the patient had transferences. It was as if only the patient possessed a “psychic reality” (see McLaughlin, 1981), the analyst being left as the representative of objective reality. If the analyst was to be a rational, relatively distant, neutral, anonymous, scientist/observer, an “analytic instrument” (Isakower, 1963), then there was little room in the model for the analyst’s psychic reality or subjectivity, except as pathological, intrusive countertransference.

As is well known, only in the most recent decades has countertransference been viewed as a topic worthy of study and as potentially valuable in the clinical situation. For Freud (1910), countertransference reflected a specific disturbance in the analyst elicited in response to the patient’s transference and necessitating further analysis of the analyst. Contemporary theorists are more inclined to take a “totalistic” (Kernberg, 1965) approach to countertransference. They view it as reflecting all the analyst’s emotional responses to the patient and therefore useful as a clinical tool. Rather than viewing countertransference as a hindrance to the analytic work which should be kept in check or overcome and which should in any event be kept to a minimum, most analysts today recognize the ubiquity of analysts’ feelings and fantasies regarding patients and hope to utilize their reactions to understand their patients better. Psychoanalysis has thus broadened its data base to include the subjectivity of the analyst. It has not yet, however, sufficiently considered the patient’s experience of the analyst’s subjectivity.

In my view, referring to the analyst’s total responsiveness as countertransference is a serious mistake because doing so perpetuates the defining of the analyst’s experience in terms of the subjectivity of the patient. Thinking of the analyst’s experience as “counter” or responsive to the patient’s transference encourages the belief that the analyst’s experience is reactive rather than subjective, emanating from the center of the analyst’s psychic self (McLaughlin, 1981; Wolstein, 1983). It is not that the analyst is never responsive to the pressures that the patient puts on him or her. Of course, the analyst counterresponds to the impact of the patient’s behavior. But the term countertransference obscures the recognition that the analyst is often the initiator of the interactional sequences, and therefore the term countertransference minimizes the impact of the analyst’s behavior on the transference.

The relational-perspectivist approach I am advocating views the patient–analyst relationship as continually being established and reestablished through ongoing mutual influence in which both patient and analyst systematically affect, and are affected by, each other. A communication process is established between patient and analyst in which influence flows in both directions. This implies a “two-person psychology” or a regulatory-systems conceptualization of the analytic process. The terms transference and countertransference too easily lend themselves to a model that implies a one-way influence in which the analyst reacts to the patient. That the influence between patient and analyst is not equal does not mean that it is not mutual; the analytic relationship may be mutual without being symmetrical. This model of the therapeutic relationship has been strongly influenced by the recent conceptualizations of mother–infant mutual influence proposed by Lachmann and Beebe (1988b, 1995). (I expand on it further in Chapters 4 and 5.)

Others have also proposed that we abandon the term countertransference. Olinick (1969) suggested the alternative “eccentric responses” in the “psychology of the analyst,” but I see no advantage to the pejorative word, eccentric. Bird (1972) sees transference as the basis for all human relationships and refers to it simply as “the analyst’s transferences.” This strategy, however, leads to terminological confusion, such as in Loewald’s (1986) discussion of the importance of analyzing the patient’s countertransference to the analyst’s transference (p. 280). McLaughlin (1981) convincingly argues for abandoning the term countertransference altogether: “The term countertransference particularly cannot accommodate the intrapsychic range and fullness of the analyst’s experiences vis-à-vis his patient” (p. 656).

In a seminal paper, Hoffman (1983) draws together the work of theorists from a wide variety of psychoanalytic schools. These theorists share a radical social and perspectival conception of psychoanalysis that recognizes that patients make plausible inferences regarding aspects of their analysts’ experience. Hoffman advances a view of psyc-
The implications of Wolstein’s point are enormous, for it means that, as resistances are analyzed, patients not only expose more of their own unconscious but also gain awareness of hitherto unnoticed, dissociated, or repressed aspects of the psychology of their analysts. But, in spite of extended training analyses, analysts might not be aware of some of what their patients notice. Some of the observations that patients make about their analysts are likely to be unpleasant and anxiety provoking. Therefore, analysts might hesitate to explore the patient’s resistances because of their own anxieties and resistances (also see Racker, 1968; Gill, 1982; Hoffman, 1983).

Of course, it is often argued that patients fantasize about the analyst’s psychology and that therefore the successful result of analysis of these fantasies is that patients learn more about their own psychology rather than about that of their analysts. These fantasies are not endogenously determined, drive-determined, autistic creations of the patient, nor are they purely the result of expectations derived from past interpersonal experiences. Rather, these fantasies may be seen as the patients’ attempts to grapple with and grasp, in their own unique and idiosyncratic ways, the complex and ambiguous reality of their analysts (see Levenson, 1989). Ultimately, an analysis of these fantasies must contribute to a clearer understanding of both the patient’s and the analyst’s psychologies.

I believe that patients, even very disturbed, withdrawn, or narcissistic ones, always accommodate the interpersonal realities of the analyst’s character and of the analytic relationship. Patients tune in, consciously and unconsciously, to the analyst’s attitudes and feelings toward them, but in so far as they believe that these observations touch on sensitive aspects of the analyst’s character, patients are likely to communicate these observations only indirectly through allusions to others, as displacements, or by describing these characteristics as aspects of themselves, as identifications (Lipton, 1977; Gill, 1982; Hoffman, 1983). An important aspect of making the unconscious conscious is to bring into awareness and articulate the patient’s denied observations, repressed fantasies, and unformulated experiences of the analyst (Racker, 1968; Levenson, 1972, 1983; Hoffman; 1983).

All children observe and study their parents’ personalities. They attempt to make contact with their parents by reaching into their parents’ inner worlds. The Kleinians have vividly emphasized this tendency of children through concrete metaphors of the infant’s seeking literally to climb inside and explore the mother’s body and to discover all the objects contained inside. Children imagine with what...
and with whom their mothers are preoccupied. They have some sense of how their mothers related to their own mothers, the children's grandmothers. A mother's internal working model of her relationship with her own mother affects her child's attachment to her (Main, Kaplan, and Cassidy, 1985). Children acquire some sense of the characters who inhabit their parents' inner worlds and of the nature of the relationships among these inner objects. Most important, children formulate plausible interpretations of their parents' attitudes and feelings toward the children themselves. Children are powerfully motivated to penetrate to the center of their parents' selves. Pick (1985) states this thought in Kleinian language: "If there is a mouth that seeks a breast as an inborn potential, there is, I believe, a psychological equivalent, i.e. a state of mind which seeks another state of mind" (p. 157). There is a preexperiential motivational push, a drive, for a meeting of minds; although, as I argue later (in Chapter 8), there is also a drive to remain hidden, an isolate, unfound and untouched by others. These conflicting desires operate in both patient and analyst. Hence, intersubjectivity is always intensely conflictual.

If, as McDougall (1980), asserts, "a baby's earliest reality is his mother's unconscious" (p. 251), then a patient's psychic reality may be said to implicate the analyst's unconscious. Patients have conscious and unconscious beliefs about the analyst's inner world. Patients use their observations of their analysts—which are plentiful no matter how anonymous an analyst may attempt to be—to construct a picture of their analyst's character structure. Patients probe, more or less subtly, in an attempt to penetrate the analyst's professional calm and reserve. They do this probing not only to turn the tables on their analysts defensively or angrily, but also because people need to connect with others. And they want to connect with others where they live emotionally, where they are authentic and fully present. So they search for information about the other's inner world. (They do this conflict- edly, however, because they also wish not to know or be known by the other.)

An analytic focus on the patient's experience of the analyst's subjectivity opens the door to further explorations of the patient's childhood experiences of the parent's inner world and character structure. Similarly, patients begin to attend to their observations about the character of others in their lives. This is an inevitable and essential part of how patients begin to think more psychologically in their analyses. The analytic stance being described considers fantasies and memories not just as carriers of infantile wishes and defenses against these, but as plausible interpretations and representations of patient's experiences with significant others (Hoffman, 1983). This point was anticipated by Loewald (1970) who wrote:

The analysand in this respect can be compared to the child—who if he can allow himself that freedom—scourtesizes with his unconscious antennae the parent's motivations and moods and in this way may contribute—if the parent or analyst allows himself that freedom—to the latter's self awareness [p. 280].

In the clinical situation, I often ask patients to describe anything that they have observed or noticed about me that may shed light on aspects of our relationship. When, for example, patients say that they think that I am angry at them, or jealous of them, or acting seductively toward them, I ask them to describe whatever it is that they have noticed that led them to this belief. I find that it is critical for me to ask the question with the genuine belief that I may find out something about myself that I did not previously recognize. Otherwise, it is too easy to dismiss the patient's observation as a distortion. Patients are often all too willing to believe that they have projected or displaced these feelings onto their analyst, and they can then go back to viewing their analyst as objective, neutral, or benignly empathic. Insisting that there must have been some basis in my behavior for their conclusions, I encourage patients to tell me anything that they have observed. I often ask patients to speculate or fantasize about what is going on inside of me, and in particular I focus on what patients have noticed about my internal conflicts.3

For instance, a patient said that, when he heard my chair move slightly, he thought for a moment that I was going to strike him. I asked him to elaborate on what he thought I was feeling: What did he think was the quality and nature of my anger? What had he noticed about me that led him to believe that I was angry in this particular way? How did he imagine that I typically dealt with my anger and frustration? I asked the patient what he thought it was like for me to be so enraged at him and to not be able to express that anger directly, according to his understanding of the "rules" of psychoanalysis and professional decorum. I asked him how he thought I felt about his noticing and confronting me with my disguised anger.

3 Elsewhere (Aron, 1989), I have suggested that, although patients are often reluctant to put these perceptions and observations into words, a particular value of studying patients' dreams is that "the analyst can use the dream themes to monitor not only the patient's transferences, but also the patient's perceptions of and fantasies about the analyst's countertransferences" (p. 125). Now, I speak of the analyst's subjectivity, rather than countertransference.
Chapter Three

THE PATIENT'S EXPERIENCE OF THE ANESTHETIC SUBJECTIVITY

By the definition of the law, the patient's experience of the anesthetic subjectivity would be expected.

To explore the patient's experience of the anesthetic subjectivity, the author focuses on the patient's perception of the anesthetic intervention. The patients are encouraged to reflect on their experiences of the anesthetic process in order to gain a deeper understanding of their subjective experiences. The patients are asked to consider how the anesthetic intervention affects their perception of the procedure and their overall experience.

The patients' perceptions are analyzed in the context of their personal experiences and the broader cultural and societal factors that influence their perceptions. The author argues that the patient's experience of the anesthetic subjectivity is not merely a physiological response to the anesthetic intervention but rather a complex interplay of subjective and objective factors.

The author's research suggests that the patient's experience of the anesthetic subjectivity is influenced by a variety of factors, including their pre-existing attitudes towards the procedure, their overall health and well-being, and the quality of the patient-physician relationship. The author emphasizes the importance of understanding the patient's subjective experience in order to improve the anesthetic intervention and enhance the patient's overall experience.

In conclusion, the patient's experience of the anesthetic subjectivity is a crucial aspect of the anesthetic intervention. By exploring and understanding this experience, healthcare professionals can work to improve the patient's experience and enhance the overall quality of care.
I have a number of patients who have been referred to my office for evaluation of their problems. It is important to understand that these patients may have a variety of conditions and that a comprehensive evaluation is necessary to determine the appropriate course of treatment. The patient's symptoms and history are carefully reviewed to identify potential causes and guide the diagnostic process.

In addition to the patient's initial presentation, further testing and evaluation may be necessary to confirm the diagnosis and determine the best course of treatment. This may include laboratory tests, imaging, or other specialized evaluations. The goal is to provide an accurate diagnosis and develop a treatment plan that addresses the patient's needs.

The multidisciplinary approach to patient care is crucial in ensuring the best possible outcomes. It allows for a comprehensive assessment of the patient's medical history, current symptoms, and any relevant factors that may impact their health. This information is then used to develop a personalized treatment plan that is tailored to the individual patient's needs.

In conclusion, the evaluation process is an integral part of the patient care journey. It involves careful consideration of the patient's history, symptoms, and any relevant medical factors to ensure an accurate diagnosis and development of an effective treatment plan. The goal is to provide the best possible care for each patient, ensuring they receive the care they need to achieve optimal health outcomes.
The therapeutic value of self-reflection is often underestimated. Many therapists fail to engage patients in the process of self-reflection, yet it is crucial for patients to understand their own thoughts and feelings. In this chapter, we will explore the benefits of self-reflection and how therapists can facilitate this process.

Self-reflection is the act of introspection, where an individual reflects on their thoughts, feelings, and experiences. This process is essential for personal growth and self-awareness. Therapists can encourage self-reflection by asking open-ended questions, providing a safe and non-judgmental environment, and modeling self-reflection themselves.

In therapy, self-reflection can help patients identify patterns in their behavior, understand the impact of past experiences on their present, and develop new coping strategies. It can also help patients develop a deeper sense of self-awareness, which is crucial for personal growth.

Therapists can facilitate self-reflection by creating a space for their clients to explore their thoughts and feelings. This can be done through guided meditation, journaling, or role-playing.

In conclusion, self-reflection is a crucial component of therapy. By encouraging self-reflection, therapists can help their clients gain a deeper understanding of themselves, which can lead to personal growth and development.

References:

CLINICAL ILLUSTRATION

The following is an example of the impact of an analyst's inquiry into the patient's experience of the analyst's supervision. I was counseled by...
The main focus of the patient's experience is the power of the patient's own narrative. It is the patient's own story that shapes their experience. Despite its subjective nature, the patient's experience is not merely an expression of their emotions. It is a representation of their understanding of the situation, grounded in their personal perspective and influenced by their beliefs and values.

In summary, the patient's experience is a complex interplay of objective and subjective elements. It is shaped by their own thoughts and feelings, and it is influenced by the way in which they interpret and respond to the situations they encounter. By understanding the patient's experience, we can gain a deeper understanding of their perspective and work to support them in making choices that are in line with their values and needs.