

SYMPOSIUM: *Reality and the Analytic Relationship*

The Patient's Experience of the Analyst's Subjectivity

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This article highlights the analysis of the patient's experience of the analyst's subjectivity in the psychoanalytic situation. 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 has considered the analyst only as an object while neglecting the subjectivity of the analyst as the analyst is experienced by the patient. The analyst's subjectivity is an important element in the analytic situation, and the patient's experience of the analyst's subjectivity needs to be made conscious.

Patients seek to connect to their analysts, to know them, to probe beneath their professional facade, and to reach their psychic centers much in the same way that children seek to connect to and penetrate their parents' inner worlds. The exploration of the patient's experience of the analyst's subjectivity represents one underemphasized aspect of the analysis of transference, and it is an essential aspect of a detailed and thorough explication and articulation of the therapeutic relationship. The paper explores controversies regarding the analyst's self-disclosure and countertransference.

THE PURPOSE OF THIS PAPER is to highlight the clinical centrality of examining the patient's experience of the analyst's subjectivity in the psychoanalytic situation. 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

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perspective has emerged predominantly out of our accumulated clinical experience in psychoanalytic work with patients. I would like to begin by noting some developments in two areas not directly related to clinical psychoanalysis: feminist thought and infancy research. My purpose is not to base clinical theory on the grounds of laboratory research nor to rest it on the movement to rectify social inequities; rather, because the implications of an intersubjective view are being clearly spelled out in these areas, they provide an illustration of what I mean by 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, 1973; Chodorow, 1978; Balbus, 1982; Benjamin, 1988). In all of 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, Benjamin (1988) recently wrote:

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 [p. 24].

Benjamin has argued that the child must come to recognize the mother as a separate other who has her own inner world and her own experiences and who is her own center of initiative and an agent of her own desire. 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 in terms of a separate developmental line, and she has begun to articulate the complex vicissitudes involved in this advance. This developmental achievement is radically different from that which has previously been described in the literature. The traditional notion of "object constancy"

is limited to the recognition of the mother as a separate "object." What is being emphasized from an intersubjective perspective is the child's need to recognize mother as a separate subject, a need that is a developmental advance beyond viewing mother only as a separate object. Dinnerstein (1976) anticipated this when she wrote, "Every 'I' first emerges in relation to an 'It' which is not at all clearly an 'I.' The separate 'I'ness of the other person is a discovery, an insight achieved over time" (p. 106).

Intersubjectivity refers to the developmentally achieved capacity to recognize another person as a separate center of subjective experience. 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 expands to include 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.

Winnicott (1954-1955) anticipated the importance of an intersubjective perspective and provided a preliminary hypothesis regarding the establishment of intersubjectivity. He expanded Klein's depressive position to include the development of the capacity for "ruth" (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) elaborates a theory of "object usage" that 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. Other theorists who have been examining the nature and development of intersubjectivity include Stern, 1985; Ogden, 1986; Kernberg, 1987; Stolorow, Brandchaft, and Atwood, 1987; and Bollas, 1989. It was perhaps Lacan (Miller, 1988) who, in his seminars of the mid-1950s, first discussed the implications of intersubjectivity within the psychoanalytic situation. I will not elaborate here on the developmental aspects of intersubjectivity since my present aim is to discuss intersubjective psychology as it is related to clinical psychoanalysis.

The theory of intersubjectivity has profound implications for psychoanalytic practice and technique as well as for theory. (It should be noted that in my understanding of intersubjectivity I have been influenced by

Benjamin [1988] and that my approach to psychoanalytic technique is quite distinct from that being developed by Stolorow, Brandchaft, and Atwood [1987].) 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 has considered analysts only as objects while neglecting the subjectivity of analysts as they are experienced by the patient.

The traditional model of the analytic situation maintained the notion of neurotic patients who brought their irrational childhood wishes, defenses, and conflicts into the analysis to be analyzed by relatively mature, healthy, and well-analyzed analysts who would study the patients 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 hopefully rare, 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 it was only the patient who had transferences. Furthermore, it was as if only the patient possessed a "psychic reality" (see McLaughlin, 1981) and the analyst was left as the representative of objective reality. In sum, 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, it is only in the most recent decades that countertransference has 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 and view it as reflecting all of 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 that should be kept in check or overcome and that 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 own reactions as a means 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 with the term *countertransference* is a serious mistake because it perpetuates defining 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 analysts are never responsive to the pressures that the patients put on them; of course, the analyst does counterrespond to the impact of the patient's behavior. The term *countertransference*, though, obscures the recognition that the analyst is often the initiator of the interactional sequences, and therefore the term minimizes the impact of the analyst's behavior on the transference.

The relational approach that I am advocating views the patient-analyst relationship as continually 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 approach implies a "two-person psychology" or a regulatory-systems conceptualization of the analytic process (Aron, 1990). The terms *transference* and *countertransference* too easily lend themselves to a model that implies a one-way influence in which the analyst responds in reaction to the patient. The fact that the influence between patient and analyst is not equal does not mean that it is not mutual. Mutual influence does not imply equal influence, and 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 Beebe and Lachmann (1988b).

Others have also suggested 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 term *eccentric*. Bird (1972) broadened the meaning of the term *transference* and sees it as the basis for all human relationships. He then suggests referring simply to "the analyst's transferences." This strategy, however,

leads to terminological confusion, such as in Loewald's (1986, p. 280) discussion of the importance of analyzing the patient's countertransference to the analyst's transference. McLaughlin (1981) convincingly argues for abandoning the term countertransference. He writes, "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 concept of psychoanalysis that recognizes that patients make plausible inferences regarding aspects of their analysts' experience. Hoffman advances a view of psychoanalytic technique that makes central the analysis of the patient's interpretations of the analyst's experience. In many respects the present paper may be seen as my efforts to grapple with and elaborate on the implications of Hoffman's contribution. While Hoffman entitles his paper "The Patient as Interpreter of the Analyst's Experience," he continues to refer to the patient's interpretation of the analyst's countertransference. Because of my objections to the implications of the term *countertransference*, I prefer to describe the focus of this paper in terms of the patient's experience of the analyst's subjectivity.

Racker (1968) was one of the first to make the technical recommendation that "analysis of the patient's fantasies about countertransference, which in the widest sense constitute the causes and consequences of the transference, is an essential part of the analysis of the transferences" (p. 131). Gill (1983) puts it simply and directly, although in my view this point has not received nearly the attention it deserves: "A consequence of the analyst's perspective on himself as a participant in a relationship is that he will devote attention not only to the patient's attitude toward the analyst but also to the patient's view of the analyst's attitude toward the patient" (p. 112).

Since, from a classical perspective, the analyst was viewed as participating with the patient in only a minimal way (Gill, 1983), very little attention was given to the impact of the individual analyst and the impact of the analyst's character. Analysts did not consider that patients would inevitably and persistently seek to connect with their analysts by exploring their own observations and inferences about their analyst's behavior and inner experience.

Wolstein (1983) has pointed out that resistances are defensive efforts

by patients to cope with a particular analyst and that these resistances must therefore be patterned by the patient to accommodate to some aspect of the analyst's unconscious psychology. The point is that the patient could find a specific defense or resistance to be effective only if in some way it was designed to match the personality of the patient's particular analyst. Therefore, the ultimate outcome of successfully analyzing resistances is that patients would learn more not only about their own psychologies but also about the psychology of others in their lives, particularly about the psychology of their analysts. Wolstein (1988) writes:

Nothing was more natural than for patients to turn the strength of this new awareness and reconstruction toward the psychology of their immediately enviroing others—especially their psychoanalysts—and describe the perceived aspects of countertransference against which they thought they had gone into resistance [p. 9].

The implications of this 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. 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 back off from exploring the patient's resistances because of their own anxieties and resistances (Racker, 1968; Gill, 1982; Hoffman, 1983).

Of course, it is often argued that patients can and do 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 than about that of their analyst. My point here is that these fantasies are not endogenously determined, drive-determined, autistic creations of patients, nor are they purely the result of expectations derived from past interpersonal experiences. Rather, these fantasies may additionally be seen as patients' attempts to grapple with and grasp, in their own unique and idiosyncratic way, the complex and ambiguous reality of their individual analyst (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 patients, are always accommodating to the interpersonal reality 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 inasmuch 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 through descriptions of 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 emphasized this point vividly through concrete metaphors of the infant's seeking literally to climb inside and explore the mother's body and to discover all of the objects contained inside. Children imagine with what and with whom their mothers are preoccupied. They have some sense, although they may have never thought about it, as to how their mothers related to their own mothers. There is now empirical research that documents that 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). The child acquires some sense of the characters who inhabit the mother's and father's inner worlds and of the nature of the relations 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 idea 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).

If, as McDougall (1980) asserts, "a baby's earliest reality is his mother's unconscious" (p. 251), then patients' psychic reality may be said to implicate their analyst's unconscious. Patients have conscious and unconscious beliefs about the analyst's inner world. Patients make use of their observations of their analyst, which are plentiful no matter how anonymous the 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 because they want to turn the tables on their analyst defensively or angrily but also, like all people, because they want to and need to connect with others, and they want to connect with others where they live emotionally, where they are authentic and fully present, and so they search for information about the other's inner world. 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 parents' inner world and character structure. Similarly, patients begin to attend to their observations about the characters of others in their lives. This development 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 wishes, but as plausible interpretations and representations of the 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—scrutinizes 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 patients' observations as distortions. Patients are often all too willing and eager 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. I encourage patients to tell me anything that they have observed and insist that there must have been some basis in my behavior for their conclusions. 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.

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 the patient to elaborate on what he thought I was feeling, what he thought was the quality and nature of my anger, what he had noticed about me that led him to believe that I was angry in this particular way, and how he imagined 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 not to 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.

I choose first to explore the patient's most subtle observations of me, which reflect my attitudes toward the patient as well as my character and personal conflicts, in preference to examining either the patient's own projected anger or the displaced anger of others in the patient's current or past life. All of this anger ultimately needs to be explored, but following Gill's (1983) recommendations, I begin with an analysis of the transference in the here and now, focusing on the plausible basis for the patient's reactions. It is important to note that I proceed in this way whether or not I am aware of feeling angry at that point. I assume that the patient may very well have noticed my anger, jealousy, excitement, or whatever before I recognize it in myself.

Inquiry into the patient's experience of the analyst's subjectivity represents one underemphasized aspect of a complex psychoanalytic approach to the analysis of transference. A balance needs to be maintained between focusing on the interpersonal and the intrapsychic, between internal object relations and external object relations. While at times exploring patients' perceptions of the analyst serves to deepen the work, at other times this focus is used defensively, by patient and analyst, to avoid the patient's painful inner experience (see Jacobs, 1986, p. 304 for a clinical illustration of this problem). For each time that I ask patients regarding their experience of me, there are other times that I interpret their focus on the interaction with me as an avoidance of their inner feelings and of looking into themselves.

While asking direct questions about the patient's observations of the analyst is often necessary and productive, the most useful way to elicit the patient's thoughts and feelings about the analyst's attitudes is to analyze the defenses and resistances that make these thoughts and feelings so difficult to verbalize. Asking patients direct questions about

their experience of the therapeutic relationship entails the disadvantage that it may appeal to more surface and conscious levels of discourse. The analyst needs to listen to all of the patient's associations for clues as to the patient's experience. Often the patient fears offending the analyst and provoking the analyst's anger by confronting the analyst with aspects of the analyst's character that have been avoided. Patients fear that they are being too personal, crossing over the boundary of what the analyst is willing to let them explore. Patients are especially likely to fear that if they expose the analyst's weaknesses and character flaws, the analyst will retaliate, become depressed, withdrawn, or crumble (Gill, 1982). Implicit in this fear are not only the patient's hostility, projected fears, or simply the need to idealize the analyst but also the patient's perception of the analyst's grandiosity, which would be shattered by the revelation of a flaw. The patient's expectations of the analyst are related to the ways in which the patient's parents actually responded to their children's observations and perceptions of them. How did their parents feel about their children's really getting to know who they were, where they truly lived emotionally? How far were the parents able to let their children penetrate into their inner worlds? Was the grandiosity of the parents such that they could not let their children uncover their weaknesses and vulnerabilities? To return to the rich Kleinian imagery of the infant's attempts in unconscious phantasy to enter into the mother's body, we may wonder whether the violent, destructive phantasies encountered are due only to innate greed and envy or whether they are not also the result of the frustration of being denied access to the core of the parents. Could these phantasies be an accurate reflection of the child's perceptions of the parents' fears of being intimately penetrated and known?

What enables patients to describe their fantasies and perceptions of the analyst is the analyst's openness and intense curiosity about patients' experience of the analyst's subjectivity. The patient will benefit from this process only if the analyst is truly open to the possibility that patients will communicate something *new* about the analyst, something that the patient has picked up about the analyst that the analyst was not aware of before. If, on the other hand, the analyst listens to the patient with the expectation of hearing a transference distortion and is not open to the likelihood and necessity of learning something new about himself or herself, then the analysis is more likely to become derailed or to continue on the basis of compliance and submission to authority.

The recognition of the analyst's subjectivity within the analytic situ-

ation raises the problem of the analyst's self-disclosure. The issues involved by the analyst's self-revelations are enormously complex and can only be touched on here. There are, however, a few comments that should be made because they are directly raised by the line of inquiry advocated in this paper.

When patients are encouraged to verbalize their experiences of the analyst's subjectivity, it is most likely that they will put increased pressure on the analyst to verify or refute their perceptions. It is extremely difficult and frustrating for patients to be encouraged to examine their perceptions of the analyst's subjectivity and then to have their analyst remain relatively "anonymous." Once analysts express interest in the patient's perceptions of their subjectivity, they have tantalized the patient (Little, 1951) and will surely be pressured to disclose more of what is going on inside themselves. Furthermore, the ways in which analysts pursue the inquiry into the patient's perceptions of themselves are inevitably self-revealing. I assume that one reason that analysts have traditionally avoided direct inquiry into the patient's experience of the analyst's subjectivity is that they recognized that pursuing this line of inquiry would unavoidably result in self-disclosure.

Self-revelation is not an option; it is an inevitability. Patients accurately and intuitively read into their analyst's interpretations the analyst's hidden communications (Jacobs, 1986). In unmasking the myth of analytic anonymity, Singer (1977) pointed out that the analyst's interpretations were first and foremost self-revealing remarks. It cannot be otherwise since the only way we can truly gain insight into another is through our own self-knowledge, and our patients know that fact.

Hoffman (1983) emphasized that patients know that the psychology of the analyst is no less complex than that of themselves. He challenged what he termed "the naive patient fallacy," the notion that the patient accepts at face value the analyst's words and behavior. For analysts simply and directly to say what they are experiencing and feeling may encourage the assumption that they are fully aware of their own motivations and meanings. The analyst's revelations and confessions may tend to close off further exploration of the patient's observations and perceptions. Furthermore, we can never be aware in advance of just what it is that we are revealing about ourselves, and when we think we are deliberately revealing something about ourselves, we may very well be communicating something else altogether. Is it not possible that our patients' perceptions of us are as plausible an interpretation of our

behavior as the interpretations we give ourselves? If so, then it is presumptuous for the analyst to expect the patient to take at face value the analyst's self-revelations. Pontalis (cited in Limentani, 1989) asks, "What is more paradoxical than the presupposition that: I see my blind spots, I hear what I am deaf to . . . and (furthermore) I am fully conscious of my unconscious" (p. 258).

We hope that we, as analysts, have had the benefit of an intensive analysis of our own, but this in no way ensures that we have easy access to our unconscious or that we are immune from subtly enacting all sorts of pathological interactions with our patients. This recognition has led to our contemporary acceptance of the inevitability of countertransference. Whereas in the past idealized, well-analyzed analysts were thought to have no countertransference problem, today's idealized analysts are thought to be so well analyzed that they have immediate and direct access to their unconscious. It is well to keep in mind that the trouble with self-analysis is in the countertransference! When analysis is viewed as a coparticipation (Wolstein, 1983) between two people who are both subjects and objects to each other, then the analyst can read the patient's associations for references to the patient's perceptions of the analyst's attitudes toward the patient. This method provides additional data with which analysts can supplement their own self-analysis. In this way the analyst and patient coparticipate in elucidating the nature of the relationship that the two of them have mutually integrated.

Bollas (1989) advocates that analysts need to establish themselves as subjects in the bipersonal analytic field. Bollas encourages analysts to reveal more of their internal analytic process to their patients, for example, describing to a patient how the analyst arrived at a particular interpretation or sharing with the patient the analyst's associations to a patient's dream. He argues that if the analyst's self-disclosure is congruent with who the analyst really is as a person, then the disclosure is unlikely to be taken as a seduction. In establishing themselves as subjects in the analytic situation, analysts make available to the patient some of their own associations and inner processes for the patient to use and analyze. It is important to note that Bollas's revelations have a highly playful and tentative quality in that he does not take his associations or "musings" as containing absolute truth but rather puts them into the analytic field and is prepared to have them used or destroyed by the patient. Furthermore, Bollas is reserved and cautious in his approach because of his awareness that an incessant flow of the analyst's associations could be intrusive,

resulting in "a subtle takeover of the analysand's psychic life with the analyst's" (p. 69). Bollas's clinical contributions are enormous, but while I agree that analysts should be available to the patient as a separate subject, the danger with any approach that focuses on analysts' subjectivity is that analysts may insist on asserting their own subjectivity. In the need to establish themselves as separate subjects, analysts may impose this on the patient, thus forcing the patient to assume the role of object. Analyst's imposition of their own subjectivity onto their patients is not "intersubjectivity"; it is simply an instrumental relationship in which the subject-object polarities have been reversed.

In my view self-revelations are often useful, particularly those closely tied to the analytic process rather than those relating to details of the analyst's private life outside of the analysis. Personal revelations are, in any event, inevitable, and they are simply enormously complicated and require analysis of how they are experienced by the patient. We as analysts benefit enormously from the analytic efforts of our patients, but we can help them as analysts only if we can discipline ourselves enough to put their analytic interests ahead of our own, at least temporarily.

The major problem for analysts in establishing themselves as subjects in the analytic situation is that because of their own conflicts they may abandon traditional anonymity only to substitute imposing their subjectivity on patients and thus deprive patients of the opportunity to search out, uncover, and find the analyst as a separate subject, in their own way and at their own rate. While a focus on the patient's experience of the analyst needs to be central at certain phases of an analysis, there are other times, and perhaps long intervals, when focusing on perceptions of the analyst is intrusive and disruptive. Focusing exclusively on the presence of the analyst does not permit the patient temporarily to put the analyst into the background and indulge in the experience of being left alone in the presence of the analyst. Analysts' continuous interpretations of all material in terms of the patient-analyst relationship, as well as analysts' deliberate efforts to establish themselves as separate subjects, may be rightfully experienced as an impingement stemming from the analysts' own narcissistic needs. To some degree this outcome is inevitable, and it can be beneficial for a patient to articulate it when it happens.

Winnicott (1971) has suggested that psychoanalysis occurs in an intermediate state, a transitional space, transitional between the patient's narcissistic withdrawal and full interaction with reality, between self-absorption and object usage, between introspection and attunement

to the other, and between relations to a subjective-object and relations to an object, objectively perceived, transitional between fantasy and reality. In my own clinical work I attempt to maintain an optimal balance between the necessary recognition and confirmation of the patient's experience and the necessary distance to preserve an analytic space that allows the patient to play with interpersonal ambiguity and to struggle with the ongoing lack of closure and resolution. A dynamic tension needs to be preserved between responsiveness and participation on the one hand and nonintrusiveness and space on the other, intermediate between the analyst's presence and absence. My manner of achieving this tension is different with each patient and varies even in the analysis of a single analysand. I believe that each analyst-patient pair needs to work out a unique way of managing this precarious balance. The analysis itself must come to include the self-reflexive examination of the ways in which this procedure becomes established and modified. Analysis, from this perspective, is mutual but asymmetrical, with both patient and analyst functioning as subject and object, as coparticipants, and with the analyst and patient working on the very edge of intimacy. The question of the degree and nature of the analyst's deliberate self-revelation is left open to be resolved within the context of each unique psychoanalytic situation.

In my initial attempts to present these thoughts to varying groups of colleagues and students, I was struck by the overwhelming tendency on the part of my listeners to focus the discussion on the issue of the analyst's self-revelations. I wondered why analysts were so eager to discuss self-revelation when it was not the main point of the paper. In my view, what is important is not the analyst's deliberate self-disclosure but rather the analysis of the patient's experience of the analyst's subjectivity. The very expression by patients of their perceptions of the analyst leads to the establishment of the analyst as a separate subject in the mind of the patient. So why do analytic audiences focus on self-revelation?

I believe that people who are drawn to analysis as a profession have particularly strong conflicts regarding their desire to be known by another, that is, conflicts concerning intimacy. In more traditional terms these are narcissistic conflicts over voyeurism and exhibitionism. Why else would people choose a profession in which they spend their lives listening and looking into the lives of others while they themselves remain relatively silent and hidden? The recognition that analysts, even those who attempt to be anonymous, are never invisible and, furthermore, the insight that patients seek to "know" their analysts raise

profound anxieties for analysts who are struggling with their own longings to be known and defensive temptations to hide.

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 an object but as a separate subject, as a separate psychic self, as a separate center of experience?

For most of its history psychoanalysis has been dominated by the metapsychology of drive theory. Freud conceived of mind as a closed energy system fueled by biological drives pressing for discharge. This model of mind is based on the notion that there are drives striving for gratification and that the ego regulates, channels, and defends against these drives while attempting to find objects suitable to meet their fulfillment. 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 only relevant variable is whether the person is gratifying or frustrating the drive. The dimension of gratification-frustration becomes the central if not the exclusive characteristic of the object since the object's individual subjectivity is of no relevance in as much as they are an object. Only with the shift in psychoanalysis away from drive theory and toward a relational theory of the development of the self and of "object relations" (that is, of interpersonal relations—conscious and unconscious, real and fantasied, external and internal [Greenberg and Mitchell, 1983]) could psychoanalysis begin to study the other not as an object but as a separate subject (Chodorow, 1989). Adopting a "two-person psychology" or a relational perspective opens up the possibility for the investigation not only of subject-object relations but of subject-subject relations. As Mitchell (1988a) has recently stated, "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).

It should be clear that it is not only the classical drive/structure metapsychology that narrows our view of people, deprives them of subjectivity, and reduces them to objects. This limitation is true of any asocial, "one-person" psychology. (For a discussion of asocial paradigms, see Hoffman, 1983; for a discussion of one-person psychologies, see

Aron, in press). For example, Kohutian self psychology provides an important contribution to clinical psychoanalysis in its emphasis on the need for the analyst to be responsive and empathic and in its recognition of the vital experience of emotional attunement in the analytic process. Self psychology, however, maintains the classical view that who the analyst is as a unique character is irrelevant to the process of the analysis. Kohut (1977) wrote that the patient's transferences were defined by "pre-analytically established internal factors in the analysand's personality structure" (p. 217). The analyst's contribution to the process was limited to making "correct" interpretations on the basis of empathy with the patient. Similarly, Goldberg (1980) has stated:

Self psychology struggles hard not to be an interpersonal psychology . . . because it wishes to minimize the input of the analyst into the mix . . . It is based on the idea of a developmental program (one that may be innate or pre-wired if you wish) that will reconstitute itself under certain conditions [p. 387].

In the self-psychological model, the analyst is restricted to being a selfobject, focusing only upon what the patient (as subject) needs from the analyst (as object). It is important to recognize that in this respect self psychology does not differ from the classical model (see Hoffman, 1983). For classical analysts, the function of the psychoanalytic situation, and in particular of free association, "is to ensure that what emerges into the patient's consciousness is as far as possible endogeneously determined" (Arlow, 1980, p. 193). If the analyst is analyzing correctly, the patient's associations are not seen as largely or predominantly determined by the current interpersonal relationship with the analyst. The psychoanalytic situation is thought to represent "a standard, experimental set of conditions" (Arlow, 1986, p. 76) whose purpose is to minimize external stimuli so as to allow the spontaneous unfolding, from within, of derivatives of drive and defense. Both the classical model, with its focus on drive and defense, and the self-psychological model, with its reliance on the notion of a "developmental program," require that the psychoanalytic situation remain free of the contaminants of the analyst's subjectivity so that the patient's transferences can "unfold" in pure form from within. The presuppositions of a one-person psychology demand that the only psychology in the consulting room that should matter is that of the patient.

The patient's subjectivity, the patient's transferences, the patient's psychic reality are there to be examined. The person of the analyst is ignored in favor of a conception of an "analyzing instrument," and the subjectivity of the analyst is to be kept out of the equation so as to produce an objective experimental situation. (I recognize that this critique of Kohutian self psychology may not apply to certain post-Kohutian developments within the self psychology school. For a similar but more thorough critique of Kohut's self psychology as a one-person psychology, see Bromberg, 1989 and Ghent, 1989.)

Similar objections could be raised regarding the clinical stance taken by psychoanalysts of the British object-relational school and of the American interpersonal school. The metaphors of the analyst as "good enough mother" and "holder" (Winnicott, 1986) or as "container" (Bion, 1970) and "metabolizer" of the patient's pathological contents have been extremely useful inasmuch as they have drawn attention to nonverbal and subtle exchanges and to the ways in which the analyst needs to respond to these "primitive communications." The danger with these metaphors, however, is not only that the patient may be infantilized and deprived of a richer and more complex adult kind of intimacy, as Mitchell (1988b) rightly points out, but that the analyst is similarly instrumentalized and denied subjective existence. Instead of being seen as subjects, the mother and the analyst are transformed into the baby's and the patient's "thinking apparatus" (Bion, 1970). The blank screen has simply been replaced with an empty container, free of the analyst's psychological insides (Hoffman, 1983; Levenson, 1983; Hirsch, 1987). In parallel to this view, Chodorow (1989, p. 253) has recently pointed out that most object-relations theorists still take the point of view of the child, with mother as the object, and do not take seriously the problem of the subjectivity of the mother.

While contemporary interpersonal analysts (Levenson, 1972, 1983; Wolstein, 1983) emphasize the analyst's personal contributions to the patient's transferences, this emphasis was not true of Sullivan's clinical position. Sullivan saw the therapist as an "expert" on interpersonal relations who would function as a "participant-observer" in conducting the analytic inquiry, and as an expert he assumed that the therapist could avoid being pulled into the patient's interpersonal entanglements (see Hirsch, 1987). Sullivan's interpersonal theory, while interpersonal in its examination of the patient's life, was asocial inasmuch as it neglected the subjectivity of the therapist as inevitably participating in the analytic

interaction. Sullivan's description of the principle of participant-observation soon brought attention to the analyst's subjective experience and the patient's perceptions of the analyst's experience, which became the focus of attention for later interpersonal analysts. Historically, Hirsch attributes the contemporary interpersonal focus on the participation of the analyst to the influence of Fromm. I see this clinical movement, which emphasizes the contribution of the analyst's subjectivity, as deriving more from the influence of Thompson in the United States and Balint in England, both of whom were deeply influenced by and attempted to extend the later contributions of Ferenczi. Ferenczi was the first analyst seriously to consider the impact of the analyst's subjectivity within the analytic situation (see Dupont, 1988), and the origins of relational theory and practice can be traced back to the conflict between Freud and Ferenczi.

I will conclude by highlighting eight clinical points:

1. The analytic situation is constituted by the mutual regulation of communication between patient and analyst in which both patient and analyst affect and are affected by each other. The relationship is mutual but asymmetrical.

2. The analyst's subjectivity is an important element in the analytic situation, and the patient's experience of the analyst's subjectivity needs to be made conscious.

3. Patients seek to connect to their analysts, to know them, to probe beneath their professional facade, and to reach their psychic centers much in the way that children seek to connect to and penetrate their parents' inner worlds. This aggressive probing may be mistaken for hostile attempts at destruction.

4. Self-revelation is not a choice for the analyst; it is an inevitable and continuous aspect of the analytic process. As patients resolve their resistances to acknowledging what they perceive interpersonally they inevitably turn their gaze toward their analysts, who need to help them acknowledge their interpersonal experience.

5. Establishing one's own subjectivity in the analytic situation is essential and yet problematic. Deliberate or surplus self-revelations are always highly ambiguous and are enormously complicated. Our own psychologies are as complicated as those of our patients, and our unconscious are no less deep. We need to recognize that our own self-awareness is limited and that we are not in a position to judge the accuracy of our patients' perceptions of us. Thus, the idea that we might

“validate” or “confirm” our patients’ perceptions of us is presumptuous. Furthermore, direct self-revelation cannot provide a shortcut to, and may even interfere with, the development of the patient’s capacity to recognize the analyst’s subjectivity.

6. It is often useful to ask patients directly what they have noticed about the analyst, what they think the analyst is feeling or doing, what they think is going on in the analyst, or with what conflict they feel the analyst is struggling. The major way to reach this material, however, is through analysis of the defenses and resistances that inhibit the expression of each patient’s experience of the analyst.

7. Focusing exclusively on the presence of the analyst and on establishing the analyst’s subjectivity does not permit the patient temporarily to put the analyst into the background and indulge in the experience of being left alone in the presence of the analyst. This focus may be experienced by patients as an impingement that disrupts their encounter with their own subjective experiences. Instead of leading to an intersubjective exchange, analysts’ insistence on asserting their own subjectivity creates an instrumental relationship in which the subject-object polarities have simply been reversed.

8. The exploration of the patient’s experience of the analyst’s subjectivity represents only one aspect of the analysis of transference. It needs to be seen as one underemphasized component of a detailed and thorough explication and articulation of the therapeutic relationship in all of its aspects.

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