Experience as a Guide to Psychoanalytic Theory and Practice

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Psychoanalysis traverses the terrain from the most poignant personal moments to the broadest domain of theory. I shall cover this terrain starting with personal experience, in order to then pass through the concept of “lived experience” into other theoretical concepts and circle back again to the personal. The rationale for beginning with my personal experience is that the choices of concepts and techniques you will hear are inevitably influenced by it (Stolorow and Atwood 1979). After completing college and three years in the navy as a deck officer, I decided to go to medical school in order to become a psychoanalyst. By becoming a doctor, I was fulfilling my grandmother’s ambitions for herself and me. With rebellious pleasure I knew that becoming a psychoanalyst was strictly my own idea. After the second year of medical school, I went to work in a state mental hospital and began a personal analysis. The analyst was a warm and attractive young woman, probably a candidate, with whom I developed a strong transference. The analysis proceeded with positive results for my emotional well-being. Having joined an institute as a candidate, however, I was required to switch from her to a training analyst. Then a terrible thing happened: she died suddenly of a rare complication of pregnancy. I began a training analysis with an esteemed analyst whose reputation was not that of a cold and silent nonresponder. At this time I was in a state of mourning for my beloved grandfather, who had recently died, and for my prior analyst. Unfortunately, the “training” analysis, rather than helping me, became a source of added psychic pain and ended in failure. Looking back now after an effective third analysis, the resumption and completion of analytic training, and years of productive, deeply satisfying practice, I can recognize that I learned from that troubled experience a most important lesson—what not to do. Two interventions the analyst made stand out as negative direction-giving beacons. At a point when it seemed he could no longer stand my crying and yearning, he stated, “What she was doing with you was not analysis; she was only holding your hand.” A second intervention, offered in a tone of exasperated disapproval, was, “You don’t think of me as like your grandmother; I have become your grandmother to you!” In both instances I did not yet have the courage to be spontaneous with my deep sense of hurt, confusion, and disagreement. The lesson became clear years later: if an analyst assumes the privilege of ignoring or hiding his or her contributions to the intersubjective nature of the exchanges, the analysis cannot succeed. Such a titled relationship, in which responsibility for problems in the exchange is placed solely on the analysand, is always in danger of sinking under the weight of the
patient's shame, humiliation, and guilt. Years later I realized from reading Kohut's elucidation of idealization (1971), that my second analyst and my grandmother were indeed alike, in that both desperately required being idolized to bring out their kindly, affectionate side.

Drawn to ego psychology (Hartmann 1964), I found a conceptual system that allowed the positivist illusion that having mastered its complexity one could explain all psychic phenomena. However, delight in my intellectual prowess was tempered by the constant feeling that in the clinical setting these treasured concepts often seemed as remote as Sanskrit. The need for grounding outside the "wheels-within-definitional-wheels" of ego psychology led me first to cognitive psychology, from which I learned that the defense mechanisms, as Freud had hinted, are derived from ordinary means of regulating and sorting perception and cognition. Subsequently, I was drawn to the growing literature on infant and child development. In these studies by Stern (1985), Brazelton and Als (1979), Sander (1975), Stechler (1982), Papousek and Papousek (1975), Mahler (1968), Emde (1981), Trevarthan (1980), Beebe and Stern (1977), and a host of others were to be found systematic observations often tested by ingenious experimental designs. Finally we could supplant conjectures based on reconstructions with empirical findings that recast progressive development. We could jeftison the incorrect assumption that development consists of stages of a pathological nature (e.g., autism and undifferentiation) and replace it with a schema of relatedness beginning at birth and progressing in an intersubjective context.

Following Stern (1988, 1990), I came to regard "lived experience" as the principal concept linking the formation of the mind in infancy with both adult life and the clinical exchange. Thus, while we can speak of the significance of factors such as temperament, constitution, maturation, the oedipal stage, object relations, and hormonal changes, the central feature of infancy and subsequent life lies in the progression of an individual's moment-to-moment experience. Lived experience is fluid and multidimensional. It is exquisitely sensitive to the influence of the intersubjective field in which it is embedded. The nature of lived experience is frequently unpredictable. Although the qualities of lived experience at any moment are open to empathic perception, this "sensing in" is subject to error. Momentary and accumulated lived experience is not only the final common pathway of multidimensional factors but is itself a salient factor influencing further the development of brain, personality, transfersences, and the sense of self.

Once the salience of lived experience is accepted, further questions arise. How does memory encoding of lived experience occur, and what are the rules for recall and re-creation of past experience? How do we explain the persistence of patterns, even across generations, and the alteration of patterns by maturation, by development, and—especially—by psychoanalysis? And, lest anyone conclude that I have become a surface phenomenologist, I also ask what part, in any lived experience, is played by immediate focal awareness, by contents at the edge of awareness, and by others momentarily or by their nature permanently inaccessible to awareness. What governs the opening or closing of the path to awareness of unconscious fantasy (Arlow 1969a) and unconscious beliefs (Weiss and Sampson 1986)? Looking at particular contents in and out of awareness, we may ask, Are they organized primarily by linear secondary process mentation or by nonlinear primary process mentation?

**Five Motivational Systems**

A decade ago I suggested to a panel on psychic structure (Lichtenberg 1988) that psychoanalysis is fundamentally not a theory of structure but a theory of structured motivation. And how is motivation structured? My knowledge of infant research and various psychoanalytic theories, as well as my clinical experience, led to a conceptualization of five motivational systems (Lichtenberg 1989; Lichtenberg, Lachmann, and Fosshage 1992). Each

system is based on a recognizable innate need and associated patterns of response. One system develops in response to the need for psychic regulation of physiological requirements for nutriment, elimination, sleep, tactile and proprioceptive stimulation, equilibrium, warmth, and general health. Another system develops in
response to the need for attachment and, later, affiliation. A third system develops in response to the need for exploration and the assertion of preferences. A fourth develops in response to the need to react to aversive experiences through antagonism and/or withdrawal, and a fifth develops in response to the need for sensual enjoyment and, later, sexual excitement. Each system becomes self-organized and self-stabilized, exists in a state of dialectical tension (both internally and with other systems), and undergoes continuous hierarchical rearrangement. Motivational systems are constituent defining aspects of moment-to-moment lived experience. Constantly and fluidly shifting, each system may be dominant in any lived experience, the others being dormant or less active.

In infancy the five systems can develop only when responded to by caregivers. Empathic, intuitive responses by parents are “guaranteed” within at least survival limits by the development of comparable motivational systems in the parents out of their own lived experiences. Throughout life, and especially in the clinical exchange, shifting motivational dominance is constantly influenced by the intersubjective context of the moment, contributing to a dynamic, often unpredictable subjectivity.

Contributions to the idea of physiological regulation are found in psychoanalytic theory in Freud's notion of the body ego and in research on psychosomatics, eating disorders, and the like. Contributions to the idea of attachment have been made by Bowlby (1958), Ainsworth (1979), and the vast array of attachment research, as well as by Winnicott (1956), Fairbairn (1952), Sullivan (1953), Mahler (1968), Stern (1985), Kohut (1977), and communication theory. The concept of affiliation draws on Freud's group psychology (1921), ideas developed at the Tavistock Clinic, and cultural anthropology. The basis of exploration and assertion as a motivational system can be found in Hendrick (1942), White (1959), Piaget (1951), Stechler (1987), and investigations of play, work, and assertiveness. Fundamental aspects of aversiveness have been explored in the fight-flight studies of ethologists, the conflict and territorial studies of evolutionists, object relational studies of aggression, and Fraiberg's studies of withdrawal and early defensive measures (1982), as well as by Freud (1930), Klein (1932), Kernberg (1976), and Paren (1979). From Freud (1905), Escalona (1963), Kleeman (1965, 1974), Roiphe and Galenson (1981), Kesterberg (1965a, b), and Stoller (1975) we derive the role of sensuality and sexuality and their distinction.

Let us return now to our questions about the encoding in memory of lived experiences. From birth on, and even in utero, the repetition of patterns of need (and of cognitive-affective-motoric responses to it) leads, in conjunction with caregiver activity, to the formation and organization of the five motivational systems. These repetitive patterns are recorded, categorized, generalized, and abstracted in two forms. In one the pattern is remembered as a procedure, what Hartmann (1964) called automatisms (e.g., the automatic receptive opening of the mouth to receive a nipple or spoon). Our greeting responses as adults also draw on procedural memory. The other form is that of event memory, which is established at first in small units of time and complexity, (e.g., a feeding, a conversational exchange with mother, being tossed in the air by father, watching and trying to grab a mobile). With each repetition, the affect and the actions involved are re-created with small variations. These repetitions create the sense of familiarity that is a component of the abiding sense of self. In the beginning, this experience of recreating an affective-cognitive state is a principal source of recognition of self, just as each day on awakening we re-create a sense of self by experiencing the familiarity of our eyes opening, our affective state (“Oh no, do I have to get up?”), and our surroundings. After the lived experiences that contribute to the formation of each motivational system, most subsequent lived experiences are re-creations with new variations. Thus, what we call memory is a re-creation of prior experiences of self alone or self with others, altered to meet the intersubjective circumstance of the present. By the middle of the second year of life and probably earlier, the duality of primary (nonlinear) and secondary (linear) process organization of each motivational system, in verbal and nonverbal forms, gives human lived experience its imaginative creative potential. Play, alone or with others, and playfulness in general are the outcome and facilitators of a broadening world of conscious and unconscious fantasy and symbolization (Meares 1993; Lichtenberg and Meares 1996).

How does the concept of five motivational systems help us in the clinical situation? I believe that each clinical exchange can be viewed
from an intrapsychic perspective, from an intersubjective perspective, and from the standpoint of assessing the affective-cognitive state. From the intrapsychic perspective we can ask, What motivational system has become dominant, what other systems are active, what tensions or conflicts exist between systems, and what prior lived experiences are influential in the current mode of experiencing? We can ask these questions individually for analysand and analyst. From the intersubjective perspective, we can attempt to identify the nature and quality of the field of mutual influence that has developed in the foreground and background of the exchanges. Since analyst and analysand operate with the same five motivational systems, each can “sense into” the state of mind of the other. The recognition and matching of dominant motivations facilitate optimal mutual responsiveness. An appreciation of the intersubjective field allows us to examine disruptions in the dialogue that result when one system is dominant in the patient and another in the analyst (or in the analyst’s conjectures about the patient). From the perspective of affective-cognitive state, we can see that the presence of discrete affects (e.g., affection, anger, fear, joy, sadness) provides a red thread with which to identify the dominant motivational system. Unlike discrete affects, however, a patient’s intense affect state adversely affects cognition and reflective awareness (Lichtenberg, Lachmann, and Fosshage 1996). There is little point in trying to talk “reason” to a child in the middle of a temper tantrum or to a patient in a state of all-consuming euphoria, depression, panic, rage, hatred, righteous indignation, shame, humiliation, or guilt. In contrast to discrete affects, then, affect states and dissociative states dominate the clinical experience so that the intrapsychic and intersubjective perspectives temporarily lose significance as areas of investigation.

Ten Technical Principles

Let us turn now to the principles of psychoanalytic technique that I and my colleagues (Frank Lachmann, James Fosshage, Alan Kindler, Ernest Wolf, Susan Lazar, Russell Meares, and Rosemary Segalla) have formulated. The first principle is to establish arrangements that promote a frame of friendliness, consistency, reliability, and an ambiance of safety for both patient and analyst. This principle refers to an approach similar to Stone’s physicianly attitude (1961). The second principle is the systematic application of the empathic mode of perception. By this we mean the analyst, as consistently as possible, attempts to “sense into” an analysand’s inner world, his or her thoughts, feelings, intentions, fantasies, and beliefs. We try to sense how the analysand perceives him-or herself and the analyst. We can never completely decenter from our own point of view. Even if we could surrender our own perspective, to do so would cost us useful information. Nonetheless, we regard comprehension of the analysand’s point of view as a central goal of our exploration. Our third principle involves emotions. To appreciate an analysand’s experience, we discern the emotion he or she feels or has felt. This aspect is straightforward. If a patient (say, a young woman) tells us she went to a movie, we know little of her experience. If she says, “I went to the movie and I hated it, it was full of violence,” we can appreciate much more of what she felt. To appreciate the patient’s motivation we need to go even further: we need to discern the emotional experience he or she seeks. At times the goal sought will be self-evident to patient and analyst alike. At other times the goal will lie out of awareness and be difficult to ascertain. The red thread in assessing motivation lies in discovering the affect being sought in conjunction with the behavior being investigated. Too often concepts such as masochism and self-destructiveness are applied reductionistically, thereby short-circuiting the search for the affect sought by the patient. Rather than pain or punishment, the goals being sought in many repetitive or addictive pursuits are affect responses of vitalization or soothing, however momentary. From the individual’s standpoint, an affective state of vitalization or soothing, even if short-lived, can seem so immediately desirable or absolutely necessary that a negative long-term consequence will have little deterrent effect. Because of shame and the expectation of condemnation, analysands are often reluctant to acknowledge to their analyst and to themselves the vitalizing and soothing they experience through smoking, drug use, athletic highs, anorexic states, bulimia, or perverse sexual activity. Without this recognition, analytic understanding cannot proceed.

Our fourth principle is that the message contains the message. I had been trained to regard with a jaundiced eye the message delivered by the patient. If a patient was talking about the present, he was to be
regarded as defending against the past; if about the past, as defending against the transference; if about the transference, as defending against remembering; and so on. This prejudicial approach devalues both message and messenger. Open-minded attention to the communication

as delivered allows us to recognize what content is conveyed, what problems of sharing with self and others are inherent in it, and what affective and gestural hints are furnished. Staying with the immediate communication longer and more intensely usually yields more understanding than is achieved either by a defense focus or a genetic focus on what isn't said.

The fifth principle of technique is to fill the narrative envelope in order to learn the who, what, when, where, and how. To sense oneself into the experience of a patient requires a rich and vivid description of the experience. In the past, a patient's faulty ability to organize a coherent and revealing narrative was regarded as the result either of conflict and resistance or of cognitive style. Availing ourselves of research using the Adult Attachment Interview (Main 1991), we now regard many instances of narrative organizational difficulties as products of attachment categories recognizable at one year of age. Adults who as infants fit in the securely attached category give coherently organized accounts of their primary relational experiences, including traumas that have occurred. Adults who were avoidantly attached give dismissive headlines, such as “my mother was great,” and then cannot back up the claim with relevant examples. Ambivalently attached infants, as adults, ramble on and on, their speech full of irrelevancies—the obsessive preoccupied speaker. Infants whose attachment was disorganized and disoriented evidence, as adults, fragmentation of coherence and dissociation of affect. Analytic patients who have limited capacities to organize narratives cannot provide productive free associations. Expecting them to do so leads to inevitable frustration for both analyst and analysand. To gain the information we need for analytic exploration, we must help dismissers to expand, ramblers to contract, and disorganized speakers to create relevance in their narrative. In helping these patients form a cohesive narrative, we may also be helping them to repair a developmental deficit.

The sixth principle, “wearing” the patient’s attributions, is a technique essential to the exploration of transferences. I define transferences as expectations arising from past experiences and, as Weiss and Sampson (1986) emphasize, inferences drawn from these experiences. The expectations lead to creation in the present of a relationship that is regarded either as undesirably similar to some prior trauma or as different in some hopeful fashion. A current version of an expectation may be formed in response to minimal cues in the present or in response to

more intense triggers, negative or positive. Transferences are newly created in consonance with some aspect of the intersubjective field. Transference expectations are always creations—there are no immaculate reconceptions. When a patient makes an overt or implicit attribution of positive or negative qualities to the analyst, I suggest that the analyst, both inwardly and in discourse with the patient, view him- or herself as the patient has indicated in the attribution. By working within the patient’s attribution, the analyst fulfills the goal of exploring and understanding the patient’s perception, rather than the earlier goal of correcting presumed distortions. Sometimes the analyst’s contribution to the attribution is easily recognized. At other times, the imputed quality will at first seem without a triggering source, but on reflection and after further discussion of what the patient observed, the analyst may come to accept the attribution, if only partially. Even when the analyst can in no way identify with the attribution, it should be kept in mind that much communication in an intersubjective field takes place unwittingly, that analysts’ affects are often more transparent than we think, and that patients often form inferences far from the analyst’s recognized intent. We are all familiar with the manner in which patients attune to the rhythm of our hmsms and uh-huhs, our shallow or rapid breathing, our body movements and stomach gurgles, and our silences, brief comments, or long-winded explanations. From the patient’s point of view, our message, too, contains the message.

The seventh principle is the joint construction of “model scenes.” The analytic clinical exchange inevitably arouses recurrent states of uncertainty for both participants. Meanings in general and role enactments in particular puzzle both analyst and analysand. These common enigmas often are resolved by
the recognition that a scene serves as an exemplar of their meaning. The model scene may be suggested by either patient or analyst. It may originate as a past memory, a dream image, a description of a current event, or an association to a movie or novel. The narrative of the scene will strike one or both participants as fitting in with and exemplifying the nature of the puzzling problem. The model scene concept differs from traditional genetic reconstructions in two ways. First, the goal is not to construct or reconstruct a repressed memory; rather, the goal is to explore the meaning of a current pattern, especially one brought to light by the clinical exchange. Thus, the explanatory scene may not take the form of a memory at all. Second, the work of exploration involves back-and-forth play with the

imagery and its application. Analysand and analyst work together amending and altering text and nuance, expanding and contracting, in contrast to the more traditional one-way flow of analyst-to-patient interpretation. When a model scene is being jointly constructed, analyst and analysand can be visualized as sharing an “observational platform,” the view from which allows them to create conceptual order from what previously was inchoate.

The eighth principle holds that aversive motives are a communicative expression to be explored like any other message. This principle is likely to be the most controversial. I use it in arguing against the generally accepted position that privileges defense interpretation. As the manifestations of any motivational system become dominant, we explore the affects, contents, and actions only to the extent the patient can experience them; they are not to be regarded as functions or mechanisms the analyst must tell the patient about. When manifestations of antagonism and withdrawal dominate the patient's associations and behavior, as they often do, we explore what has triggered the aversiveness, what affects are involved, and where the patient perceives us to stand. Are we, through a perceived empathic failure, the source of the aversive response, or are we a listener sensitive to the patient's aversive stance? We are especially attentive to aversive responses that create disruptions in the clinical exchange itself and lead to disturbed self states. We do not regard defensive activity as impediments to the availability of memories but as opportunities to explore the impact of current and past experiences of shame, humiliation, embarrassment, guilt, fear, sadness, anger, hatred, vengefulness, and contempt. Many instances of antagonism and withdrawal that I had been taught to regard as resistance I now consider a patient's trusting response to an ambiance of safety. In these instances, analysands who have gained confidence in the security of the “holding environment” can fully experience and expose their aversiveness. Analysts holding this view provide a less judgmental ambiance for the analytic enterprise (Friedman 1995).

The ninth principle concerns the analyst's interventions. I do not regard our verbal interventions as following the pattern of knowing analysts informing analysands of what they are blind to. Rather, I consider our actual interventions to involve a wide range of verbal and nonverbal communications, the direct purpose of which is to institute a joint collaboration in expanding awareness. I identify three types of

spoken intervention: the first and most frequent are the analyst's statements and questions that reflect the patient's point of view, the second are those that state observations from the analyst's point of view, and the third and least common are those I call “disciplined spontaneous engagements.”

When accurate, reflection of the analysand's point of view through simple hmms and uh-huhs of affirmation, and affective identification, as well as through more complex acknowledgments of meaning such as “So what you are telling me is . . .,” confirms that the analyst understands. In addition, it gives patients a chance to hear the essence of their message—something they may not appreciate when telling it. A less accurate reflecting by the analyst allows the patient to correct a misconception of fact or a mistaken emphasis. When analysts amend their reading, analysands can feel that they are able to influence the analyst. This awareness gives the patient a sense of efficacy. Even attempts to reflect the patient's viewpoint that misconstrue the message may have the beneficial effect of conveying the analyst's interest and good intentions. Misreadings, if not too frequent, will be ignored by the patient, who may then simply restate the message, giving the analyst another opportunity for empathetic perception.

The second type of intervention shifts from a patient-centered mode to an analyst's observational stance (Lichtenberg 1983; Fosshage 1997). The analyst offers a personally drawn inference, opinion,
appraisal of meaning, clarification of intention, or self-disclosure. Interventions made from the analyst's point of view have the advantage of bringing the analyst's individuality more into focus and relieving what might seem to the patient a contrived repetitiveness of phrasing and an inauthentic suppression of the analyst's self. An analyst's observational stance often stretches empathic responsiveness toward a more confrontational interaction. The patient may be receptive to the appraisal and be ready to grasp a new perspective, or the patient may be aversive to the perceived intrusiveness of the suggestion. If disruptions occur in the subsequent dialogue, patient and analyst must pay close attention to the meaning the interaction had for each.

A third group of interventions, suggested by Lazar (1998), is that of "disciplined spontaneous engagements." By disciplined we mean that the analyst does nothing in words or actions that would breach the frame of essential friendliness, consistency, reliability, and safety. Discipline is exercised also in maintaining ethical standards and fostering a therapeutic goal. The spontaneity refers to the analyst's often unexpected comments, gestures, facial expressions, and actions that occur as a result of an unsuppressed emotional upsurge. These communications seem more to pop out than to have been planned or edited. The analyst may be as surprised by them as the patient. By engagement, we refer to communications and disclosures that are more enactments than thought-out responses. While an analyst is attempting to remain in empathic touch with a patient's inner experience through largely verbal exchanges, because of the intense intersubjective interplay roles are being created and mutual role-responsiveness is occurring. While an analyst is attempting to influence a patient to explore, the patient may be attempting to influence the analyst to put aside the role of calm inquirer-interpreter and to fight, love, reassure, feed, or advise—that is, do, not talk and reason. The tension that results from this motivational disparity leads to inevitable role engagements. Frequently even the most experienced analysts will fail to recognize the incipient stages of an enactment until they are more deeply involved. But this is not really a failing. Rather, it is a desirable openness to influence, to play and interplay. To quote Boesky (1990), "If the analyst does not get emotionally involved sooner or later in a manner he had not intended, the analysis will not proceed to a successful conclusion" (p. 573). Why do we suddenly "erupt"? From an investigation of spontaneous reactions, I conclude that our spontaneous involvements occur at moments when we, as analysts, believe we can no longer be authentically ourselves without saying something about what is going on. This characterization may fit the example of Kohut's telling the patient who bragged about driving across Chicago "like a bat out of hell" that he was going to give him the deepest interpretation he had so far received: "You are a complete idiot!" (1984, p. 74).

The tenth and final principle is to follow the sequence of our interventions and the patient's responses to them in order to evaluate their effect. We look to see if the patient's subsequent associations and affects indicate that our interventions have facilitated exploration, are enlivening or soothing, or have enveloped us in an enactment. We are particularly observant of inevitable disruptions in the optimal level of shared communication. Patients rarely experience an analyst's interventions primarily as "interpretations"; rather, they are more commonly experienced as a sequence of involved or uninvolved listening, spoken words, and nonverbal communications. Through the sequence of interventions the analyst conveys a coherent sense of purpose, enabling successive interventions to have a cumulative effect. Tracking the nature of the mutual responses, especially their affective tonality, is an analyst's main means of assessing therapeutic efficacy.

**Three Processes in Development and Psychoanalysis**

How does positive change come about through analysis? I believe that empirically derived aspects of the analytic process must tap processes present in ordinary adaptive development. My search has led me to three overlapping processes: self-righting, shared expanding awareness, and the reorganization of representational schemas.

*Self-righting*, a term borrowed from biology (Waddington 1947, 1966), refers to a tendency present at every level of the organism, from individual cell to psyche. As a factor in development, self-righting occurs
when an inhibiting condition has been removed. Self-righting is based on an inherent tendency to rebound from states of disequilibrium or impairment in physical and psychic growth when a positive change has occurred. Clinically, self-righting refers to an intrinsic tendency during psychoanalysis to rebound from an altered (lower-level) state of functioning to a more adaptive state. After an hour of intense affective involvement, we depend on self-righting to enable analysands to resume the state of adaptive functioning needed to leave and return to other occupations, and analysts to prepare their receptivity for the next hour. We particularly depend on self-righting to enable our patients and ourselves to restore the capacity for exploration and attachment after the inevitable disruptions that follow empathic failures. Self-righting restores the capacity to explore the meanings of a disruption, not the other way around: understanding does not precede and then lead to self-righting. The facilitation of self-righting comes largely from the many nonexploratory aspects of analysis. An analyst's reliability, care, concern, tact, and willingness to accept responsibility, make appropriate self-disclosures, and communicate affective involvement represent a positive change in an inhibiting experience for all patients. Following Schore (1994), I believe an analyst's capacity to regulate his or her aversive affect, especially shame and humiliation, in the face of disruptions is a critical factor in facilitating a patient's self-righting. An irony in my second analysis was that the analyst pointed accurately to

the developing problem when he denigrated the significance of the nonexploratory aspects of our failed interaction with his comment, “She only held your hand.” Self-righting as a designation may have leapt out to me since it fit the fantasy of my self-rescue from the impasse. I became preoccupied with an image of myself as a crab that was on its back, thrashing with all its limbs to get back upright in order to survive. As I recognized the meaning of this fantasy, I literally got up off the couch. Knowing that I could self-right was a powerful sustaining influence in my second, more successful effort at a training analysis.

Shared expanding awareness is my replacement for the traditional view of an analyst offering insight through interpretations—a one-sided transfer of knowledge. The view I hold is that the dynamic, transformational quality of expanding awareness during analysis results from the facilitation of two individuals sharing affective experiences within an exploratory context. Along with the patient's descriptions of events and gestural and linguistic renderings of self experiences, analyst and analysand are concurrently developing an expanding awareness of self, both with and apart from the other. And because of the need to discover the nature of a transference configuration, each is seeking to find the self as experienced by the other. The model for this conception is the ordinary attachment experience of caregivers and developing children. Parents try to discover who their baby is, and the baby seeks and tries to confirm an identity through and with the parents. This mutuality of search impels the acquisition of information. The most significant information sought is the sensing, conscious and unconscious, of the subjectivity of the other, organized as fluid, emotion-laden perceptions and memories of events and procedures.

In an analysis, as between parent and child, the searching is joint, but what is searched for is uneven. The mutual search to find the patient involves the long axis of the patient's life as a narrative construction in the minds of both participants. The mutual search for the analyst involves largely the shorter axis of the dyad's experience together. The consistent effort to bring into awareness the impact of what develops spontaneously during each clinical exchange involves a struggle against collusions in deception and denial. Patients are often all too willing to overlook an analyst's obfuscations of emotional responses and responsibility for disruptions. To return to my personal experience, my first and third analyses could succeed because in each the analyst's privileged position was not abused. Both analysts took appropriate responsibility

for their part in aversive responses. In contrast, my second analyst never acknowledged that opening his mail, rapping his coffee cup, or, more important, his sarcastic tone of voice (as I heard it) were having an impact on me. Without that recognition and acknowledgment, regardless of his interpretive skill, no shared expanding awareness of current and past lived experiences could develop.

While self-righting and shared expanding awareness underlie progress in all exploratory psychotherapies, the rearrangement of representational schemas is a principal benefit of the systematic
focus on transference configurations particular to psychoanalysis. The reorganization of representational schemas refers to changes in the manner in which the self, significant persons and events, and the interactions and emotions involved are imaged or symbolized. The changes at first may be imperceptible, requiring many repetitions of the transference configurations to achieve flexibility of representation and plasticity of responsiveness. Changes in representational schemas during treatment have as precursors the changes that take place at the transition point of every stage of development. At each transition, the sense of self and the sense of others are categorized differently, so that later versions of self alone and self with others are built into representational networks, while earlier versions remain. Recategorization at each stage is forced by the disparity of experience that comes with maturation and change. During analysis, too, recategorization of rigidly held representational schemas results from an experience of disparity. The discrepancy is not the natural consequence of maturation but arises out of the simultaneous experience of two contrasting subjective realms. One perception of the analyst arises when an affect-laden transference fantasy, belief, or interaction dominates the analysis. The contrasting perception derives from the analyst as empathic professional listener-observer-interpreter of the transference. For example, one perception may involve the analysand’s full affective sense of being especially preferred and loved by the analyst. The discrepant perception recognizes that the analyst interprets the meaning of being special, ends the session at a prearranged time, and charges a fee. Or the patient may perceive the analyst as hating and hated, blaming and blamed, depriving and deprived. The disparate perception recognizes that the analyst listens to the attribution and interprets what he can identify as triggering acts involving hate, blame, or deprivation, thus making the aversive experience open to shared consideration and reflection. The one representational schema, that

involving self and analyst, is categorized largely in a primary process mode by the right cerebral hemisphere linked to vestibulocerebellar input that draws on related past experience, the other largely in a secondary process, left hemisphere logical mode (Levin 1991). Discrepancies in categorization are monitored by comparator functions that operate at three hierarchical levels of the brain (Stuss 1992). The recategorization of representational schemas following intense transference experiences may lead to recast configurations that are less “etched in stone.” To paraphrase General MacArthur, old transferences never die, they just fade away. More accurately, expectations based on intense past lived experiences can always be re-created; the representational schemas on which they are based remain as neural networks. The success of analysis lies in the reduced probability that unconscious triggering will take place automatically. Instead, an alternative network is activated and a different experience created.

Now to recast these concepts through my experience. My second analysis founder precisely on the intervention “You don’t think of me as like your grandmother; I have become your grandmother to you!” and my conviction that his arrogance and sarcasm were actualized repetitions of similar shaming put-downs. I was helped to recognize that something was amiss, since in the earlier analysis I had experienced the disparity between my unconscious expectations, based on my previous lived experience, and the prevailing therapeutic ambiance. In the second analysis, the absence of this discrepancy failed to lead to what Chused (1996) has called “informative experiences” and thus to the rearrangement of representational schemas.

Concluding Remarks

This completes a condensed survey of the psychoanalytic terrain I have been exploring. I would like to tell you briefly about a current project. My colleagues and I are investigating the development of one’s intimacy with oneself. We believe the pendulum has swung too far from Freud’s original studies of the intrapsychic domain. The criticism of mechanistic macrostructures and what Stolorow calls the myth of the isolated mind has led to an almost exclusive emphasis on the interpersonal, intersubjective, and object relational. Without neglecting the valuable insights regarding the interplay of self with other, we want to refocus on the development of the sense of self and ask, How do we

learn to live within our skin and like what we find? How do we learn to know what we need to know about
ourselves? How do we form the inner monologue that permits us to have a running discourse with
ourselves? How do we form the narrative that gives us a personal story (or stories) as unique as our
fingerprints?

A number of years ago, when presenting clinical material to a group of colleagues, I was told that the
group concluded that I understood the patient and the patient understood me, but they did not understand
what I was doing. In my strong desire to be understood as a clinician, I have published many examples of
my work, culminating in the lengthy verbatim accounts in my coauthored book The Clinical Exchange:
Techniques Derived from Self and Motivational Systems (Lichtenberg, Lachman, and Fosshage 1996). It
is my hope, in presenting here my efforts to puzzle out answers to theoretical and practical problems we all
face, that I have succeeded in making myself better understood. I sincerely wish to be.

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**Article Citation [Who Cited This?]**