The Analyst's Response

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The impact of psychoanalytic theories on analytic understanding and technique is most evident in comparative responses to a detailed clinical study. Each discussant has assessed and organized the clinical material from his/her vantage point. Espousing and proving one's particular constructions resulted in very disparate readings of the patient's experience and of the analyst's premises and subjective experiences. Clearly, with the plurality of psychoanalytic theories differences abound.

For purposes of comparing and contrasting the various clinical approaches to the material I will address the premises of the discussants and assess, from my perspective, their constructions of the clinical material. In the comparison I will also further elucidate my understanding and approach to the clinical experience. Space constrictions require me to focus succinctly on specific highlights of each discussion.

First, I will schematically present the model of therapeutic action fundamental to my understanding and technique. Because the functions of the transference dimension of idealization were addressed and understood so differently by the discussants, I will compare the various approaches to idealization under that heading. And I will discuss under a separate heading my "nonstandard" response in the "Cadillac" incident because it elicited strong reactions.

My general orientation within psychoanalysis is self psychological. However, no orientation is uniform, and wide divergences exist among those who claim a similar orientation. Even wider divergences exist between orientations, although still much is shared. Additionally, each analyst and patient within his or her individual personality, as Ornstein points out, idiosyncratically shape each analytic experience.

Therapeutic Action

Therapeutic action in psychoanalysis, from my perspective, is based on (1) an ongoing, sufficiently consistent and reliable experience of idealizing, mirroring, and twinship selfobject components of the analytic relationship; (2) the subsequent analysis and consequent management of the self-selfobject ruptures; (3) the illumination within the current context of primary experiential themes and organizing principles (schemas) and their geneses (transference and countertransference); and (4) the fundamentally new relational experience (that is, self with other) that in large measure is created by the above-mentioned components of the analytic process. These processes bring about psychological organization and an increase in attendant regulatory management capacities (structure building), and modification of problematic invariant schemas (structural change). It was on the basis of these components, I believe, that new hope emerged in P and her depression gradually lifted.

Analytic Interventions

Interpretation has been the primary sanctioned mode of analytic interpretation. Based on a positivistic scientific outlook, interpretation is viewed as an “objective” statement aimed to increase insight. From a relativistic scientific perspective, interpretation is understood to be shaped by the analyst's models as well as by the data in an attempt to comprehend the patient's subjective “reality.” The model has so much impact on the content of interpretation that adherents of various models occasionally will not agree as to whether or not a particular intervention is an interpretation. Moreover,

analyst, be it facial, bodily, verbal, or tonal, as well as the overall presence of the analyst, as a meaningful “response” that might be self-enhancing or self-depleting, or as conflict-inducing or conflict-reducing.

The Menninger Project (Wallerstein, 1986), in contrast to expectations based on theory, found that “supportive-stabilizing” elements were intricately intermingled with “expressive-interpretive” elements in psychoanalysis. Although the more supportive-stabilizing interventions are often viewed as temporary parameters rather than as mainstream interventions, I believe that they need to be included more fully in our theory of psychoanalytic technique. Not to do so distorts the psychoanalytic process as practiced.

These distinctions accounted for some of the differences in the assessment of my clinical interventions. For example, I noted that “I found myself conveying more directly than is customary for me … my genuine caring for her.” Discussants viewed this either as countertransference acting in (Roth & Segal) or as the product of my model portrayed as an attempt to fill “unconflictedly poised” developmental needs (Mitchell). In contrast to these views, I experienced P as developmentally striving at a deep level to consolidate a feeling of being, and worthy of being, cared for and at the same time as having fears, expectations (schemas), and protective measures, all of which I worked with interpretively. But as Curtis and Ornstein speculated, my awareness of the terminal impasse of the previous analysis and my experience of P’s developmental or selfobject “pull” contributed to my sense that the patient needed to experience sufficient authentic caring from the analyst in order for the analysis to proceed. Analytic exploration, understanding, and explanation added to an experience of caring, but was, in this instance, insufficient without additional emotive expression. A too limited response would have provoked the “corpse-like” image in the transference before sufficient self-consolidation and some sense of the other as caring could have weathered the anticipated storm of its emergence. I was under no misconception that I could or would want to avoid the emergence of this “corpse-like” image in the transference that ultimately needed to be experienced, interpreted, and gradually transformed. However, understanding transference as variably shaped by both patient and analyst within a two-person field model enables us to recognize that the degree to which the analyst contributes to this “corpse-like” image will determine “whether the transference experience becomes solely a nonanalyzable replication of the traumatogen experience and, thereby, confirming of the particular schema; or the transferential experience becomes analyzable and helpful in illuminating the particular organizing theme” (Fosshage, 1990). In this instance, if I had been too wooden in my responses, the patient would not have been able to discern her contribution (via her schema) to the experience, but would have concluded simply and “realistically” (from her viewpoint) that the analyst was indeed a “walking corpse.”

In contrast to the position ascribed to me by Burland and Mitchell, I do not believe that developmental needs can just be “filled.” No analyst of whatever persuasion, in my opinion, believes that developmental needs can be unconflictedly “filled.” Within a self-psychological perspective these needs are viewed as embedded in conflict that emanates from traumatic failures of the past, fears of their potentially self-fragmenting reoccurrence (Ornstein, 1974), expectations that the failures will reoccur, and all of the various self-protective measures. Both the developmental strivings (selfobject dimension of the analytic relationship) and the repetitious relational configurations (transference) are played out in the analytic arena.

Idealization

The discussants viewed idealization primarily as a defense against guilt and aggression, or against the negative transference. Only

Ornstein and Mitchell noted the use of idealization in the service of development.

As I came to understand it, the idealization within the analytic relationship served for P both a developmental function and a self-protective (defensive) function. Developmentally, idealization provided the necessary safety and caretaking functions, along with an affirming function, that enhanced her sense of self and resulted in greater “energy” and vitality. Self-protectively, idealization provided protection against the expected repetitious traumatogenic relational experience of a “fragile and vulnerable” father and of an “overwhelmingly” deathlike, needy” mother, who would “obliterate” P as well as be unavailable for her requisite developmental needs, and protection against the consequent rage. Over the first two and a half years of treatment the idealization gradually matured in developmental or selfobject function and diminished in protective function as the result of analyzing the ruptures and transference configurations. Moreover, as the idealization diminished with less developmental imperative (e.g., P saw me as more “human”), the idealization became less available for providing a self-protective function. These changes, in combination with my contribution vis à vis the project, precipitated the particular transference configuration and a profound selfobject rupture.
The Cadillac Incident

Not unexpectedly the Cadillac incident, wherein I deviated from “standard” procedure (Ornstein's discussion of what constitutes “standard” is especially cogent) and responded directly to a question, evoked numerous responses from the discussants, Burland and Mitchell interpreted my response to P's question essentially as a countertransference collusion to maintain myself as a “benign figure” and to circumvent confrontation of the negative transference. Curtis suggests that I mistakenly saw the patient as too narcissistically vulnerable to be able to confront her.

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- 605 -

rage and chose to reinforce the “narcissistic defense” of idealization. However, my response was not intended to circumvent, nor did it blunt P's critical feelings: the “hated” sweater and powerful dream immediately followed. The patient was confronting her rage and associated meanings sufficiently to enable her to say in the last session, “It was very helpful for me [with a more energetic tone] to be able to tell you, to feel that I could tell you the things I despise about you.”

Only Ornstein directly raised the crucial question: Did my response interfere with the analysis or did the analysis proceed? Depending on our models, the answer probably would differ. Certainly a meaning (the meaning according to the patient and this analyst) of the Cadillac was illuminated before as well as after my response. And I believe that the meaning was deepened both in her dreaming and in the subsequent sessions, (assessed similarly by Burland as well as Ornstein).

The discussants, except for Ornstein, did not observe that two simultaneous processes were occurring: the first was P's criticisms and reactions to the Cadillac, and the second was her emergent reaction to my not answering a question, engaging a different transference theme. Not answering was provoking this second transference theme of not-treating-her-as-a-person (a theme that was most familiar to us and was still an area of vulnerability for P) and, consequently, could have sidetracked us from pursuing the at-that-moment “hottest” issue, namely, the criticism and rage related to the Cadillac. For these reasons I would have answered the question honestly even if the Cadillac had been mine, in order not to provoke what at that moment I considered to be a secondary issue. In deciding which transference issue had priority, I answered the question to further P's expression and the analysis of the criticism and rage rather than disrupt or avoid it. Of course, I am not recommending answering questions as a general guideline, but am suggesting that at certain times such actions are necessary and even facilitative in analytic work.

With our “standard” exploratory-interpretive mode based on positivistic science, we tend to lose sight that the patient experiences

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- 606 -

this mode as a response of the analyst. Because of its meaning for the patient, this mode of response can at times disrupt rather than facilitate the analysis. To remain un-“pliable” (Balint, 1968) iatrogenically can disrupt the analysis in recapitulating the traumatogenic experience and inducing rage that prevents further information processing (see Lichtenberg, 1989).

Mrs. Roth and Dr. Segal

Roth and Segal's Kleinian formulation pivots around the aggressively based “exploitative,” “demanding,” “envious,” and “omnipotent” aspects of the patient, for which the patient is experiencing “persecutory guilt.” They shift, without noting, from the patient's subjective viewpoint, the empathic mode of observation (for example, “felt-to-be-exploitative, felt-to-be-invasive aspects”) to an external or so-called “objective” perspective (that is, “this patient does exploit her objects and feels badly about it”). With their external view of the patient they assert that the analyst “capitulated” to this “ruthlessly demanding” patient in deviating from standard analytic practice by making caring gestures and by answering her question about the Cadillac. They write, “the analyst’s failure to survive her demanding attacks as a functioning analyst confirms in her mind her omnipotence [meaning, omnipotence in her destructiveness] and leaves her in despair.”

My reading of the patient's experience as articulated in these sessions contrasts markedly with their formulations. For example, when reworking the hospital incident, the patient said, “I do remember thinking that I had caused it,” feeling responsible and guilty. This theme, corresponding with one of Roth's and Segal's formulations, has validity for P; however, in my assessment, because this was the only direct reference, it was not in the experiential foreground in these sessions.

Roth and Segal suggest that I did not explore and uncover “unconscious anxieties, needs, and conflicts” and that I took “her communications at face value and only at face value.” From my
perspective, analysis begins with listening to the "face value" of the patient's articulations. The analyst's models and schemas variably shape the perceived data, partially determined by the degree of ambiguity and complexity of the patient's expressions and by the extent that the analyst departs from the patient's articulated subjective experience in his/her formulations. Analysts differ from session to session and between one another as to the degree of departure from the patient's articulated experience. The advantages and disadvantages are too complex to detail here (see Schwaber, 1982, for example). Self psychologists in general, and I in particular, stress remaining relatively close to the patient's articulated experience, partially to facilitate the emergence of unconscious material from within and the gradual emergence and consolidation of the patient's inner direction or "self." At the beginning of these sessions, P expressed feeling anxious and conflicted, having a sense of which she was unaware. Through exploration we were able to illuminate deeper unconscious meanings (that is, previously outside of awareness). Roth and Segal's notation that exploration does not take place appears to occur at those junctures when the meaning arrived at does not correspond with their formulation, e.g., the meaning of the Cadillac. Similarly, they invoke the concept of the unconscious at those times when the patient's statements do not correspond with their understanding and thereby conclude that P's statements must conceal their "deeper," "unconscious" meaning (suggesting, in turn, that I am not dealing with unconscious meanings). All analysts attempt to illuminate unconscious meanings; but our respective models clearly affect the selection and organization of those meanings.

Roth and Segal's formulations are the reverse of mine. They begin with the patient's aggression, expressed in attacking her parents. Her parents' difficulties "confirm" the persecutory guilt linked with her omnipotence," making it difficult for the patient to digest her destructiveness. In my view, the parents' difficulties precipitated a rage that was a reaction, a protection from anticipated future injury, and a reassertion of her self (from a passive victim to an active agent). Contradicting the primary thrust of their formulations in which aggression is intrapsychically generated, Roth and Segal in their last statement shift to a view of aggression as reactive and occurring within a two-person field, corresponding with my view, stating, "when she attacked her [mother] with all the rage, fury, and pain that a little girl left alone in a hospital might well be expected to feel" [my italics].

In contrast to the Kleinian formulations, I believe that P experienced the analyst as vulnerable, needy, and exploitative in his request for her participation in this project, which resonated deeply with traumatogenic experiences of a similar nature with her parents. The exploitation and writhing vulnerability were experienced as aspects of the other that potentially drained her, not as aspects of herself. Roth and Segal's translation of the attributes of the other as projected self-attributes ignores the importance of this particular relational experience as well as potentially blurs self and object differentiation. Although future developments might indicate that P also experiences these attributes as aspects of herself, in my reading this was not the associationist theme of the moment. I conceptualized P's intense need for recognition or acknowledgment (for example, her potentially exasperating attempt to have me answer her question) as developing out of a relational matrix in which she experienced her parents as absorbed with their self-preoccupations and agendas, and not sufficiently attuned to her needs. To me, there was no evidence that P experienced the analyst as "captivating" when I answered her question, as these discussants assert. Apart from the momentary relief from potentially losing me as an idealized person, I believe P experienced my willingness to respond as reassuringly treating her as a person and as conveying my understanding of the meaning of withholding for her (see Bacal, 1985). In contrast to the assumed countertransference, which is always shaped by the analyst and the analyst's model as well as by the patient, I did not experience my response as a capitulation. Whereas Roth and Segal saw the dream as indicating my defeat, I saw the dream as further mentational efforts to deal with the powerful transference configuration that

had emerged in the previous session. In contrast to Roth and Segal's assertion that the analyst had not been able to withstand the patient's criticism and P had "defeated" her analyst with her "demanding attacks" leaving her "in despair," P stated: "It was very helpful for me [with a more energetic tone] to be able to tell you, to feel that I could tell you the things I despise about you. That I felt you were strong enough.... And you're still here and [with laughter] not dead." In my assessment P was affectively connected and speaking authentically and clearly no longer in despair. If Roth and Segal did not believe P, I wonder, when would they believe the patient's expressed affectively grounded articulated experience?
Roth and Segal state: "The patient needs to know that the analyst can tolerate knowing about these more destructive aspects of her and can ‘accept’ them as readily as he can accept her more attractive qualities.” I concur that this is certainly one goal (allowing for our very different views as to the origins of the “destructiveness”); however, in contrast to Roth and Segal, I believe P is making it clear that this is occurring.

**Dr. Curtis**

In noting the helpfulness of my responsiveness in comparison to the “unnecessarily constricted and less than empathic” stance of the previous analyst and that “corrective experiences appear to be part of the therapeutic strategy, and indeed go on in every analysis whether planned and/or noticed by the analyst,” Curtis acknowledges both the contribution of the analyst to the patient’s analytic experience and the curative aspects of the relational experiences occurring within all analyses.

Curtis notes the beneficial effects of my “responsiveness to her needs for affirmation and caring, with clarification and delineation of the precariousness of her self-esteem and doubts about deserving to be cared for,” and then reframes the clinical material according to a conflict/defense model in which P’s “conflict about guilt over hurting the analyst” becomes central. He views the narcissistic components as primarily defenses against “a more object-related conflict around guilt over hurting a loved one.” I agree that this conflict emerged during the first reported session which initially we attempted to explore. However, in the material that followed, the most intense affect was connected to the content of the criticism, not to criticism as an expression of aggression and corresponding guilt. Curtis and I agree that there is conflict, but we disagree about the nature of the conflict that has priority in these sessions. For me, the more affectively charged conflicts revolved around the “old man,” Cadillac, and sweater in conjunction with her recognition of my vulnerability and humanness, which meant I became the terrifying, enraging, deathlike drainer figure of her past and, secondarily she would angrily lose me for the developmentally needed idealization.

Curtis suggests that I use the word *genetic* in the sense of memories of experiences during childhood” and little “in the sense of the etiologic contribution made by the patient's internal efforts to master the external trauma by fantasy and defensive distortion. For example she might well have projected her own neediness and rage onto the image of her parents, thus disclaiming her own and magnifying her parents' motivation.” I believe this misunderstanding (for I do use the word genetic to refer to etiology) arises out of the fact that our etiological formulations are different. P is, to me, encountering in these sessions the terrifying and rage-provoking *neediness of the other* within the transference, which was a primary thematic experience of her past. P is dealing with this “external trauma” at this juncture of treatment. In illuminating this thematic experience it is crucial to explore all her internal and external responses. However, I do not assume that the patient has defensively distorted her experience of her parents (an untenantable position, I feel, still anchored in positivist science). From my perspective, what is “real” and what needs to be explored comprehensively is her *subjective experience as she has access to it*. All analysts can explore only what the patient has access to; but, as previously mentioned, we differ on how close to the patient's articulated experience we remain in our formulations. To frame P's experience, in contrast to her explicit articulations, as a “projection” and to shift the focus onto her neediness during these sessions would have risked missing the relational (self with other) experience that P was articulating and implicitly invalidating the patient's immediate experience of terror and rage. To remain closer to the “face validity” or thematic structure of the patient's articulated experience at these moments facilitates the deepening of the analytic process and self-understanding. I would anticipate P's neediness subsequently to emerge more fully to be understood at that time.

Curtis raises the question of “why the patient had to repeat in a dream what is already known and talked about in the sessions.” Assuming that the “manifest” drama is known (others — for example, Roth and Segal — assessed the dream as manifestly revealing something new) enables Curtis to impose more easily his “latent” theory onto the dream: “the patient writes the script of suffering that horrifies her, a dramatized depiction of her guilt over her own rageful wishes.” In my assessment, P *continued to work* in her dreaming mentation (see Fosshage, 1983; Fosshage & Loew, 1987, for my view on the function of dreams) on the frightening image of the old, deathlike, needy other that was emerging in the transference in the previous session. This understanding corresponds with the *thematic structure* of the dream content, not requiring a translation of the dream imagery.
Dr. Mitchell

Mitchell delineates three fundamental premises regarding relational patterns, transferences, and hate and aggression. He focuses on "the analysand's neurotic constrictions derived from deep loyalties ... to old relationships and familiar relational patterns," which corresponds with my emphasis on repetitious relational configurations. Yet differences do emerge with regard to our underlying motivational models. These "neurotic" loyalties"

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as rooted patterns of relational connection are maintained for purposes of attachment, Mitchell's emphasis, and for purposes of self-cohesion, my emphasis.

Mitchell's emphasis on attachment and repetitious relational patterns as the patient's primary motivation emerges more clearly in his statement: "New forms of relation are not likely to be immediately possible, nor even really sought [my italics], but emerge only through reexperience, reexamination, and resolution of old patterns." Although Mitchell alludes to the new relational experiences in his reading of this case material, his motivational emphasis on the repetitive patterns positions him, in my judgment, to underestimate what is developmentally sought. With his emphasis on old allegiances, I also wonder if he underestimates the patient's fear and actual dread of the repetition (Ornstein, 1974) of these traumagenic relational configurations. I believe that patients seek the "new" or developmentally enhancing experiences, as well as expect the "old" (schemas that can be terrifying and/or relieving) and tend to connect in those characteristic ways established in past relationships.

Although Mitchell notes my recognition of both the repetitive and developmental aspects of the transference, he tends to portray my position as focusing mainly on the latter. For example, he states: "These sessions represent not only [italics added] an anxious retreat in the face of a striving to deepen the intimacy between them, but the emergence of important relational configurations." Although an "anxious retreat" corresponds with my initial speculation, the subsequent illumination and interpretation of the repetitious relational configurations indicates that I also did not view the patient as simply anxiously retreating. Mitchell asserts that I tend to regard the key interactions in these sessions as representing a striving for a "new beginning." This misunderstanding is undoubtedly related to my general emphasis on developmental strivings; but in these sessions, as well as Mitchell, viewed the repetitive transference configurations to be in the forefront of the analysis.

Mitchell's assertion that within self psychology "the competent

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analyst is still generally regarded as striving to hold a position outside the patient's dynamics" and "as not participating in the creation" of the patient's experience is perhaps based on early self psychological theory, but is not reflective of current theory and practice. The application of the empathic mode of observation is to view from within the patient's perspective how the patient experiences the intersubjective field. Embedded within the concept of the self-object matrix is recognition of the analyst's contribution to that matrix (evident, I believe, in my interpretations and in Ornstein's discussion). In contrast to his portrayal of my position, I emphasize, as Mitchell, that the patient's experience is generated in actual interactions between patient and analyst (see Fosshage, 1990). The complex interactional field illustrated in this clinical material I explicated with interpretations like, "So as you idealize me less and as I become more human and show vulnerability, as I did when I discussed the project, you are prone to experience." I believe that the analyst's subjectivity is variably a codeterminer of the analytic experience (see Stolorow et al., 1987) and is not adequately reflected in the term countertransference. Although Mitchell and I both conceive the analytic arena as a two-person field, in his description of what he calls "inevitable" countertransferences, he does not adequately acknowledge at those moments how the countertransference is always variably shaped by the analyst as well as by the patient, resulting in different intersubjective encounters for each analyst-patient pair.

Mitchell states that remnants of the classical model of transference remain in self psychology and delineates differences in his approach. I disagree with this characterization of "my" self psychological approach. Some of these differences are undoubtedly related to his having limited clinical material, and also entail a different reading of the clinical material. The major difference between us is not, I believe, the overall conceptualization of transference, but the utilization of different theories for understanding the transference. Mitchell's general thesis is that I reflected the "full implications of her perceptions and criticisms" of me and is in keeping with his view that I was attempting to fill

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her “poised” developmental need. Although it is always possible that I may have unknowingly deflected (others felt similarly), I disagree with his overall assessment in light of the depth and intensity of P’s criticisms and the illumination that occurred in these sessions. An example of his offering support for his thesis is his reading that I “implicitly accept her claim that she doesn’t know him very well.” It is unclear to me what suggested to Mitchell that I accepted her claim, for I said nothing at that moment. An alternative reading is that the patient's characteristic view of me at that moment is shaken because of the emergent terrifying perception of me as “old,” creating a cognitively unstable situation for her as to who the analyst really is. P then immediately proceeds to the criticism of my sweater, and we begin to illuminate it's specific meaning, all of which seem to indicate that the criticisms were not deflected from the transference.

Based on his reading of the clinical material, Mitchell suggests that I underplay the “darker passions” and see aggression as “flashlike” and “shallow.” His assessment partially emerges out of his view and comparative emphasis on the patient’s “destructiveness.” Apart from this difference in the conceptualization of the “darker passions,” I believe that the predominance of intense hate, rage, and criticalness in these sessions squarely counts his thesis. Mitchell states: “her passionate criticalness is not seen as an expression of her deepest self, but rather as protection for her deepest self.” Is he suggesting that “protection” cannot be part of her “deepest self”? Mitchell then describes his “alternative” view that, based on P’s past experience of betrayal, she believes others will be needy, exploitative, and betraying. In turn, “These beliefs underlie character traits of extreme wariness, scepticism, and hateful minimizing of others, all of which are likely to have been very adaptive strategies for best surviving in her family.” Are these characterological traits not protective? Although I do not see these traits as dominant as Mitchell, I concur that the hatefulfulness and wariness are deeply embedded and not just, as Mitchell ascribes to me, “a shallow, protective, reactive ‘mode.’” Moreover, P arrived at a similar understanding in these sessions: “And I can see that my

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-despising the other person, hating him, not caring about him, hating his neediness, hating his suffering, hating his vulnerability, is a way of remaining intact.”

How might we differ around the issue of “darker passions”? I believe Mitchell tends to emphasize the “darker passions” in his clinical understanding because of his motivational model. Although our conceptualizations of the “darker passions” differ, I do not believe that any analyst can avoid the “darker passions” or treat them as “shallow,” as this clinical material, to my mind, amply illustrates. However, I do place greater emphasis on the patient's developmental strivings. An illustration of our different models occurs in the assessment of P's despair at the beginning of the last session. Whereas Mitchell apparently would have remained focused on her despair which, he hoped, would lead to a “deeper understanding of her conflicted feeling about wanting and also not wanting something new and different”; at that moment I felt that what was in the foreground was not conflict, but P's searching for and openness to a way out of the profoundly disturbing and demoralizing repetitious reactions to neediness (what Kohut called the “leading edge” of the material [Miller, 1985]). Following my response, P reflected more comprehensively and expressed that now she was “relate[ing]” to me “at a deeper level.” Not to have given her at that moment a vision of the way out, that is, an explanation as to how analysis works, would, I believe, not only have been unhelpful, but would have iatrogenically induced even greater despair. Not to be available for those moments of developmental “pull” would have been indeed “corpselike.”

**Dr. Burland**

Burland sets up a series of dichotomies: “to what extent the analyst is a ‘real new object’ and to what extent he or she is a transference object”; is the patient “suffering from a deficiency or a conflict disorder”; and is the curative agent the new relational experience

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-or interpretation and insight. In each instance he places me as representative of the first side of the dichotomy and himself on the alternative side. In contrast, I believe that the complexity of the analytic situation, in general, and of these sessions, in particular, cannot be captured through the lenses of these dichotomies, but requires instead a new synthesis that includes and transforms “both/and.”

Because of space constrictions, I can only provide several examples. Burland notes our “very rich interpretive work together,” but
then suggests that, in my emphasizing the "real" dimensions of [our] experience together", I "underestimate the importance of the insights." I am unclear as to how he concludes this, but I believe both interpretation and the relationship are crucial for analytic progress. Burland recognizes the importance of the "positive transference" and of "empathic attunement in the 'dialogue' of analysis" in what he characterizes as part of the "real" relationship, but does not recognize that interpretation is also part of a "real" relational experience which can have a variety of meanings for each patient.

As previously stated, I consider the dichotomy between "a deficiency or a conflict disorder" erroneous. I concur with Burland that the patient is psychologically a complexly organized adult with developmental needs surrounded with complex psychological organization and conflict (see Stolorow et al., 1987). However, his emphasis is clearly "on the interpretation of the negative and conflicted transferences."

I fundamentally disagree with Burland's "classical" model of transference. Whereas he views positive transference as emerging from a "dyadic mode of interaction," a two-person model, he posits that negative transference is a projection of the past and "distorts" the present, a one-person model. He therein perceives P's negative reactions to the previous analyst, as well as to myself, to be solely P's responsibility. P is portrayed as "perversely" and "sadomasochistically" "demanding" the analyst to break his analytic frame and his "technical neutrality." He writes: "when she saw her [past] analyst as firm in her resolve, P's fantasied

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perception of her as a 'walking corpse' seemed to express the power of her destructive, and I assume largely narcissistic, rage rather than as evidence of her analyst's real lack of empathic attunement." Burland delineates a picture that the analyst did not participate in eliciting these negative reactions; rather, as I viewed it, these negative reactions arose out of an interaction to which both P and I contributed. Burland, as analyst, would have remained convinced of his innocence when he states, "that the patient's perceptions of me as cold and ungenerative are transference projections ... not related to the actuality of my feelings for the patient or my efforts at silently and internally affectively tuning in." Accordingly, the patient's rage is based on "distortions" of what Burland, as analyst, perceives as his reality. Although Burland suggests that I attempted to be the "good object" even to the point of risking "a kind of therapist reaction-formation to P's hostility," I question who risks defending (or is it the model?) against the patient's hostility when he would see P's analyst as "clean" and not implicated in contributing to the patient's negative transference. I claimed my contribution to the interaction not, as far as I am aware, to remain the "good object" but to illuminate the intersubjective field and the patient's schemas.

Dr. Kohon

In his pejorative but undefined view of narcissism Kohon considers patients' desires to be liked by their analysts as a "neurotic demand," ultimately to be renounced. He sees the patient as most destructive—"turn[ing] her husband into a Humpty Dumpty; "transform[ing] her previous analyst into a 'walking corpse'" and "threatening to do the same with her present analyst should Dr. Fosshage refuse to support her narcissism." I suggest that Kohon's perjorative view of narcissism and his one-person psychology view of her destructiveness as the primary pathogenic factor positions him to feel "tyrannized" by the patient. He then shifts his focus away from the patient to the analyst's concerns: "The analyst

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should feel free to like or dislike his patients, to think whatever he likes about them." His particular experience of the patient's desires or "demands" (the words frame the phenomenon) as tyrannical would position him inadventently to reject rather than welcome and understand P's desires. This, in turn, could trigger more "tyrannizing" rage and "demandingness" in a deteriorating intersubjective scenario that had occurred in the previous analysis and could, I believe, have easily occurred again. I do not believe, as Kohon suggests, that "the analyst [was] so interested in making the patient feel 'liked' and 'cared for,'" but that it was the patient who needed to feel "liked" sufficiently in order to establish a sense of safety, trust, and self-consolidation to proceed with the analysis.

Kohon asserts: "There is no sense in this account that an analysis of what the patient does to her objects is taking place" [my italics]. Because Kohon focuses exclusively on the patient's narcissistic rage and demandingness and what she "does to her objects," he neglects P's repetitive relational configurations (in this instance, her experience of the other) as experienced in the transference. He also overlooks Ps articulated understanding of her rage in the last session, which is precisely his emphasis. Kohon's model does not include what the analyst does to his/her objects.

Dr. Schwartz

Applying a learning model to analysis, Schwartz paints a complex and subtle interactive (two-person psychology) picture of the analytic relationship. He lauds my careful and sensitive attention “to prosodic and other forms of stereotypic nonverbal data.” However, such data are primarily to be used as “reliable guides to interpretive content, focus, timing, and tact.” In not addressing my interpretive interventions, he concludes and criticizes my “tendency” toward “noninterpretive interventions.” I do believe that the psychoanalytic process involves a wide range of interventions.

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...many of which are not openly acknowledged. In the final analysis Schwartz appears to reaffirm interpretation as the only legitimate and sanctioned intervention, a position which, in my judgment, does not fully reflect his own learning model.

**Dr. Muller**

Muller redefines, in keeping with Lacan, “need” as *biological*, denoting “an organic tissue deficit” and suggests that it should not be used in psychological discourse. He then criticizes me for not using the term as he defines it. He overlooks that the term *need* has often been used in psychology and generally refers to something that is fundamental for one’s psychological development and preservation and, undoubtedly, has a corresponding neurobiological base (see Lichtenberg, 1989). Kohut saw selfobject needs as, to use Muller’s phrase, universal imperatives. What Muller describes pejoratively as the patient’s “addictiveness to [the analyst] as an object,” I would describe as intense selfobject needs. Apart from these semantic problems, Muller fails to recognize that I use “needy” and “neediness” with my patient because these are her terms.

Muller indicates that P and I were dealing with what at first was an “unnamed trauma” (in the area of the “Real”) related to her mother. It seemed contradictory for Muller, on the one hand, to claim that I was excluding “the mediating role of the unconscious” while, on the other hand, to note that we were uncovering this previously unconscious “unnamed trauma.”

Muller imposes his own theoretical constructions with his use of words that do not reflect the patient's constructions. For example, he minimizes the difference between P’s use of the terms, “exploitative” and “needy.” P used them largely to describe distinctly different experiences related to her father and mother respectively. Similarly, he *imposes his preference* for the term *demands* instead of *needs*, using his terminology rather than the patient’s.

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**Dr. Ornstein**

Because Ornstein and I share an overall self psychological psychoanalytic perspective, it comes as no surprise that I found his discussion compatible with my experience and understanding of the analytic sessions. Since his viewpoint is so similar to mine, I will limit my discussion to a central issue. Ornstein illustrates the consistent application of his method, the empathic mode of observation, in his attempt to understand the analytic encounters from within the patient's and analyst's subjective experiences. In his efforts to resonate affectively and vicariously introspect he attempted to remain relatively close to the affective experience and articulations of the patient and analyst, arriving at understandings of these encounters that differed significantly from his initial impressions based on his external perspective. (All analysts use the empathic mode observation, but differ, I believe, in the consistency of its application as well as in the guiding models.) His use of the empathic mode and his self psychological model resulted in an assessment, similar to mine, of my intervention at the beginning of the last session in response to P’s question, “But how am I going to change that?” Ornstein writes: “The analyst described (within the patient’s idiom) his view of the working through process; how P will be able to manage her pain, and offered this as a reassuring direct response to her genuinely reflective question, holding out some hope for change.” Ornstein noted how the patient proceeded to reflect on what she found most helpful in these last sessions and suggested that the patient and analyst were getting into “the deeper connection.”

**Postscript**

It is now 15 months since the reported sessions occurred. The thematic experience of the other as “exploitative” and “needy” has substantially subsided. As the schemas of the “other” both transferentially and extratransferentially have been illuminated and interpreted and subsequently modified, P has experienced the...

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analyst as more reliably present; that change has also extended to her husband. She no longer feels repelled by her mother and now can hug her for the first time in years. The emergent identification with her mother was illustrated with a frightening dream of a “stomping elephant” that was pursuing her and her mother. Whereas she was faster and ran up the hill, her mother ran up against a wall in danger of the elephant. The stomping elephant was undoubtedly, from her viewpoint, her father. Illuminating, understanding, and explaining (interpreting) these unconscious scenarios has alleviated the fear of the stomping elephant and has enabled her to more easily claim her womanhood. Her womanliness and sexuality has subsequently emerged more fully, but now without the idealized romantic fantasies previously serving other self-consolidating and -protective functions.

The analysis continues....

References

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