On the Conceptualisation of Clinical Facts in Psychoanalysis
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ABSTRACT

After defining 'facts', 'clinical facts' and 'psychoanalytic clinical facts' the authors describe their conceptualisations of these facts from experience-near to experience-distant levels. They maintain that psychoanalytic clinical facts are jointly created by patient and analyst and are to a great degree dependent on the analyst's mode of observation and theory. They illustrate the various levels of conceptualisation within the broad outlines of self psychology with three detailed clinical vignettes from the analysis of Mr K. A starting central question in the authors' minds arises out of their focus on the patient's selfobject transference (in this instance a mirror transference), hence on the function they serve for the patient in this transference: the role he assigns to them in the restoration and maintenance of the cohesiveness of the self. It is the recognition of this function that serves as the basis for their conceptualisation of the patient's psychopathology as well as the curative process of his analysis.

INTRODUCTION

In a slowly developing post-positivist climate in psychoanalysis, the question of what is a psychoanalytic clinical 'fact' has to be spelled out briefly before we can move on to our task of discussing the conceptualisation of these facts (Ornstein, P. H., 1993a), (1993c).

According to Webster, the simple word 'fact' has a complex and multilayered meaning. It is: 'a thing done' (from the Latin facere, to do, to make); 'an action in general'; 'something that has actual existence'; 'an occurrence, quality, or relation the reality of which is manifest in experience or may be inferred with certainty'; and 'an actual happening in time and space'.

In psychoanalysis, clinical facts are 'created' by both participants. In our present state of knowledge they can no longer be conceived of as the sole property of the patient, recognised and objectively interpreted by the analyst, who does not participate in their making. The clinical facts are shaped not only by what becomes activated in patients in the analytic situation, but also—importantly—by all of the analyst's responses, especially those directed at the patients' transference expectations and demands. These

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1 Transference here is not simply a reference to the 'analytic relationship': it is more specific than that. The concept is used throughout this paper to designate both (a) the repetitive aspects of early infantile and childhood patterns of wishes, feelings, thoughts, fantasies and behaviours; and (b) the manner in which these patterns are affected and shaped by the analyst's verbal and nonverbal responses. Selfobject transference (Kohut, 1971) has to be distinguished from the traditional view of transference, in that it becomes established in relation to structural deficits, rather than in relation to intrapsychic conflicts. Neither displacement nor projection is considered to operate in the selfobject transference. The underlying structural deficit reactivates the patient's 'thwarted need to grow'—hence, the various selfobject transferences (mirror, idealising and twinship) manifest themselves ubiquitously and may be especially intensely and insistently focused on the analyst during the analytic process. Rather than displacing or projecting, patients in their selfobject transferences express currently-felt needs; needs that have remained unresponded to, or unreliably responded to, ever since infancy and childhood and left them with structural deficits in the self. We might say that a selfobject transference reflects the re-opening of the patient's deficiently structuralised psyche for belated maturation and development.
facts, as they emerge in a context in which their meaning is continually negotiated, can be observed with reasonable certainty and their meaning can be inferred with growing certainty over time. It is this on-going negotiation between patient and analyst (with all that its turbulence entails), that shapes the clinical facts and captures their meaning(s).

We define clinical facts as psychoanalytic when the patient's subjective experiences (including his or her experiences of us) are formulated and organised in the language of one of the psychoanalytic theoretical systems (ego psychology, object-relations theory or self psychology), within each of which there are several levels of abstraction, from experience-near (with minimal inference), to the experience-distant (with a greater inferential leap). Thus, our psychoanalytic clinical facts are thoroughly intertwined with and dependent on the interpretive process, and on the theory we hold. It is in the manner in which we formulate our interpretations and the way patients experience our attitudes and behaviour (the nonverbal aspects of communication) that we create the clinical facts. Such facts are therefore not wholly independent of the particular observational method we use and the theories we apply to organise them—both of which determine the nature of the interpretive process and are in turn determined by it.

One could easily object to these ideas by stating that what the patient brings to the analyst is already his or her property, a symptom or personality feature, an habitual or ingrained characteristic, in whose development we have not participated. What the patient brings to us is therefore present in him or her at the first encounter and will 'unfold' its details in the course of the ensuing analysis. The facts are there; they are not created by us. Rather, the transference is expected to reveal the repetitive nature of the patient's reaction patterns and their developmental-genetic sources.

While this focus on transference as repetition only—within a radical empiricist-positivist view—has become problematic over the years, along with the philosophical conundrum involved in the declining prestige and explanatory power of positivist theories, we have these two fundamentally divergent views on what constitutes a psychoanalytic clinical fact.3

As we move along to the conceptualisation of clinical facts we note some significant constraints: the method of observation and the theory we have adopted to organise our data determine the nature of our clinical findings. Thus, to a large extent we are locked into an existing interpretive or explanatory system. Our very observations of observation and the theory we have adopted to organise our data determine the nature of our clinical findings.

2 A radical empiricist-positivist view assumes that reality out there is ultimately knowable: '… Kohut's view of reality (external as well as internal reality) [was] that (reality) is unknown and that we can only grasp aspects of it on the basis of the specific operation(s) we apply to it in the process of our inquiry. Kohut grew up with this modern, postpositivist, view of reality … it informed his view of psychoanalysis as an empirical science … [he] was thus not a radical empiricist, holding that we could know reality as it actually existed out there … his notion of psychoanalysis as an empirical science could … [therefore] accommodate, without apparent contradiction, the postpositivist "constructionist" (i.e. hermeneutic, or interpretive) view of reality, in which the observer had a direct and definite impact on the observed and in which a jointly forged reality emerged as a result' (Ornstein, 1993ap. 5).

3 Our immediate task does not require a further discussion of these contrasting views and the differing interpretive approaches they prescribe. However, a brief comment, countering the radical empiricist-positivist view, should further highlight here the necessity of viewing each analysis as an encounter between patient and analyst in which the data of their experience of each other [and of themselves in that situation] constitute the clinical facts. As long as we worked with the classical assumption of the mind as a closed system we were constrained to view the patient's characteristics in health and illness as his or her own exclusive, intrapsychic properties; and to view the relations between the patient and analyst as existing between two well-delineated, separate entities, whose transference relations could be seen as reflected in the mechanisms of projection, introjection and displacements. These assumptions of the mind as a closed system were challenged by the new assumptions of self psychology: 'The clinical concept of the self/object transferences and the … developmental concept of selfobject needs and experiences … further anchored psychoanalysis in the post-positivist, constructivist reality … theses concepts have led us to view the self … as an open system one that is not delimited by the physical boundaries, the skin, of the person. Thus the self is open to include others or be included in the self of others. This view has permitted us to transcend the concept of transference as a phenomenon played out between two well-demarcated selves, each of whom is the recipient of projections and introjections in the transference–countertransference experience within the closed system of each participant in the analysis' (Ornstein, P. H., 1993ap. 7).
obtain them and are suffused with our theories. However, observation and theoretical conceptualisation are by no means identical: observations (even if theory-determined) have to be raised to some level of abstraction and generalisation. Raising these facts to a generalisable conceptual level demands that we formulate them within the very theoretical system that guided our observations. It is here that we have to be particularly careful not simply to apply a 'blueprint' to a particular observation. For example, using classical theory, observations of triangular or sexual content cannot automatically be conceptualised as having 'oedipal' meanings. Using the theory of self psychology, observations of an inability for sustained initiative (for example, in delaying the completion of a doctoral thesis), accompanied by feelings of emptiness and despair, cannot automatically be conceptualised as reflecting a primary self-disorder. In both of these instances the development of the transference, rather than the manifest symptoms, will guide our conceptualisations. Thus, by focusing on the transference, we are always interested in the unconscious (disavowed or repressed) roots of the patient's manifest (subjective) experience.

Each theoretical system provides a detailed blueprint of what we can expect to find in the course of analysis. As clinicians we always have room, however, for our own creativity, especially in relation to the idiosyncratic, microscopic details that are the nitty-gritty of every analysis and valid for each patient–analyst pair only, and for no other. For this part of our work there exist no detailed blueprints to follow. As our 'facts' multiply and become more and more complex, we engage ourselves consciously, but mainly preconsciously, in the process of 'locating' the patient's associations on the theoretical map we carry in our minds for the journey of the analysis. Many side-streets have to be traversed; many roads, including subterranean (unconscious) channels or reservoirs, are not immediately recognised on the map; and we often feel lost until further experiences help us discover and then mark the road on the map—that is, we continually integrate our findings into the broad frame of our theory. This is the process whereby observations achieve an increasingly more abstract conceptualisation as well as a progressively increasing certainty about the meaning of the patient's experience. In this process we do our best when we are more focused on what is unique in the patient's experience (personality and psychopathology), rather than on what might be generally valid in his or her psychodynamics and psychogenetics.

In this spiral advance of the process of conceptualising our observations we gain more data and also greater certainty about their meaning. We have to keep checking on the usefulness and validity of our tentative understanding through a constant scrutiny of the patient's responses. We have to be open to correct, enlarge or change our views based on these responses, in order to gain the increasing certainty and 'prove' the jointly conceived formulations right or wrong. In this connection, we also have to be willing to negotiate any aspect of our theoretical system. Openness to the patient's responses as a possible corrective of our understanding is all the more necessary since the concepts we use may lock us rigidly into our explanatory system, which could then close off further observations that might lead us to different conclusions.

To demonstrate the process of our conceptualisation of clinical facts, we have selected three segments of the analysis of Mr K (with P.H.O.), for which self psychology provided the theoretical frame. These segments should also demonstrate the reciprocal impact of observation, interpretation, clinical generalisation and clinical theory on what we regard as the 'facts'.

**FROM THE ANALYSIS OF MR K**

We shall present: (1) a synopsis of the preliminary encounters and their conceptualisation; (b) the beginning of the analysis and a quick survey of its course; (3) three segments on which we wish to focus in greater detail; and then (4) conclude with a discussion of the

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4 For other excerpts of the analysis of Mr K, see Ornstein, P. H. 1987, 1993a; Ornstein P. H. & Ornstein, A., 1985.
The preliminary encounters and their conceptualisation

Mr K began his analysis with me\(^5\) as a single man in his early thirties, after a few years of floundering and trying to find himself on the West Coast, while living ‘totally carefree and without responsibilities’ in various anti-establishment settings. Prior to moving to the West, Mr K had had a ‘trial analysis’ in his hometown in the Midwest, which lasted about five years and ended when his analyst died after a protracted illness. He called it a ‘trial analysis’ because ‘that experience never worked for me’. He and his analyst, he claimed, had never made a meaningful emotional contact. There would be prolonged silences on both sides; and when his analyst spoke, Mr K never quite understood ‘where he was coming from’ and could not emotionally confirm for himself the validity of what he had heard. It was ‘as if the whole thing wasn’t about me’. When I asked him what had made him hold out so long in a situation that he experienced as unsatisfactory, Mr K said that it was a combination of not knowing what else there was or could be; ‘that this is what analysis was and that it would change if [he] could give himself to it more fully’—as his analyst often remarked, ‘in trying to break through [his] defences’. He then added that a pervasive depression, passivity and apathy had also contributed to his ‘just staying’, and in the last years of his analyst’s terminal illness he had been unable to leave him.

On the last Christmas visit to his family, while still living on the West Coast, Mr K stopped off in a large Midwestern city to see some friends with whom he could freely discuss his failure to find any resolution to his problems during his stay on the West Coast. He was given my name as an analyst who was in commuting distance from his hometown—although the trip would take one-and-a-half hours each way and thus require a substantial time-commitment on his part. Once he had reintegrated himself in his hometown and become financially comfortable, he called for an appointment.

Mr K gave a very good account of himself in these preliminary sessions. He focused on the fact that in spite of his external successes—or what others would see as successes—in his current circumstances (financially, socially, in his work and love-life) he felt empty, emotionally unconnected to anything or anybody—‘as if I were dead inside; I cannot feel my own feelings’. People only see and know the mask he wears. He had long been depressed and unable to take any joy in life. He had been feeling ‘dysfunctional’ for quite some time in relation to many of the simplest everyday tasks, such as washing the dishes, cleaning the house and writing cheques to pay his bills on time; he procrastinated over every task and finally assigned them to underlings. He was part-owner of the enterprise he and his next older brother had jointly founded, and therefore he was able to camouflage his various dysfunctions up to a point, but was exceedingly unhappy, ashamed and constantly feared exposure. Mr K had never finished engineering school at D because he just could not concentrate and focus; therefore, he was not able to complete his homework or take examinations. Nevertheless, he managed to attain a good life without financial worries, owing to his native ability and his inventiveness (he had several patents to his name).

Mr K is the fifth of ten siblings in a Catholic family; he has three elder sisters, one elder brother, three younger sisters and two younger brothers. He felt that he had never quite fitted in with the others; he thought of himself as more sensitive, more intelligent; he also showed considerable mechanical abilities and creativity early on. He was easily hurt and humiliated when ruthlessly teased by his siblings and was easily brought to tears. Because of the intense shame he felt about these experiences, he had vowed never to cry and never to allow himself to be humiliated by others. Mr K spoke a

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5 In the clinical-report section of this paper the pronouns 'I' and 'me' will be used to reflect the analyst speaking; and in the discussion that will follow, the resumption of the use of 'we' will reflect the authors' joint consideration of the broader clinical-theoretical issues involved in the conceptualisation of the analysis of Mr K.
great deal about his 'dysfunctional family', especially about his father, whom he experienced as distant, brutal, competitive, controlling, and in relation to whom no one could ever win in the family. For his emotionally unavailable mother, Mr K felt he was just one of the children she needed to care for and whom she needed to control. He felt that he had been abruptly dropped by his mother at the time of the birth of his younger brother and had been expected to fend more for himself emotionally. His elder sisters were not quite satisfactory as stand-ins for his mother, for whose affection, he recalled, he had yearned for desperately and in many complicated ways still did. (The details emerged only much later.)

During these preliminary interviews, I found Mr K highly intelligent and unusually articulate. His initially serious and mutedly depressed demeanour contrasted sharply with the vivid artistic imagery and richly varied metaphors he used in our subsequent meetings to describe his inner experiences and his childhood, as well as his current relationships. Whenever I reflected back to him what I had heard him tell me, he felt that I understood him. He reiterated this at the end of the final preliminary session and, with a comfortable certainty and a smile on his face, he said that he thought that we could work well together. I realised later that I was quite freely active and more animated in these sit-up sessions with Mr K, perhaps because I enjoyed the level of communication we were able to establish, and perhaps also (without my full awareness) to demarcate myself from his previous (silent) analyst and to establish a different relationship with him.

**Conceptualisation of the preliminary encounter**

The first step in conceptualising the nature of this preliminary encounter with Mr K is highly personal. This is so because there are no explicit rules as to how to begin or with what specific data to begin the process of conceptualisation. We all begin with what strikes us as significant—based on who we are and a mixture of our empathic capacities, as well as our theoretical predilections and previous clinical experiences. Since we attempt to be attuned to the patient's fluctuating affective states (fluctuations both in the quality and intensity of affects), these affects are used as pointers to locate those themes in the patients' associations that have the greatest significance in their current experiences. Thus, although the beginning step is inevitably idiosyncratic, once our initial understanding is silently formulated, we are in a position to reflect more deliberately on the experience we just have had from the perspective of our theory and to continue to search for evidence that will either buttress or question our formulations. This particular sequence is countlessly repeated throughout the analytic process, especially when we articulate our understanding in the form of specific interventions. It is to be hoped that each of these sequences enlarges our grasp of the nature of what the patient is searching for and attempting to revive in the transference, since these sequences serve as the bases on which further conceptualisation of the emerging data becomes possible.

As is usually the case, Mr K communicated a great deal more in our initial encounter than I was able to grasp. These initial sessions gained in richness and depth throughout the analysis, but I wish to focus (in keeping with the task) only on that which I reacted to and understood then. The central message I heard in what Mr K told me was this:

I have been disconnected from my own inner feelings and activities as well as from things and people around me nearly all my life. I failed to get reconnected to my own feelings, to my own experiences and to activities and people around me both in my previous analysis and in my efforts through my free, authentic, anti-establishment life-style in the West—nothing helped so far. I am still disconnected from myself as much as from others. At the same time I need relationships badly, but I fear that they would end up hurting me again. How much and how desperately I need them is clear to me from my having stayed with my first analyst in spite of not having achieved a meaningful emotional connection with him. I felt that maybe this was my own fault. But my apathy, passivity and depression not withstanding, I have not given up my search. I am searching for this connection right here.

In fact, Mr K portrayed in the progressive
change in his demeanour and behaviour that he felt 'energised' and 'enlivened' by my active and animated participation; it gave him hope and he expressed it.

Two aspects of this initial experience-near formulation provide us with the beginning steps of the process of conceptualisation: (1) what I considered to be of central significance in the patient's presentation—which foreshadowed the patient's core psychopathology; and (2) the observation I could make regarding the manner in which my animated participation in our interaction affected the patient's affective state—which foreshadowed the nature of his pathognomonic transference.

How correct I was in this initial assessment had to await confirmation, which I derived primarily from the patient's transference expectations and their inevitable frustrations. However, in keeping with our earlier contention that the analyst's manner of participation helps create the emerging facts, I took special note of Mr K's experiences with me. It struck me in this connection that Mr K's lifelong search for 'energising' and 'enlivening' experiences, without which he felt 'dysfunctional', was now evident in the session and not only reported about as having been pervasive in his whole life. This search was actually at the centre of his immediate experience with me. I was impressed with his description of feeling paralysed, of not having the initiative for his everyday activities; his feeling empty and dead inside; his feeling disconnected from himself and his surround on the one hand, and what he actually displayed in these initial sessions with me, on the other. I drew the tentative conclusion that his description of himself and his behaviour in these sessions might well be the expression of having been deprived of developmentally-needed experiences of feeling mirrored and validated by significant archaic selfobjects.

Thus far, the clinical facts and their experience-near tentative conceptualisation. Carried further, to a more experience-distant (yet still sufficiently experience-near) level on additional reflection, the data indicated to me the tendrils of Mr K's emerging selfobject transference—his intense, lifelong 'mirror-hunger' was about to be remobilised in a selfobject transference, whose nature (how archaic or how advanced) I could not yet perceive adequately. I accepted Mr K for analysis without any hesitation because it appeared to me from this initial experience that his core psychopathology (no matter how archaic it might turn out to be) could ultimately be fully activated and potentially resolved in the analysis.

I felt during these initial sessions that this formulation covered most of what I had heard so far. There was, however, also a hint of unresolved oedipal issues in Mr K's description of his father's 'brutal competitiveness' and in his statement that no one in the family could ever win in a battle with him. There was also considerable sibling rivalry in his family. But I could not yet encompass those data under the umbrella of the main theme I have discerned and summarised above; nor did these themes appear so central that they could have served as the broader umbrella for my other observations.

The beginning of the analysis and a quick survey of its course

Within a fairly short time, Mr K's optimism gave way to a pervasive and sustained gloom and despair around weekend interruptions and the regular one-day mid-week interruption. He would begin each session with a prolonged silence and an inability to maintain the continuity from one week to the next; later on, even from one session to the next. He complained that he was invited to open up and

6 Kohut's conceptualisation of the mirror transference was based on his observation that transference needs and expectations arose in relation to the absence of developmentally crucial experiences of feeling affirmed and valued (Kohut, 1971), (1977), (1984). As will be seen later. Mr K's difficulty in establishing contact with his own feelings, and his struggle to establish such an affirming connection with me, had indeed become a central issue in his analysis. Without affirming and validating experiences in the transference, Mr K was unable to experience his own reality and authenticity. The question often arises of how do we actually 'mirror' the patient? Only a general statement can be offered in this context. Reflecting back our grasp of the patient's subjective experiences—the simple fact of having registered them—and communicating our understanding of those experiences, constitutes analytic mirroring.
then at the end of the sessions felt abruptly dismissed. It took me a while to grasp the archaic fantasy that fuelled these feelings and to respond to them with empathic understanding. He pictured 'total, continuous contact', having me at his beck and call, as he wished his mother would have responded to him. He retreated into feelinglessness and all of his dysfunctions returned whenever contact was interrupted through regular or episodic absences on my part, or when I failed to understand and appreciate his experiences of the moment. When I initially searched for the precipitants of these reactions in his experiences in the previous sessions, he became exasperated with me because he felt his reactions were 'simply a function of the time that elapsed between sessions'. Among the many initial metaphors that helped us understand his reaction to the interruptions was his idea that, like a battery that is plugged into an electric outlet and becomes filled up and then over time loses its electric charge, so does he lose what he is filled up with in each session. After he leaves on Friday, the charge lasts for about 24 hours (it depends on how good an hour he has had), and by Sunday he is again empty. For a long time, no amount of understanding of what was involved helped, because Mr K felt that if I truly understood, I would not let him go without the 'electricity' or 'fuel' that he needed and could not do without.

What he experienced as 'deliberate deprivation', and the fact that he could not control my comings and goings and that I could not see him seven days a week, infuriated him and after each interruption he felt that he needed to avenge himself for the mistreatment of my letting him go, knowing that he would not be able to function in my absence. He made me so quickly a part of his self-system that I could (and regularly did) easily disrupt the cohesiveness of the archaic merger-mirror transference.

After a considerable period of analysis, the severity of Mr K's reaction to physical separation became less intense, but by no means absent. However, the rupture in the analytic bond was now much more frequently jeopardised by 'misunderstandings' (which he always interpreted as deliberate efforts on my part to foil him, in order to control him as his father did) as well as certain countertransference intrusions that interfered with my responsiveness to Mr K's archaic needs and demands (which were as callous and uncaring as his mother used to be). For example, Mr K frequently described how his mother would be unavailable to him emotionally and respond to his recalcitrant, affection-extracting behaviour punitively. She would deny his need for her by saying: 'You can do that yourself, you shouldn't need me for that!' This same 'extracting behaviour' in the analysis (as he himself called it) elicited in me a reluctance to be responsive to his 'excessive' demands (excessive from my perspective), without my recognition of it at first. Perceiving this, he felt that I was retaliating against him for his expression of his need for me, as his mother had done. My reluctance to accept his transference demands and find an appropriate response to it reflected the intrusion of my countertransference, in that I lost my empathic observational perspective and became the judgemental external observer. This had inadvertently reinforced the repetitive aspects of the transference. He would then accuse me of punitively withholding my 'responsiveness' or my 'genuine presence' from him (as his mother had), making his emotional presence with me impossible. (For additional details regarding similar experiences with Mr K, see also Ornstein, P. H., 1987), (1993).

To illustrate the slow, but definite structural accretions that permitted the evolution of a higher-level mirror transference to take the place of the earlier archaic one, I shall present three segments of the advanced stages of the analysis, where this change had become more clearly evident.

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A mirror transference may become established out of various levels of psychological organisation. Merger-mirror transfence refers to the most archaic nature of the mirroring need, where physical separation leads to a painful collapse of the self. Mr K called this need—originally an unconscious fantasy—'my symbiotic scenario'. More advanced levels of psychological organisation would give rise to needs for affirmation and validation without the need for being merged with the mirroring selfobject. Kohut referred to this constellation as the 'mirror transference proper'.

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THREE SEGMENTS OF THE ANALYSIS AND THEIR CONCEPTUALISATION

Segment one

Many years into the analysis, Mr K began one of his Monday sessions as follows: 'I am internally silent and invisible—to myself as much as to you'. Brief pause. I interrupted this pause with a question, since I knew by then that continued silence on my part in response to his first communication in the session, especially after a break in continuity, would derail our dialogue for days, if no longer for weeks. ['Can you say more about it? '] 'I am frustrated that I am unable to affect the outcome'—he said. 'I feel powerless to do anything about that choice of that part of me' [referring to his 'inner self' or the 'child inside' that needs to maintain the silence and invisibility]. 'It's a posture of extraction in order to fill its need. It is a feeling of deprivation and a lack of significance.' Pause. 'It is my agenda to let it be filled through my passivity. Waiting for Godot is my tool of choice as opposed to some activity. I am believing that the more passive and dysfunctional I am, the more I can claim significance.'

[Somewhat reflectively, 8 he continued:

My method now is the method of that time; feelings of withdrawal and depression. Now I feel my adult powerlessness of having any effect on my inner self. If I let go of those feelings of last week [anger and revengefulness for having been dropped abruptly by my brief silence at one point] and go beneath them [meaning: if I analysed them] then I feel the powerlessness of any effort. If I remain patient and receptive there is still no effect on [my] silence and the unavoidability of my reaction of last week.

[So, is it preferable then to hold on to your feelings of anger and depression in order to extract a response even if it delays your being able to get reconnected to me?]

Yes, but that is not my main point. My main point is that I have to avoid my own feeling of powerlessness—you still didn't get that. And you made your point so strongly just now, with such assertion in your tone of voice. That always makes me feel that we are in an adversary situation and you create it. Consciously I am powerless regarding the intensity in your voice. By attending to what is [focusing on his immediate experience and not asking 'why?'], I can affect it. By your attending to it I can bridge the alienation; the connection to you allows it to change. The first level is what you do—not as you, P. O., but as the representative of the outside. You have to explore the actual architecture of my experience. What is, is on the screen. My agenda is to present myself in a way that it will be seen, accepted and received. It is contradictory. You have to see that it doesn't make sense. Upside down you have to see it. Don't turn it over! Your effort to turn it over has always been counterproductive. It guards you against seeing. Fine for you to see the illogic, but don't have the agenda of changing it. Only see it. It will self-correct in the light of day. My agenda is, will I be accepted with my 'No' or not? Or do you have to change my 'No' to a 'Yes'? Internally, I am holding that 'No' for survival and the important thing is not how illogical it is. Not being here [saying 'no' to being emotionally present] is survival; I survive my own fear of rejection; not being here protects me against rejection.

[I see more clearly your sharp distinction between your fear of your own rejection of your inner self and then your need to protect yourself against my rejection of it. You added to it something very important today: that I should not worry about what is contradictory in what you say; I shouldn't try to make logical sense of it. I should leave it upside-down and make no effort to turn it over.]

Your effort to turn it over never worked—I still have to convince you of that.

8 Some readers of the verbatim quotes of Mr K's free associations throughout this paper (as well as in previous reports of other segments of this analysis) remarked on the 'strangeness' or 'unfamiliarity' of his particular way of speaking and reacted with: 'People never talk like that on my couch or in my office'. On a number of occasions throughout this analysis I have felt that way myself. Wondering, even if only transiently, about the genuineness or authenticity of his free associations, during the early years of the analysis this has led me to explore the fact that Mr K's words have often sounded hollow, his expressions stylised. At such times he would acknowledge that he was not 'emotionally connected' to what he was saying, but he considered the content of what he was saying as nevertheless 'valid', and this appeared to 'emerge freely'. The issue of 'not feeling emotionally connected to anyone or anything' has been a pervasive problem in his life as well as in the analysis. Another aspect of Mr K's manner of speaking is his need to express himself with great precision and a variety of metaphors, as a way of dealing with his deep and abiding concern that he will not be understood.

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Brief pause. 'I gained some degree of presence through this work, but inside I am still unhooked from the experience. The inner self is unhooked.' Referring to some vivid imagery in a dream a few weeks ago, he said:

The choice of a parrot is closer to the beatific self [the hidden, genuine part of him; the pre-traumatic self] rather than a prairie-dog: a wild dog. The one can fly, the other can't. I can now feel a conscious trust in what you are doing and that you will not grab the parrot—if I present what is vulnerable, will you violate it or respect it? Will you judge it or try to change it? I am experiencing a surprising relief … that you actually understand and care … tremendous relief. I picture an ability to collapse the defensive structure without an inner collapse.

[I hear you say that what makes it necessary for you to be emotionally absent has to do with your persistent fear that I will not accept what you present, who you are. So you refuse to be emotionally present because hiding has become an important part of insuring your survival; you are afraid that I will want to turn your feelings around, look at them logically, question them, examine them with an agenda to change them—that fear still keeps you unhooked inside. Then you expressed a significant shift in your feelings: you can now trust me and you are experiencing a 'surprising relief', a 'tremendous relief'. I hear for the first time that you can picture being able to collapse your 'defensive structure' without fearing that that would lead to your total inner collapse, as you always feared it up to now.]

This sudden collapse of Mr K's 'defensive structure' in response to my intervention nevertheless surprised me, although such dramatic moments—their effects still lasting only briefly—had begun to occur with greater frequency. These experiences indicated that when Mr K's experience of me was optimal, he dared to relinquish his defences—although at first only temporarily.

Mr K continued:

There was a moment of great hesitation and uncertainty when I presented my feeling of relief; you said other things before you reflected the relief I felt. I felt the uncertainty of whether you will reflect it or not and that was more important than anything else I said. When I question whether I can trust you, I quickly go to the interpretation that I can't trust you. Uncertainty and ambiguity are dangerous to the process. I get the feeling of being played with and teased. I don't see it in your behaviour but internally that is how I interpret it. I am triggered by ambiguity and that hasn't turned the 'No' to a 'Yes'. The time factor is more important—we are not doing that badly now. I feel substantial relief, but not enough.

It is at moments of such relief (whether he verbalises it or not) that Mr K usually presents a dream from the night before:

With L [his wife] in Chicago by car. Parking. No space and outrageous amount, $100.00, for an evening. Can't stay anywhere else, caught there. Uncertain and very dangerous in that area. I do go up into the City to find G.'s apartment. He is not there; he is in a hospital. But when we go there, he is not there either. There was some lurking presence near us—a reasonably positive experience. A large presence, like a dinosaur—potential capacity; unclear. There was a vacant lot there instead of the hospital.

'The dream depicts my inner landscape'—Mr K began without any prompting—and my struggle and confusion in trying to deal with it. The lurking presence is my inner self. It was a powerful presence. Like the horse in the field [a frequently recurring image, representing the eluding, powerful, intractable inner self] that is strong, capable and out of reach. It stays out of reach and maintains its distance; it eludes you. 'The horse cannot be caught if you pursue it vigorously—he said on many previous occasions—you simply have to be receptive to it and demonstrate your receptivity, then it will return. The same conditions apply to his effort at establishing a connection with his inner self; he [his adult self] has to be receptive to the needs of the inner self and I, too, have to be receptive to it, with all of its needs.

In his further associations, Mr K understood the meaning of the 'vacant lot instead of the hospital' as reflecting his fear of my abandonment of him [my consulting room is in a building adjacent to a hospital], but also the possibility that with the hospital removed, he no longer had to be concerned with my disappearing or being unavailable to him—there could be no further unpleasant surprises.
about that. The neighbourhood was a jungle, where everything was possible, nothing could be trusted. 'It reflects the way the outside feels to the inside.' The outrageous price of parking was the expression of his fury about my fee, which recurs whenever he feels mistreated by me [i.e. not understood, 'dropped' abruptly by my silence, etc.] and feels the threat of my abandonment of him. Mr K then translated his fury about the fee to mean that he has 'for long been paying dearly with shame and being controlled, even for small everyday things', and he now refuses to pay the price; he withdraws and becomes passive and indolent instead.

It was near the end of the session when it dawned on me that the dream, as well as Mr K's opening feeling of being 'internally silent and invisible' might have been triggered by the preceding weekend interruption. So I asked him about it. He put the emphasis on the fact that what the dream portrayed was his chronic inner landscape, so was his feeling at re-entry at the beginning of this session—but he allowed that the latter might well have been intensified by the weekend interruption.

My interventions thus far reflect my on-going, immediate, low-level or experience-near conceptualisations—most of which occur spontaneously, as if outside of awareness. But these should now be made more explicit and should also be supplemented with further, higher-level or more experience-distant conceptualisations, as far as the data permit.

**Conceptualisation of segment one of the analysis**

Mr K experienced himself at this point in the analysis as 'unbridgeably polarised internally'. His outer, adult, rational, 'left-brain self' felt to him out of touch with his inner, intractably demanding, 'right-brain, childhood-self', and he felt that his 'centre of initiative' resided in his inner self. It is on this account that he felt helpless and in despair that he could not have an impact on his inner self. His need and demand to be seen, accepted and 'received', that is, to be validated in his subjective experiences without an agenda on my part to change him, attests here again to Mr K’s archaic need for mirroring and thus to the presence of a cohesive, archaic, mirror transference. He put up a 'No' to any sign he perceived as an effort on my part to change him. He demanded to be accepted and affirmed as he was. Both his 'No', his refusal to be emotionally present, as well as his being unhooked from his inner self, were a part of his personality structure by now—his base-line attitude as he referred to them—and he automatically assumed a 'defensive posture' in the analysis whenever he felt that I wanted to examine the illogic of his experiences and thereby wanted to change them. If I accepted the illogic as he presented these experiences and explored with him their source without questioning their validity, he could then 'turn them around' and examine them himself, and turn his chronic 'No' into a 'Yes' [meaning he could then be emotionally present with me]. He demonstrated this in feeling an unexpected relief when I responded to him in a way that made him feel accepted and understood in the session just presented.

This interaction demonstrated how my effort and occasional success in encompassing his subjectivity functioned to consolidate his fragmentation-prone self. The resultant increase in self-cohesion accounted for several changes: Mr K could be more self-reflective without degrading himself; he could say, without ambiguity, that his analyst was not teasing or playing with him, although he still experienced him that way, saying: 'I know you are not [teasing me or playing with me], but I feel that you are'. Most importantly, and in keeping with our theory of cure, Mr K was able to reduce his defensive vigilance and withdrawal, because he felt increasingly safer to present his self to me for approval.

Such changes in analysis do not come about in a straight uphill fashion; Mr K continued to direct his heightened sensitivity toward the possibility that I will fail to hear and validate his experiences. For example, he was still listening for evidence whether I had noticed and would comment on his expression of relief. At times like this, one is reminded of the need children have to be validated in their feelings, in order to experience them as 'real'. My including and thereby underlining the importance of his idea that he could picture being...
able to let his 'defensive structure' collapse without anticipating a total inner collapse, served here as a particularly self-enhancing selfobject function. His sensitivity—the legacy of the original developmental deficit—could be recognised in the way in which the delay in my acknowledging his feeling of relief (and the ambiguity this engendered) created some anxiety. Such anxiety regarding the uncertainty of my perception of the subtlest nuances of his experiences would lead to painful and prolonged disruptions in the past. This time, however, with his increasing sense of safety, the experience could be jointly explored and did not initiate the previously observed disruptions and haughty withdrawal.

The dream Mr K reported after his feeling of relief in response to our work together portrays his chronically-unmirrored self, and his struggle to fight off feelings of abandonment, and with it an emotional collapse. Importantly, he was now not only fully aware of all this but could also picture the possibility of change—a change which his momentary relief foreshadowed.

It is important to keep in mind that we are here engaged in a process of conceptualisation. As we have indicated in relation to the preliminary encounter, our conceptualisations have two aspects to them: one is related to the increasingly more refined understanding of the nature of the psychopathology, and the other to the changes as these occur in the course of the analysis.

In terms of the conceptualisation of the psychopathology, this segment illuminated the extent of the defensive use Mr K had made of dissociation of affect to protect his vulnerable childhood self, and how the characterological use of this particular defence had 'split off' the most authentic part of his self. This was the source of his chronic complaints of not being able to make contact with his own emotions. From the perspective of the analytic process, this segment has to be conceptualised in terms of self-cohesion depending on optimal selfobject experiences: whenever Mr K experienced the analyst's genuine emotional presence, which resulted in increased self-cohesion, he could abandon—at least temporarily—his habitual defence of affect.

**Segment two**

The next vignette, of a session several weeks later, brings back another facet of Mr K's self-disorder into the transference. It is the problem of his 'infatuations'. He had just seen the movie, *The Age of Innocence*, which had made a deep impression on him because he recognised a similarity between the function that his own pre-marital (and much earlier) infatuations and that of the protagonist's extramarital infatuation had served. The session began thus: 'From an adult standpoint, what I need to do is to speak from that part of me that resides in the infatuation. I don't know how to get to that voice. Just do analysis I guess. I have the familiar tension in my rear-end. Thinking of withholding the dream; I have the basic posture of withholding'. I acknowledged registering his feeling tension in his anus (this is the world he frequently used), since missing such remarks in the past meant to him that I repudiated his physical being just as his mother had. This time he corrected me:

'Rear-end; not the anus, the bottom of the spine. It means containment and defensiveness.

Anything here right now that prompts you to withhold?]

To reveal my experience is the implicit instruction and I oppose it with my withholding stance. Intense physical sensations are signs of awakening [from being numbed, anaesthetised, feelingless].

Is there more to this withholding stance?]

Resentment, defiance, futility. Habitual now—related at one time to anxiety about not being accepted. The oppositional stance was a more workable posture. Easier to take a defiant, angry posture than to acknowledge the need, the real underlying feelings. I feel safe, if I am covered with definance and hostility. [What feelings are you covering now? Is any part of all of this in your experience? Can you find it?]

In my behaviour I can find it, but not in my experience.

Mr K spoke of the male character in the movie, who was married but was infatuated with another woman. He reflected on how similarly he used his many past infatuations.

To the extent that I am trying to get you or the world to value me, because I failed to get value originally,
[infatuation] is either a trap or a middle step [transitional to his being able to feel within himself what he is looking for from the outside, from the women]. I am doomed to failure in trying to get what I am missing in myself [through infatuation], but [using infatuation] as a middle step I can get to something stable. The third step would be to reveal myself to L [his wife] and be valued and engaged by her because I trust her ability to do that. But there has to be a change in me first. I have to be able to let go of the worthlessness and repulsiveness I feel. In order not to be stuck in tragedy, I have to let go of this view of myself, to be comfortable with myself and then I can be present. I hope I'll then be able to absorb all the injuries I fear and expect all the time. Here, when I am invited to bring forward what is dysfunctional in me, it is an invitation to disaster—as long as I am significantly polarised. I know it is unreasonable to expect the invitation from you to my whole self; nobody would want the ugly, repulsive side of me.

Here I thought to myself: there appears to be less need on Mr K's part to control my responses and those of others, as well as a greater tolerance of his own sense of worthlessness and repulsiveness.

Mr K went on to say that from the ages of 5 to 19 he had always been infatuated in a dream or in a fantasy and expected that some of the little girls in grade school, and later the women he dated, would provide the valuing affirmation and invitation that would reflect the beautiful side of him. But outside of the dream or fantasy he was incapable of encountering these women.

My need could never have intersected with the reality—but I didn't even get to the reality. I remained with the fantasy. Unrequitedness sustained the intensity of the fantasy relationship. If the character in the movie could marry the woman he was infatuated with, he would have to contend with the reality. With my fantasy I had a degree of depth or intensity to what I wanted and still want. But it is not reasonable to expect that from reality. It was infantile to try to gain the mother I never had through these infatuations. It was not an adult relationship. Would not have worked with any of those people. I could create a composite [of several women] that it would work with. My own difficulty in feeling value and acceptance would have interfered with my relationship with these women in reality. As it does in this moment. I do not know how to be present without bringing my projections and fears into this moment. [Can you say more about that?]

My need for acceptance and value always ended with failure and abandonment. The obstacle here is the lack of success; makes me reluctant to be present. I expect to be seen with repulsion and attacked—if I show the negative side it will meet with repulsion; the positive side with attack.

[So you can't be here with either side of you then?] I am trying to test how I will be received. I am also here in some subtle way to find out how you are going to receive and treat me.

Pause.

[What are you finding out about that right now?] The form that is present [meaning the way I am speaking to him now] is very much aligned to invitation, safety and acceptance. The form is the antidote to my fears of rejection—the interrogative, rather than your assertion. Moving along right now, but not yet in from the tremendous cold. I know it is warm [here], but I do not feel warm. I feel the warmth, but I am not warm yet. To move out of the metaphor, the way you are engaging me now is close enough to what I have requested; within the range of the acceptable and I don't need to tune it. Because of that I am trying to move back to where I am and deal with my own obstacles rather than orchestrate you. Where am I on the trust spectrum? The 'trustmeter' within me constantly registers. I trust you with a tremendous reservation: I expect to be defeated by my trust. When I give up my vigilance, that is when you become less available. I am also up against my chronic fear. Unreserved experience of my own need will be ridiculed. My experiencing of those needs means genuine presence, but that evokes ridicule and control. E.g. it is enough if you go silent, or judgmental or directive. Those have been what have undone me. They have triggered the switch in perceiving you with fear; the present became the chronic, feared past.

[If you deny your needs and have no feelings, I can't hurt you. If you emerge here 'incomplete' that invites your destruction.]

Yes, I have lived that way all my life. In the movie when the man was with the women he was infatuated with, he was able to feel alive and complete. I need completion, too.

Conceptualisation of segment two of the analysis

In accounting for his many infatuations in the past, Mr K revealed a profound insight, namely, that to feel differently about himself,
he had needed from early on intense emotional experiences (of being invited, wanted, desired and enjoyed), and he had searched for these without lasting results in the women he was infatuated with; experiences he eventually had (in a muted way) in his analysis. By clearly recognising the function infatuation had served for him in the past, Mr K pinpointed his current struggle in the transference: to get from me what he felt he needed in order to be able to connect to his inner self and to be able to be emotionally present in the analysis. Though still vigilant about how I would receive and treat him, he no longer had to orchestrate my responses. Once he began to feel that I was responding willingly and unambivalently to his needs, because I no longer felt that he coercively made me do it, he could lay out quite daringly and poignantly many of the details of his subjective experiences. He had discovered and helped me see what allowed him to be emotionally present; what made his 'defensive stance' less necessary. It was my interrogative form of response to what he presented that made him feel invited (rather than repulsed from) and received (rather than rejected) and given a chance to define himself (rather than fight against being defined and thereby controlled by me).

These events in the analysis were crucial, since only when I was able to be unambivalently emotionally present could Mr K 'use' me as a development-enhancing selfobject. Only then could he resume his thwarted need to grow and begin to consolidate his fragmentation-prone self. In our view, defensive operations do not become modified by interpreting them directly, 'head-on'. Rather, viewing defences as protecting a vulnerable self (Kohut, 1984), they become less necessary with the increase in the cohesion and resilience of the self (Ornstein, A., 1990), (1991). With these changes occurring in the structure of the self, I could better understand the changes that had become manifest in segment three (see below).

However, it had also become clear that, while there was an increase in self-cohesion and a lessening of his defensive anger and withdrawal, Mr K still maintained a very negative image of himself: he continued to feel that because of his 'ugly' and 'repulsive' side he could not expect to be fully embraced and appreciated. Though feeling freer to show himself to me and possibly to his wife, he also felt that he would first have to develop a different image of himself in order to feel valued and appreciated by others. Mr K was consciously aware of being torn between feeling entitled to be fully embraced and appreciated, on the one hand, and feeling 'ugly' and 'repulsive' and hence undeserving of such a full acceptance, on the other. But it was not primarily this conscious conflict that interfered with his emotional presence in the analytic situation. His needing to 'unhook' internally from his experiences in the analysis, had to do with his fear of the analyst's response. And this was the crucial observation: whenever he felt optimally responded to, his need for defensive self-protection would markedly diminish.

According to our theory, such changes in Mr K's self-perception could only be brought about by my unwavering acceptance of him as he perceived himself and by progressively recognising the various sources of his self-perception. I was able then to appreciate that his self-perception had two sources: it was partly the result of unempathic selfobject responses by his caretakers and partly related to the affects associated with his characteristic defensive behaviour—his angry withdrawal when feeling slighted, dismissed or not fully understood. While Mr K responded with an improvement in his self-organisation in relation to my acceptance of him as he was and my understanding of his subjective experiences, he was rarely receptive to explanations (until much later). However, he himself frequently offered genetic explanations in relation to his current behaviour. At such times, when he was the one who turned his attention to explanations first, he could be engaged on that level of discourse effectively.

This segment offers an opportunity for further refinement of our conceptualisation of the analytic process and the process of cure. Mr K relates his efforts at self-healing through a series of infatuations, which, in this context, can best be understood as processes of idealisation. The developmental need to be mirrored
by an idealised other si in keeping with our self-psychological understanding of personality development. This explains the curative elements inherent in patients' idealisation of their analysts, whose admiration and appreciation they crave.

Segment three

Some months later, in the next two sessions following a weekend interruption, Mr K reached a significant turning point in the analysis. He began with his usual difficulty on entering.

My silence is a more authentic experience than the noise I make in talking. My speech feels artificial and abstract—further away from what I am, than the silence. The silence is also a defence. It is something I am doing to defend and avoid. To put more accurate language on it, I anticipate failure of understanding and unresponsivity and therefore I distrust. More fundamentally, I anticipate my own response of unacceptability—my own I do not trust. Fundamentally, my own experience is intolerable to me. I anticipate feeling embarrassment, inadequacy, and insufficiency; these would be met with a rejecting rather than an affirmative attitude; stoically [as he feels his father met everything Mr K ever expressed]. I feel you are teasing me the same way to ferret out insufficiency and then ridicule me; I reveal the truth and you would not accept it. Thinking of examples of exposure where nurturance followed—never.

[So you always expect defeat, control, exploitation and humiliation—that I would only want to know the truth to hurt you with it.]

True, but that is not the most difficult truth. I imagine exposing the truth about me to be an insoluble and debilitating experience [because his basic defects could never change; exposure could only confirm their existence].

Pause. Wanting to forestall a major derailment here, I broke the silence. I said:

[I was looking for some 'red words' in what you said and wanted to recapture them and highlight them. I wanted to ask whether that would enable you to go further.]

What you said hit the mark only 50 per cent, because you said something [rather then remaining silent]—but the way you said it, you did not address me directly; you said: 'I am looking for "red words" and want to ask you whether that would enable you to go further', rather than 'Could "red words" enable you to go further if I could find them?'—You see the difference?

I responded by acknowledging the difference.

The next session:

Whenever I leave here after a session lately I keep asking myself, am I able to do analysis with you? Lately, a number of 'No's regarding the question of being able to be present—occasionally 'Yes' to the sort of reception like the one in yesterday's session. Then, when you put no obstacles in my way, I can see myself as the problem—I need to acknowledge that too, not only complain. Lately there were few such places that were not handled according to our agreement—I have to acknowledge when it is working. The piece you did not have—I judge it by what you did—You don't understand the power of the interrogative that helps me locate you as having the ability and willingness to understand me. In yesterday's session, when we ran aground briefly, if you had asked: 'Can you put your experience into "red words"?' I could have found your participation in the immediate present. I experience now an insatiable need to repeat this to convince you how important this is [the interrogative and the red words].

Mr K's sessions always begin with difficulty in establishing trust. In addition, his finding fault with the wording of my remarks often escalated his mistrust. However, these 'disruptions' had become milder and much more quickly understood, adequately resolved and the connection between us more quickly re-established. I was therefore able to say: 'I could see from the way you reacted to my search for "red words" and trying to put them into an interrogative—even though it only hit 50 per cent—how much calmer and safer you felt. So I know how vitally important that is for you. Do you feel that calm and safety now?' He said 'yes' and, indicating that there was no leftover tension between us at this moment, he launched into describing his dream from the night before.

An elaborate dream, two fragments of it left. At U. of D., now or when I was actually there, not clear. There was a great deal of construction going on. I have a reasonably involved consulting role there.
need a hard hat to go out to the area. What kind of hat and what color hat to get; like a football helmet? I didn't want that. Usual hard hat; what colour; decided on white after some deliberation. The dream is about arriving at that decision.

He began his associations spontaneously:

Developmentally, the dream is from late adolescence. Hopefully, it means that I brought the difficulties through to a later developmental level. Construction: the image of structure that could be rebuilt; work done is to make a stable format: concrete or steel; fundamentally stable internal structure. It is the accomplishment of the dream that it can express that. The dream says: still incomplete and unable to function and is dependent—but there is construction going on. How to find the beatific presence in the midst of that construction process? ['What are you referring to?'] 'The character in me in the construction with the hard hat goes around freely and performs the tasks without vulnerability and exposure. My entry today was out of sync with my feelings in the dream; the presence for this process was not on the same level as the dream. How to be present here is still a struggle. Your role for the analysis is neutral, like being a gardener. Clear human participation is required for me to be able to be present. To acknowledge the achievement of the dream and the significance of the dream is on the wrong side of the line for you. You don't want to put value on it. I got more trouble with that than you do. Because you won't put value on it, I won't; then you won't, then I won't. I am dependent on your valuing me and what I am doing during the process, then I can fully participate.

Looking at some of the details of the dream, Mr K saw the whiteness of the helmet as representing his beatific self. The helmet stands for protection, without limiting his presence.

My presence on the construction site is protected, so I can participate in the construction and be protected at the same time.

[Does the construction refer to your work here?]

Yes, it is potentially a positive image of the analytic work and goes to a successful analytic end. At the end all of the contracting equipment the whole scene disappears. The whole construction scene is transformed into a classroom (it is a school)—no evidence of construction at the end in a completely finished work. Ready for its life-purpose. Through the dream I am trying to convince you by choosing the metaphor: it starts with a dependent relationship; there is an intensity of involvement in the construction, yet all the equipment, the people who worked there, they are all gone once the construction is finished.

Conceptualisation of segment three of the analysis

The two consecutive sessions of segment three portray a circumscribed disruption in the transference (in connection with my search for the 'red words') that did not get out of hand, and no longer led Mr K to a prolonged withdrawal, rage and refusal to be emotionally present. Because of Mr K's increasing readiness and ease of expressing what he felt and because of my increasing ability to face his reaction when not meeting his expectations, of 'not responding quite right', the mild disruption could be quickly repaired. Mr K was not only able to lessen his guard in response to our work in this session, he responded to it with a dream that indicated his altered inner landscape. His dream depicted a construction, with clear understanding on his part that this referred to his analysis. He also found a way to tell me (and bring about a change in me regarding this issue) that his intense 'dependence' on certain of my responses, which I offered with some reluctance initially, would ultimately free him, rather than enslave him to the analysis. His imagery impressed and freed me from my 'reluctance' and 'unwillingness' (as he so frequently observed in the past) to respond to him in the way which he said he needed a response: his imagery of the construction site where 'involvement' and the need for the many 'equipments' is at its height during construction, all disappear after the work is done. There is no trace left of the equipment and the people who participated in the building—which is then 'ready for its life-purpose'. Change can best be seen in that his demands were no longer for concrete 'total and continuous contact and care', but for the validating responses that would enable him to reconnect meaningfully to his own inner self and then to others in his life. The response Mr K needed (and demanded) in fact provided an empathically-responsive analytic ambience.

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that increased and safeguarded self-cohesion. It was the increased consolidation of the self that not only reduced the threat of fragmentation, but also provided the analytic soil in which structure building and insight could occur hand in hand.

The analyst's countertransference, namely, his hesitancy to comply with the patient's demand to conduct the analysis 'in the interrogative mode' (to ask questions only, rather than make statements), exposed the profoundly archaic nature of Mr K's psychopathology. His insistence that the analyst invite him to reveal all aspects of himself was analogous to a young child's need for the mother to accept and validate all aspects of the child's self, without which he could not experience these as parts of himself. Being invited to speak about certain experiences assured Mr K that his 'revelations', rather than being dismissed, would be 'properly' appreciated.

CONCLUDING REMARKS ON THE PROCESS OF CONCEPTUALISING CLINICAL FACTS

We have illustrated our conceptualisation of clinical facts within the broad outlines given in self psychology (Kohut, 1971), (1977), (1984) and shown how the microscopic, moment-to-moment details of the analytic interaction painstakingly (and often painfully) focused on the establishment, continuation and deepening of the psychoanalytic dialogue. In this dialogue, the learning of the patient's verbal and body language; his metaphors, his current and past experiences; dreams, etc. allowed patient and analyst to find the meaning of their interactions and grasp their respective inner experiences. Only the patient could lead the analyst to the specific requirements for his 'cure'—through the understanding and explanation of his inner experiences in the transference. It is only then, as the analyst's expanding capacity to respond in accordance with the patient's needs and his requirements for sustaining the analytic dialogue, that the working through could lead to structure-building and initiate the visible process of change in this analysis.

In our conceptualisation of clinical facts we use as our starting-point and place our emphasis on what is discernible to us in the patient's (hence also in our own) immediate experience. These are for us the most relevant facts, jointly created—as we have stated at the outset. It is on the basis of these 'analytic events' that we begin to formulate the nature of the patient's psychopathology as well as the 'curative elements' in any particular analytic process under examination. The central starting question in our minds refers to the function we serve for the patient in the selfobject transference; the role he or she assigns to us in the restoration and maintenance of the cohesiveness of the self. It is from the recognition of this function in the 'here-and-now' of the transference (the 'dynamics') that we can then extrapolate to the pathogenetic experiences of the 'then-and-there' (the 'genetics').

Most 'visible', of course, to both patient and analyst—during the analytic experience itself—are the disruptions in the transference and their repair. These experiences highlight the nature of the patient's vulnerabilities in conjunction with the nature of the analyst's responsiveness and repeated 'failures' in empathy as well as his countertransference intrusions; namely, those of the analyst's feelings and behaviours of which he is unaware, but which, nevertheless, derail the analytic dialogue. These experiences form the core of those clinical facts on the basis of which we formulate both our experience-near and our experience-distant conceptualisations.

There are several curative factors involved in the interpretive activity related to the inevitable disruptions in the transference. It is at times of these disruptions that the patient's vulnerabilities and their related defences (in Mr K the shutting off of his emotional presence; his angry withdrawal) are most clearly exposed to both the patient and analyst. Countertransference (in this case the analyst's reluctance to accept the selfobject position 'assigned' to him by the patient) frequently precipitates such disruptions or can be responsible for protracted stalemates. Once patient and analyst are able to recognise the nature of the disruption, they can proceed to the task of repair, which has to be done analytically, that is, interpretively. While the experience of re-establishing the transference bond may in itself have
curative elements, these have to be explicitly articulated in order to assure that changes on the level of experience are buttressed by insight.

The question is frequently asked whether or not interpretations, offered in an atmosphere in which the analyst is concerned with establishing and maintaining empathic contact with the patient, can address anything other than what is already conscious to the patient. In other words, are analytically meaningful interpretations possible when the analyst attempts to convey understanding of the patient’s subjective experiences?

We hope that the brief segments of this lengthy analysis have demonstrated that interpretations which convey acceptance and understanding, as well as periodic explanations (from the patient's perspective), do indeed deepen the analytic dialogue. They do so because 'feeling understood' is a self-consolidating experience, the pre-condition for lessening defensive operations (Ornstein, P. H. & Ornstein, A., 1985). Self-consolidation, on the next level of conceptualisation, represents the acquisition of new psychic structures. This assumption of the process of cure is in keeping with the theory that selfobject transferences arise on the basis of structural deficits. The clinical example given, and our on-going conceptualisation of the meaning of the analyst–patient interaction, also show that different psychoanalytic theories give rise to different theories of technique and cure.

We are aided in our effort at a broadly inclusive, systematic, conceptualisation of our analytic experiences (usually at the end of an analysis, or when we have an opportunity to present aspects of our work), by Waelder's outline of the structure of psychoanalysis (Waelder, 1962). This outline (slightly modified here) includes clinical observation, clinical understanding and explanation, 9 i.e. interpretation; clinical generalisation and clinical theory. Waelder then moved on to further abstractions: to the level of metapsychology and beyond that to Freud's 'Weltanschauung'. An encompassing grasp of the meaning of a psychoanalytic treatment process ideally includes conceptualisation on all these levels of any of the leading, multifaceted, psychoanalytic theories.

REFERENCES
KOHUT, H. 1971 The Analysis of the Self New York: Int. Univ. Press. [→]
KOHUT, H. 1984 How Does Analysis Cure Chicago: Univ. Chicago Press. [→]
ORNSTEIN, P. H. 1993c On the function of theory in the interpretive process in psychoanalysis In Festschrift for Joseph Sandler in press. [→]
WAELDER, R. 1962 Psychoanalysis, scientific method and philosophy J. Am. Psychoanal. Assoc. 10:617-637 [→]

9 Waelder did not include clinical understanding and explaining as separate steps in the interpretive process. Furthermore, he presented these levels of conceptualisation in a linear fashion, without explicitly recognising the reciprocal influence of one layer on the other—as if observation, for instance, were not already affected by theory (see Ornstein, P. H. & Ornstein, A., 1985).

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