Interaction in Psychoanalysis
A Broadening Horizon

James L. Fosshage, Ph.D.

To view all that occurs in the analytic arena, including verbal exchange, as interaction broadens the horizon and affects our understanding of the analytic process, transference-countertransference, therapeutic action, and theory of technique. This paper focuses particularly on implications of the organization model of transference: the process of illuminating transference, the mutual interactional shaping that occurs in the analytic relationship, and the distinction between the content and the process of communications. Defining countertransference as the analyst's experience of the patient, the paper proposes that all analysts, regardless of persuasion, use their experience of the patient (that is, countertransference) as the central guide to analytic exploration and understanding. Differences in analysts' experience of their patients arise not only because of different models and respective subjectivities, but also because of the variable use of two principal listening perspectives: listening from within the patient's vantage point (subject-centered listening perspective) and listening from the as-the-other (other-centered) vantage point. The paper proposes that the analyst's listening from within and as-the-other, oscillating in a background-foreground configuration, can illuminate more fully the patient's experience of self and of self in relation to others. And, finally, recognizing that all interventions are interactions firmly anchors the interpretive process and its power within relational experience and opens the door to reassessing and potentially embracing the many varied forms of interventions that contribute to the therapeutic action of psychoanalysis.

James L. Fosshage, Ph.D. is a Board Director and faculty member of the National Institute for the Psychotherapies, NYC; a member of the Core Faculty, Institute for the Psychoanalytic Study of Subjectivity, NYC; and Faculty member and Supervisor, Postdoctoral Program in Psychotherapy and Psychoanalysis, New York University.

Portions of this paper were presented at the Annual Conference of the National Institute for the Psychotherapies on "Interaction in Psychoanalysis," New York City, April 24, 1993, and at the Spring meeting of the Division of Psychoanalysis of the American Psychological Association in Washington, DC, April 16, 1994.
Interaction, a controversial concept in psychoanalysis, has been used principally in three ways. First, within the tripartite structural theory, the three psychic agencies of id, ego, and superego are viewed as interacting with each other. The social environment impinges on the ego and becomes partially absorbed within the superego, but the primary action is taking place intrapsychically. Within this elegant, one-person model of the mind, interaction focuses on intrapsychic events, not relational events, that emerge in the analytic arena.

Second, in its more prevalent use within the conflict-defense model of the mind, interaction refers to the interpersonal behavioral engagement between analysand and analyst. In contradistinction to the free-associative renderings of the mind and the analyst’s interpretive responses, the mantlepiece within traditional psychoanalysis, interaction labels what happens between analysand and analyst. The analysand’s free associations are viewed as emanating from the deep swells of the unconscious, relatively unfettered by the relational field in which it is occurring. Reactions to the analyst are viewed as emanating primarily from the intrapsychic world of the patient in the form of displacements and projections, in no way impinging upon the personhood of the analyst. The patient’s attempts to engage the analyst more directly are easily viewed as deviations from the task of articulating wishes, fantasies, and memories and are pejoratively labeled as “acting out.”

In the positivistic scientific tradition, the analyst is the anonymous, abstinent, and neutral “objective” observer positioned outside the patient’s renderings. The analyst verbally conveys these “objective” observations in the form of interpretations. Within this classical, and what for many years has been the traditional psychoanalytic model, interpretation has been so “pure” that it was not recognized, until very recently, to be a behavioral response of the analyst. If interpretation is not a response of the analyst, it cannot be considered as part of an interaction. Thus, the division occurred between interpretation and interaction. Interpretation became the sanctioned mode of intervention, while interaction was reserved to address primarily what were viewed as problematic and “nonanalytic” engagements—for example, acting out, manipulating the transference, suggestion, reassurance, education, and so forth. Relatedly, insight and relationship emerged as two centrally different processes and the debate ensued, beginning with Freud and Ferenczi, over their efficacy (Friedman, 1978).

In a more recent rendition of the intrapsychic model, Arlow and Brenner (1990) portray the psychoanalytic process as “the record of the dynamic interaction of the patient’s conflicts and the analyst’s technical interventions” (p. 686). The analyst’s communications “destabilize the equilibrium of forces within the mind” (p. 678), expanding awareness of conflicts and ways of dealing with them. Moving away from its pejorative meaning, interaction here refers to a relational event between analyst and patient. The relational event is, however, quite narrowly defined as the analyst’s technical interventions interacting with the patient’s management of intrapsychic forces. Nevertheless, Arlow and Brenner’s meaning delineates an important shift within the intrapsychic model and to some degree represents a midpoint between the second and third uses of the term interaction.

The third, and most recent, use of the term interaction, and the way that I am using it, is to consider it as a subordinat spin in that includes all the action, including the verbal exchange that occurs between analysand and analyst. This third meaning is based, in part, on relativistic science, wherein it is recognized that the observer always shapes the "observed." (First formulated by Heisenberg in physics, the choice of words, the Uncertainty Principle, is particularly apt when applied to the psychoanalytic arena.) Within relativistic science, the analyst’s observations and interpretations are viewed not as "objective" facts but as "subjective" organizations. This shift in scientific paradigms irreversibly alters the analytic field. “The analyst is ‘dethroned’ from the position of ‘objective’ observer and becomes a coparticipant in perceiving and constructing the analytic process” (Fosshage, 1992, p. 23).

What is underscored is that the analytic arena involves an interaction between two persons, each organizing and constructing the experience with his or her respective subjectivity—what is called a relational (Greenberg and Mitchell, 1983; Mitchell, 1988) or an intersubjective (Atwood and Stolorow, 1984; Stolorow, Brandchaft, and Atwood, 1987) field.

With interaction covering all that occurs between patient and analyst, interpretation can no longer be dichotomized with interaction but must be viewed as one aspect of the interactive process. Similarly, insight and relationship can no longer be divided but can be viewed as
two aspects of a whole—that is, in analysis insight emerges within, is made possible, is shaped by, and gains its potency from the relationship. Relational experience or insight can be in the foreground of therapeutic action, but, when insight emerges, it is inseparable from its relational context. In keeping with these sweeping changes, we have come to view enactment not necessarily as an acting out or a problematic, countertransference-based collusion, but more as a possible growth-producing interaction (for example, Balint’s, 1968, invitation to a patient to do a somersault in his office; Winnicott’s, 1963, description of the patient’s experience of being held within the analytic relationship. The self-psychological literature is replete with clinical examples; see, e.g., Kohut, 1984). We have also come to view corrective emotional experience, without the implication of Alexander’s (1961) directedness, as something that occurs in all successful analyses. To use the term enactment simply to specify a particularly meaningful or poignant interaction (for good or for bad) is one conceptual path to rid it of its pejorative meaning in conventional usage.

Recognizing interaction as the experiential whole, which includes verbal exchange, potentiates overcoming the elevation and assessment of interpretation as the premiere analytic intervention. Previously interventions other than interpretation were viewed, at best, as momentarily necessary parameters to be dispersed with as quickly as possible, and, at worst, belonging only to that poor stepchild of psychoanalysis, psychoanalytic psychotherapy. I believe that interpretation can now become reappraised as one among many analytic interventions that facilitate growth. For example, the Menninger Project (Wallerstein, 1986) demonstrated clearly that "supportive-expressive" interventions were as plentiful, and presumably as facilitative, in psychoanalysis as in psychoanalytic psychotherapy. The door is open to consider, evaluate, and even embrace the many varied forms of interventions that occur in psychoanalysis, not as described, but as practiced.

While philosophers and scientists for years have studied interaction and mutual influence, over the past two decades infant researchers, through extensive detailed investigations, have contributed significantly to our understanding of the dyadic system of mother-infant and, by extension, of dyadic systems at large (see Beebe, Jaffe, and Lachmann, 1992, for an excellent review). Addressing interaction,
constructivist model in that it focuses essentially on the ongoing, patterned, perceptual-affective-cognitive organization of our experience. Predominant ways of experiencing the world gradually emerge out of recurrent or thematic experience. This thematic experience is shaped by premolded givens (for example, temperament and basic needs), shifting motivational priorities (Lichtenberg, 1989), shifting self-states (for example, alert to drowsy state), and the intersubjective or relational field (Stolorow et al., 1987; Mitchell, 1988). These are self and relational contributions to experience. As I (Fosshage, 1994) have written, the predominant ways in which we have come to see ourselves and ourselves in relation to others are the affect-laden thematic organizations [the "mental sets," if you will] that variably shape our experience. These organizing patterns or schemas do not distort a supposed "objective reality," but are always contributing to the construction of a subjectively experienced "reality" (p. 8).

These organizing patterns, at least initially, are usually unconscious. Thus, I define transference as referring to the primary organizing patterns or schemas with which the analyst constructs and assimilates his or her experience of the analytic relationship. While repetitive, problematic, transferenceal organizations that are based on thematic traumatic experiences variably impede a person developmentally and in conflict resolution, other transferenceal organizations are forward-looking crystallizations of developmentally needed or self-regulating experiences (for example, mirroring, idealizing, and twinship selfobject transference; see Kohut, 1971, 1977, 1984).

Motivational theory serves as a fundamental underpinning for understanding transference. Positing attachment to be the primary motivation, object relations theorists generally emphasize repetitive ties to the bad object—that is, attachment experiences—as emergent within the transference. Using an overriding motivational model of self-actualization, self psychologists have emphasized strivings for the hoped-for, developmentally necessary, vitalizing (selfobject) experiences. While object relations theorists, from my vantage point, have tended to neglect developmental strivings, self psychologists, initially in theory if not in practice, underemphasized the importance of the repetitive dimension of the transference. Both the repetitively organ-

ized experiences and the strivings for the developmentally necessary experiences emerge in the transference and need to be addressed (Stolorow et al., 1987; Lachmann and Beebe, 1992; Fosshage, 1994)—what Stern (1994) refers to as the "needed relationship" and "repeated relationship." I believe that patients seek and hope for the "new," developmentally needed experiences; expect the "old" repetitive experiences that can be dreaded (for fear of retraumatization) or relieving (because of familiarity), and construct and connect in those characteristic ways established in past relationships.1

Lichtenberg (1989) introduced a complex motivational systems model based on five basic needs: the needs for physiological regulation, attachment and affiliation, exploration and assertion, sensuality and sexualuity, and aversiveness. This model provides a greater range of possible motivations and their shifting priorities with which to understand the analytic encounter.

Schemas can be primarily internally generated through shifting motivational priorities and self-states, or they can be externally triggered. Patient and analyst are variable codeterminers of the transference. From moment to moment the range of contribution for each varies widely from minimal to considerable and requires analytic scrutiny for understanding the patient’s and analyst’s respective contributions to the patient’s experience (Gill, 1984; Fosshage, 1994).

The view that the patient’s experience of the analytic relationship is variably codetermined by patient and analyst positions the analyst to inquire consistently, "Who’s contributing what to the patient’s experience?" And, secondarily, "Who’s contributing what to the analyst’s experience?" These assessments are not "objective" but are subject to a collaborative investigation and shaping within an intersubjective field.

For example, when a patient experiences us as critical, we inquire, if it is unclear to us, about our contribution, what we did or said that the patient heard as critical. We may subsequently acknowledge our con-

---

1 Some convergence in the conceptualization of transference is occurring within the relational models. Whereas self psychologists are currently emphasizing both the repetitive and the "selfobject-experience seeking" (Lichtenberg, Lachmann, and Fosshage, 1992) dimensions of the transference, object relations theorists are also presenting both aspects. For example, whereas Mitchell (1990), in his relational model, previously placed a fairly exclusive emphasis on the patient’s "old" ties, he presents in his recent book a more balanced view, which is conveyed by his title, Hope and Dread (Mitchell, 1992).
tribution, which is variable. For example, we might say, "I can understand how you heard that to be critical." Or "Yes, I was feeling critical, which I believe was my own impatience with your reticence." Or "Yes, I'm feeling bitchy today, which has to do with outside matters." Acknowledgment of our contribution can provide a needed validation of the patient's perceptions and, in turn, enable the patient to move from a deflated or aversive state to a more reflective and exploratory state. When feeling more consolidated and reflective, the patient is better able to consider his contribution to the interaction as well as his responses to the perceived criticism.

Every action on the analyst's part affects the transference. Interpretation of the transference, rather than being an "objective" statement, is the analyst's organization of the data that, in turn, influences the transference. Frequently, the subtle implications of interpretation that convey the analyst's attitudes most affect the patient. For example, interpretation of defenses can easily leave the patient feeling deficient or wrong.

Illumination of Schemas

To illuminate a patient's problematic organizing pattern when it is triggered within the analytic relationship is usually a gradual and complex process. Through empathic inquiry (that is, inquiry from the patient's point of view [Kohut, 1959]) we, over time, identify a thematic experience and begin a historical exploration of the experience. Each step of the way toward identifying an experience as repetitive implies that the patient is potentially contributing, to some extent, to his or her experience; each step can easily be heard, depending on the status of self-equilibrium, as invalidating the patient's perceptions of "reality." This invalidation can in turn, easily rupture, the vitalizing (selfobject) tie and, momentarily, collaborative inquiry. The patient will avert further exploration in order to protect his or her self-organization. Understanding the disruption can usually repair the tie. Yet, at times when the rupture is more severe, only attentive listening and time will aid the patient in reestablishing self-equilibrium. As the schema is triggered time and again within the analytic relationship, the patient will ultimately become aware of the repetitive organization of experience provided the analyst's contribution to the patient's experience is sufficiently minimal to enable the patient, with the aid of the analyst, to consider alternative interpretations as plausible, or if the patient is able to contrast the current problematic experience with other analytic experiences.

If the analysand experienced, for example, the father as withholding and unresponsive and encounters an analyst who tends also to be withholding and unresponsive, the thematic experience can easily be replicated, reinforcing the organizing pattern that father figures are withholding and unresponsive. If the analyst is not sufficiently different from the analysand's set of expectancies to be able to contrast, highlight, and bring to consciousness these anticipations, the interactive experience, instead, will match the expectancies and will reinforce the patient's experience of "reality." If the experience of the analyst as withholding is not too disruptive, the analyst can attempt to ferret out, with the analysand, the meaning and history of such experiences. This attempt to understand—that is, this interaction—may itself convey that the analyst is not so withholding and thus provide a new relational experience that serves as an antidote and contrast to the problematic theme. In this sense, actions may speak louder than words, but words paradoxically are actions. On those occasions when the analyst's attempt to understand is an insufficient response, the analyst must be willing to be shaped by the needed interaction in order to create with the analysand the developmentally necessary, new and contrasting relational experiences (see Lindon, 1994).

For example, J was a highly articulate, good-looking man in his mid-40s who had recently suffered a mild heart attack. The heart attack precipitated his coming for psychoanalysis, for it had brought into relief his dissatisfaction with himself and his life, specifically that he was not living at an emotionally deep, passionate level. With considerable urgency and intensity, he described how he often felt constricted and engaged in a performance. There were moments of freedom, primarily treks away from New York. He had never married, and the heart attack intensified his desires for an intimate relationship and family. He had dated one woman on and off for six years but could not bring himself to marry her, for the relationship seemed lifeless. He kept searching for the perfect woman who would keep him passionately engaged.
J's parents, who had an aristocratic European background, worked tirelessly in the father's professional business. Apart from his father's frightening violent rages aimed primarily toward the patient's older siblings, the atmosphere was formal and unemotional, even "deadly." The sterility of the home atmosphere was sharply etched in a model scene (Lichtenberg et al., 1992) where J, as a boy, set up a fix-it-shop in the doorway to his bedroom and waited longingly for hours for someone in his family to stop by and use it.

Within the analytic relationship, J both hoped for a vitalizing (selfobject) responsiveness from the analyst and expected the analyst to be lacking in emotional response. Although J's expectations, selective attention, and reactivity (that is, the organizing patterns) required analytic illumination, here I wish to focus on his hope and need for a sufficient responsiveness. I felt that J required sufficient emotional responsiveness from me for him to feel acknowledged, important, and alive (see Bacal, 1985; Lindon, 1994). This would be the new relational experience that both would facilitate consolidation of a positive cohesive sense of self and would provide leverage (that is a different and contrasting experience) for analyzing his tendency to experience the other, in this case, me, as indifferent or dead. While empathic inquiry provided some of the developmentally needed acknowledgment (Kohut, 1982), I made clear that he needed (usually when it was lacking) intense affective reactions from me, whatever they might be, in order "to feel" me, to know that I was emotionally with him and that he was important—to "overcome" momentarily the riveting mental set that the other, the analyst, was indifferent.

To provide the needed emotional responsiveness cannot be considered simply a matter of technique, for it involves a deep emotional resonance with and response to the analysand's developmental needs and strivings. In fact, too much self-consciousness interferes with spontaneous emotional expression. These spontaneous "curative" interactions are what the analysand and analyst create together. In this instance, J's passionate expression of his determination to live fully and emotionally touched me deeply, and I found myself spontaneously speaking with more affect to him. Matching affect level conveyed that I was emotionally with him. These moments crystallized as the new and developmentally needed relational experiences that provided us with the necessary leverage for analyzing J's often repeated experiences of my lack of emotional responsiveness. (I also would, not surprisingly, become routinized in his discussions, which lacked emotional depth and tended to deaden me. My muted reactions, in turn, would trigger his feelings and conviction that I was indifferent and "dead," a scenario that had to be illuminated. Illumination could only occur through contrasting these "old" experiences with the "new.")

From another angle, I was shaped, if you will, by what I felt was the analysand's need for emotional responsiveness. The ensuing mutual regulation that occurred in the analytic relationship is a radical technical departure, for traditionally within a one-person model of transference and therapeutic action, I, in this instance, would be viewed as losing my analytic stance and as colluding in the analysand's transferential demands—a technical and possibly countertransferentially based error that would be viewed as disruptive to the analysis. Whereas the classical or displacement model of transference requires the analyst to maintain a stationary position of anonymity, neutrality, and abstinence, making any deviation from that stance as problematic, the organization model of transference is anchored within an interactional field, clarifying that the analyst cannot be anonymous, neutral, or abstinent and that any such attempts are meaningless actions. The analyst contributes to the patient's transferential experience by his or her actions. From this interactive perspective, analysts must carefully anticipate and evaluate their actions for their potential impact on the transference.

The requirement that the analyst be interactively shaped by the patient to provide the necessary contrasting relational experiences is, in my judgment, not nearly sufficiently recognized. The singular emphasis on insight as the core process of change is a remnant of an intrapsychic model of therapeutic action and neglects how the relational experiences within the analytic relationship crucially affect therapeutic outcome. In a somewhat humorous, yet pointed, remark, Winnicott (as quoted in Giovacchini, 1975, p. xi) said that he offered interpretations to prove to his patients that he was still alive. Here the primary function of interpretation was to create not insight, but a new and contrasting relational experience in which the analyst survived the hate and aggression.
Allusions to the Transference

Viewing the analytic relationship as a mutual influence system renders it far more complex than previously conceived. New relational experiences (created in considerable part by our attempts to understand and explain) and replications of pathogenic experiences not only occur but substantially determine the success of the analysis.

To understand these experiences, we recognize that all communications that occur in analysis have (transferential) meaning for the analytic relationship. The primary meaning, however, may be related to either the content or the process of communicating (Fosshage, 1994). For example, when a patient is angry with a person other than the analyst, conventionally we tend to assume that the anger alludes to the transference, and we intervene to bring the anger into the transference. The assumption is based originally on an intrapsychic conflict defense model wherein the patient is viewed as defensively expressing anger toward the other person rather than in the here-and-now toward the analyst. (To view aggression as a drive seeking discharge implicitly diminishes the importance of the particular person [object] at whom the aggression is aimed, making people more interchangeable and a defense hypothesis more accessible.) To bring the focus of the anger onto the analyst at those times when the patient is expressing anger toward the other analysis can provoke anger and aversiveness toward the analyst for not having heard the patient. In turn, we can easily use the patient’s protestations to confirm our hypothesis that the patient was latently angry toward us. Rather than interpreting that the expression of anger is directed toward the analyst (that is, interpreting the content as alluding to the transference), we need to consider that the patient may be experiencing the analyst as a new, longed-for ally to whom he can relate the previously forbidden and inexplicable hurt and anger (that is, interpreting the communicative process as reflecting the primary transferential meaning). “To distinguish between content and process is essential in ferreting out the repetitive from the new relational experiences” (Fosshage, 1994). Not to make this distinction and to interpret the content inaccurately as applying to the transference can easily undermine ongoing new relational experiences and inadvertently rivet the patient to old ways of experiencing.

Countertransference

In emphasizing reactions to the transference, countertransference terminologically fails to capture the complexity of the analytic interplay. Analyst and analyst enter the analytic arena with their respective subjectivities with which they interactively construct their experience (Atwood and Stolorow, 1984; Stolorow et al., 1989). Each variably contributes to the experience of the other. Thus, in keeping with the totalistic perspective, (Kernberg, 1965; Gorkin, 1989; Tansley and Burke, 1989), I define countertransference as the analyst’s experience of the patient (Fosshage, in press). Analyst and analyst variably codetermine the countertransference, and, as with transference, the contributions of each from moment to moment can range from minimal to considerable.

The analyst’s experience of the patient ranges from engagement in a repetitious pathological scenario, such as domination and submission, to engagement in a developmentally progressive connection, such as the patient’s needs for affirmation. We can experience powerful transferential pulls that emanate both from repetitious, pathological configurations and from developmental strivings for the needed, vitalizing, selfobject experiences. While we illuminate and interpret the repetitively problematic and the developmental configurations, we must respond sufficiently at the deepest layers of our personality with the self-object pull of an analyst in order to enable the analyst to use the analyst in his or her developmental and self-regulatory endeavors.

The analyst’s experience of the patient (countertransference) centrally guides the analyst’s inquiry and interventions. In contrast to the notion that some analytic schools do not use countertransference, a

---

1 Kenneth Frank (personal communication) has questioned the asymmetry in my respective definitions of transference as the patient’s experience of the analytic relationship and of countertransference as the analyst’s experience of the patient. While I emphasize the patient’s and the analyst’s variable codetermination of transference and countertransference through their interactions and subjective organizations of the experience, I feel that the analyst is more focused on the patient (clearly through his experience of the patient within the analytic relationship) and the patient is more focused on his experience of the analytic relationship (for example, how it feels to share personal feelings with the analyst) as well as on the analyst. My respective definitions of transference and countertransference reflect this asymmetry in the analytic relationship.
toticl conceptualization of countertransference clarifies that all analysts, regardless of persuasion, use countertransference; for what is there other than the analyst's experience of the patient to guide the analytic endeavor (Fosshage, in press). Differences abound, of course, about how we organize and understand our experiences of patients. What one analyst experiences as hostile, another experiences as assertive; what one analyst calls seductive, another notes as loving; what one analyst perceives as an infantile demandingness or attention to be renounced, another sees as a developmental striving for facilitation. Clearly a central feature of our experience is the theoretical model we expose and the subjective basis for that choice. But what else might be at play to bring about such discrepant reactions?

I believe that the analyst's experience of the patient is profoundly influenced by the analyst's listening perspective (Fosshage, in press). Two principal listening perspectives affect our experience of the patient. Either the analyst can resonate with the patient's affect and experience from within the patient's vantage point, a subject-centered perspective, (that is, self psychology's emphasis); or the analyst can experience the patient from the vantage point of the other person in a relationship with the patient, an other-centered perspective (frequently the emphasis in object relations and interpersonal approaches). Countertransference discussions historically have involved listening from as-the-other perspective (for example, the patient is "provocative," "manipulative," "seductive").

When, for example, a patient "demands" that the analyst answer a question, the listening stance, as well as the analyst's subjectivity and choice of models, shapes the analyst's percept. Listening from within the analyst's world facilitates a resonance with the patient's affect and a temporary alliance with the patient's expressed experience (Schwaber, 1984). It potentiates hearing and understanding the meanings of the patient's urgency and their legitimacy within the

patient's subjective context. Listening from the other-centered perspective illuminates how the analyst's experience at these moments can affect others as demanding within a relational scenario (keeping in mind that the analyst's subjectivity variably affects this listening experience).

While a subject-centered perspective diminishes our reactions as the other person in relationship to the patient, the other-centered perspective accentuates these reactions. Both sets of data gained from these two listening perspectives are informative and analytically useful.

To note the listening perspective helps to clarify the variable uses of the analyst's experience with regard to interventions. Whereas one analyst begins exploration by sharing directly her experience with the patient as-the-other, another uses this experience to guide subject-centered inquiry further into the patient's subjective experience. Each approach has advantages and disadvantages. To reveal immediately the analyst's experience, especially when it is from the as-the-other perspective, introduces more fully the analyst's subjectivity and creates the danger of distorting the patient's attempt to articulate his experience. Never to share the analyst's experience as the other person in an interaction, however, can foster a strained, isolated, and ultimately solipsistic world for the patient and deprives the patient of the relational experiences necessary for facilitating development.

While sustained, subject-centered (empathic) inquiry, in my judgment, needs to be the primary listening vantage point (self psychology's emphasis), I propose that the analyst's listening from within and as-the-other, oscillating in a background–foreground configuration, can illuminate more fully the patient's experience of self and of self-in-relation-to-others. As the interpretive sequence clarifies the analysts's feeling from within perspective, the focus on interpersonal consequences from the as-the-other perspective becomes useful in illuminating the patient's relational experience. To begin interpretively with the analyst's as-the-other experience of the analyst can easily invalidate the analyst's perceptions and can be "heard," coming from the outside, as criticism and as an implicit demand to change. I believe that the use of both listening perspectives can provide a common meeting ground for the enhancement of both self-psychological and object relational approaches.

While I emphasize intervening on the basis of the subject-centered listening perspective initially, and even primarily, occasions arise when

---

2 Rackes (1968) described two major counttransferences based on identifications: the analyst's identification with the patient's ego and id, subsequently referred to as the patient's self, as a concordant identification; and identification with the patient's internal objects as a complementary identification. His emphasis is on the analyst's identification with various aspects of the patient's internal object world and does not directly address the experience of the analyst as the other person in a relationship with the patient. Nevertheless, I suggest that listening from within often evokes a concordant identification and listening as-the-other triggers a complementary identification.
direct use of our experience of listening as-the-other-person can be most facilitative (this will come as no surprise to some object relational and interpersonal analysts who more freely use directly experience garnered from the other-centered listening perspective). A brief clinical illustration in which I used my experience as-the-other-person in a relationship illuminated a hidden (unconscious) transference configuration.

Approximately two and one-half years into treatment J, whom I spoke of earlier, began speaking about dropping one of his three sessions, because of the financial burden and because he was feeling considerably better. In the particular session I shall focus on, he raised the issue of reducing his sessions once again, and this time I internally felt prepared to accept it. He spoke of the decrease in a seemingly non-disruptive, straightforward, and reasonable manner. After exploration, we agreed to the decrease, which was to begin the following week.

As he went on to discuss other topics with no sign of an interrupted flow of associations, I began to experience a profound sense of missing him. I felt that he was leaving, that he was de-intensifying the process and our relationship. Was I picking up J’s underlying sense of missing the relationship, which he was defending against? Was I experiencing what it was like to be in a relationship with J when he was distancing? Or was I having primarily personal reactions to his decrease in sessions? Was I tuned into his warded-off experience of de-intensifying and missing the relationship, the use of the within mode of perception? Was I tuned into the experience of being distanced in a relationship with J, the use of the other-centered mode of perception? Or was I feeling particularly vulnerable and in need and, therefore, the primary contributor to my experience? Should I remain focused on his experience, or should I use my subjective experience and the discrepancy between our subjective experiences (Wolf, 1988) more directly in our explorations? After considerable internal debate as to whether or not to share my subjective reactions—after all, he appeared to be unblemished by his decision—I decided to share them, for I felt that my experience was not primarily personal but reflected something about J and our relationship. I indicated that I was having some deep reactions to his cutting back and that I, frankly, was unsure about their meaning (putting it this way was accurate and also would, I hoped, engage him in a collaborative inquiry). I then shared with him my profound sense of missing him. With his cut-back I felt that he was leaving, that he was de-intensifying our relationship.

While I shared my experience to engage J in analytic inquiry, he declared first that he was deeply moved by my emotional expression and felt deeply affirmed. The import of my intervention inadvertently was providing an experience of feeling cared for, of feeling important—experience that was sorely missed in his family. The “fix-it shop” and the little boy waiting to be noticed and affirmed for what he could offer came to my mind. I also remembered his very early memories of feeling lonely, unnoticed, and not “missed” when he was alone in his bedroom and his mother and father were consumed by work in the living room.

In our subsequent explorations new material emerged. J felt that treatment was safe but not part of the world. Separating the two worlds in this fashion, he wanted to get on with his life “out there.” While feeling freer and vitalized in our relationship, he was beginning to fear that, if he were to stay longer, he would end up being on the “bus,” as he was at home, which meant to be in a devitalized, sterile atmosphere and cut off from the world. Vitality was typically experienced as outside: outside of his family, outside of an intense relationship. This is why it became difficult to sustain a relationship and, now, the analytic relationship. With this new understanding of the transference configuration emerging in the analytic relationship, we both concurred that it was not a time to cut back, and J continued on the three-times-a-week basis.

The technical issue here is that I directly used my subjective experience to further exploration of the patient’s subjective experience. By not assuming the origins of my experience, I was able to introduce it to J for consideration. As it turned out, my subjective experience was predominant emerging from the as-the-other listening perspective; that is, I was experiencing what it was like to be in a relationship with J, specifically his distancing action. My experience of missing him was not resonating with his experience, for he was, in contrast, feeling more vitalized as he was escaping the expected noxious sterility that was about to ensue. The direct use of my experience as the other facilitated the illumination of unrecognized aspects of the patient’s subjective world.
Interaction in Psychoanalysis


330 West 55th Street, Suite 200
New York, NY 10019