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Countertransference as the Analyst's Experience of the Analysand: Influence of Listening Perspectives

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In addressing the analyst's experience of the analysand, countertransference is an ever-expanding construct. In keeping with the totalist perspective, I propose that the analyst's experience of the patient, instead of the term countertransference, more fully captures the complexity of the analyst's involvement and correctly places it as a central guide for inquiry and interventions. Our moment-to-moment experience of the patient is shaped not only by the patient, but also by our listening perspective, be it a subject- or other-centered vantage point, our models, and our subjectivities. The analyst experientially can resonate with the patient's affect and experience from within the patient's vantage point—that is, the subject-centered listening perspective (self psychology's emphasis); the analyst can experience the patient from the vantage point of the other person in a relationship with the patient, called the other-centered listening perspective (frequently the emphasis in object relations and interpersonal approaches). I am proposing that the analyst's listening from within and without, oscillating in a background-foreground configuration, can illuminate more fully the patient's experience of self and of self in relation to others.

In addressing the analyst's experience of the analysand, countertransference is an ever-expanding construct. Anchored squarely within the positivistic scientific tradition, the “classical” model of transference required the analyst to be anonymous, neutral, and a blank screen to reflect back the analysand's distorting displacements and projections. The concept of countertransference addressed the unwanted entrance of the analyst's subjectivity that was viewed as pathological, disruptive of the analyst's objectivity, and cumbersome for the psychoanalytic process. The aim was to “recognize” the countertransference and to “overcome it” (Freud, 1910. p. 144). Evolving recognition of the inevitable, complex participation of both patient and analyst in the analytic relationship has expanded the concept of countertransference to include not just the pathological, but the entire range of the analyst's experience and its actual usefulness in ongoing analytic work—what has become known as the totalist perspective (see Kernberg, 1965, for a review; also Gorkin, 1987, and Tansey & Burke, 1989).

The development of object relations theories, interpersonal theory, and self psychology, intersubjectivity, or, more generally, relational perspectives (Greenberg & Mitchell, 1983; Mitchell, 1988) has given considerable impetus to the overriding notion that the analytic arena involves the variable and mutual interactive influence of two subjectivities. In addition, a fundamentally new model of transference, albeit with considerable variation, has emerged that refers generally to the thematic perceptual-affective-cognitive organizing activity of the analysand (for a review, see Fosshage, 1994). Similarly, countertransference is being redefined to reflect the analyst's ongoing organizing activity—namely, how the analyst experiences, organizes, and constructs the analytic process. The overall paradigmatic shift from positivistic science with its notion of an objective observer to relativistic science with the notion of reality as shaped by (i.e., relative to) the observer underlies these major theoretical shifts in psychoanalysis and especially highlights that the psychoanalytic arena encompasses the interplay of two subjectivities and two perspectives. My purpose in this article is to further this ongoing reconceptualization of countertransference by exploring theoretical and clinical considerations, particularly the impact of listening perspectives on the analyst's experience of the analysand and the clinical use of the analyst's experience.

TRANSFERENCE

Over the past decade, a host of authors, including Wachtel (1980), Gill (1982), Hoffman (1983, 1991), Stolorow and Lachmann (1984/85), Hoffman and Gill (1988), Lachmann and Beebe (1992), Lichtenberg, (1990), and Fosshage (1994), has contributed with many variations to an emergent—or, as I call it, organization model—of transference. This model corresponds in many respects with what Berger and Luckmann (1967), Hoffman (1983), and others have called the social-constructivist model. Summarizing this model of transference I (Fosshage, 1994) noted:

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> The predominant ways in which we have come to see ourselves and others are the affect-laden thematic organizations [the "mental sets," if you will] that variably shape our experience. These organizing principles or schemas do not distort a supposed "objective reality," but are always contributing to the construction of a subjectively experienced "reality." (p. 8)

Thus, transference refers to the patient's experiences of the analytic relationship that are constructed according to the patient's primary organizing patterns. The patient's constructions vary in frequency of use, openness to reflection, and modifiability.

Kohut (1971, 1977, 1984) delineated two types of transference, namely, object related and selfobject. Subsequently, the self psychological model that has emerged more clearly, as originally delineated by Stolorow and Lachmann (1984/85; also in Stolorow, Brandchaft & Atwood, 1989), conceptualizes transference as involving two fundamental interacting dimensions, the selfobject experience-seeking dimension and what I call the repetitive relational dimension.1 Within this model, developmental needs are viewed as embedded in conflict. Conflict emanates from traumatic failures of the past, leading to fears of their potentially self-fragmenting reoccurence (Ornstein, 1974) and expectations that the failures will reoccur, all of which require various self-protective measures. These are the repetitive problematic relational themes that variably impede a person developmentally and in conflict resolution. Other transferential organizations are forward-looking crystallizations of developmentally needed experiences. A patient hopes for the "new," but tends to construct the analytic experience in keeping with both the "old" and the "new" (Fosshage, 1992).

Within the interactional arena, patient and analyst variably codetermine the transference. From moment to moment, the range of contribution for each varies widely from minimal to considerable and requires analytic scrutiny for understanding their respective contributions to the patient's experience. Those analysts who believe that the patient's experience (and the analyst's experience, which I also discuss here) is variably codetermined by the two participants must, when the focus is on the analytic relationship, continually inquire about the meaning of the interaction for the patient and consistently ask "Who's contributing what to the patient's experience?" to make sense of the intersubjective encounter.

An example of recognizing the contributions of both analyst and analysand occurs in the case material I (Fosshage, 1990) presented in Psychoanalytic Inquiry when I remarked, "So as you idealize me less and as I become more human and show vulnerability, as I did when I discussed the project, you are prone to experience me as terribly vulnerable and fragile and in this dead space" (p. 473). To acknowledge the analyst's contribution recognizes and partially validates the analysand's perceptions. In turn, it enables the analysand to become more receptive to new information about his or her contribution. Frequently, both contributions need to be noted to successfully illuminate the intersubjective field.

COUNTERTRANSFERENCE

Countertransference terminologically emphasizes reactions to the transference and, therein, fails to capture the complexity of the analyst's involvement. Both analysand and analyst enter the analytic arena with their respective subjectivities with which they interactively construct their experience (Atwood & Stolorow, 1984; Stolorow et al., 1989). The analyst's constructions, as the analysand's, may involve more or less problematic organizations. Analyst and analysand variably codetermine the countertransference, and as with transference, the contribution of each from moment to moment can range from minimal to considerable.

Rather than reflecting these variable contributions, countertransference terminologically implies that the patient is always the primary elicitor (what McLaughlin, 1981, referred to as the patient-centered focus of the term). Traditionally, countertransference was the analyst's unique pathological reaction to the patient. While extricating countertransference from pathology, many analysts within the interpersonal and object relations approaches have tended clinically to portray the patient to be not only the primary elicitor, but also the principle contributor to the analyst's experience. Specific countertransferential reactions are frequently viewed as more or less inevitable responses to specific transferences, and the analyst's countertransference is seen as directly revelatory of the patient's transference. Countertransference within these approaches serves as a central guide for reading the patient's interpersonal and object relational configurations. To view countertransference as an inevitable response and as directly revelatory of the transference, however, requires assuming either that the

patient is the predominant, if not sole, contributor or that all analysts react similarly, both of which notably understate the analyst's unique contribution to his or her experience of the transferential pull. For example, just as one analyst will experience an analysand as demanding, another will experience the analysand as assertive, and a third as urgently in need. Similarly, whereas one analyst will experience an analysand's idealizing selfobject transference as anxiety producing, another will experience it as momentarily enhancing, and a third will experience it as actually needed for self-regulation, each of which will affect the understanding of the transference.

A number of authors of different persuasions have attempted to overcome the limiting patient-centered focus of the term countertransference to conceptualize more adequately the highly complex, mutually influential interaction that occurs between analyst and analysand. For example, McLaughlin (1981) suggested that we use the term transference in an assertion of relativism to refer to both the patient's and analyst's experiences. More recently and in a similar vein, Orange (1993) proposed that we use the term cotransference to refer to the analyst's experience of the analytic relationship but retain the term countertransference to refer to the interfering responses. In Gill's (1983) statement, “transference-countertransference transaction in which from the differing perspectives of patient and analyst each has a view that has its plausibility” (p. 234), he retains both terms but attempts to equalize the analytic situation. Wolf (1988) also took a totalistic perspective and then subcategorized the analyst's experience into the analyst's efficacy pleasure, residual archaic selfobject needs, and problematic reactions to the selfobject transferences. Atwood and Stolorow (1984) suggested that “from the continual interplay between transference and countertransference two basic situations repeatedly arise: intersubjective conjunction and intersubjective disjunction (p. 47). Intersubjective conjunction refers to the analyst's encumbering assimilation of the patient's material into very similar central configurations of the analyst; intersubjective disjunction is the analyst's organization of the patient's material with different configurations so that the meaning is altered for the patient. Decentered self-awareness facilitates the analyst's use of these conjunctions and disjunctions in the analytic work. Natterson (1991) eschewed the term countertransference and spoke of the analyst's subjectivity as participating fully in the intersubjective field. And Lichtenberg (1990) preferred the term counterresponsiveness to move it away from perjorative connotations.

Clearly the term countertransference is problematic, although most of us retain its use for communicative purposes. Although each of the previous formulations is useful, I propose that simply to refer to “the analyst's experience of the patient” with its phenomenological emphasis is a more comprehensive and clinically heuristic rubric.2 The analyst's experience could be called transference in that the analyst's organizing activity is involved; yet, it is not the analyst's organizing activity per se that concerns us most; more specifically, it is the analyst's experience of the patient that is central. For this reason and for clarity of communication, I prefer to retain the term transference to address solely the patient's experience. In turn, the analyst's perceptual-affective-cognitive experience of the analysand serves as the central guide for exploration, understanding, and framing interventions.

The use of the concept of countertransference within self psychology has been limited by Kohut's (1971, 1984) subscription to the traditional view of countertransference (evident in his descriptions of problematic reactions to the mirroring and idealizing transferences). It is on the basis of Kohut's position that self psychologists are frequently characterized as maintaining the traditional view of countertransference and, therefore, as failing to use their experience of the patient clinically (see Mitchell, 1990).

Reformulation of countertransference within self psychology, apart from those few previously mentioned, has been slow in coming. As long as countertransference is linked with pathology, the aim is to undo it. Moreover, self psychology's emphasis on entering into the patient's experiential world appears, on first take, to minimize the importance of the analyst's experience. Reconceptualization of countertransference is required to highlight its clinical importance and usefulness. When taking the totalist perspective that countertransference is the analyst's experience of the patient, it follows that any analyst, regardless of persuasion, has no choice but to attend to and use countertransference as a central guide in analytic work—for what else is there? Empathic inquiry requires the analyst's affect resonance and vicarious introspection, a reflective process that focuses on the patient and is filtered through the analyst's experience. Thus, in a self psychologically informed analysis, as for all analyses, the analyst's experience proves paramount. The differences between analysts lie not in whether an analyst attends to and uses his or her experience of an analysand, but how an analyst shapes and uses his or her experience; these are topics to be further addressed.

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CONTRIBUTING FACTORS TO THE ANALYST'S EXPERIENCE OF THE PATIENT

Analyst's Contribution

Several years ago, subsequent to my return from an extended vacation, an analysand fearfully and shamefully told me that she had come to my home, where I regularly saw her in my home office, and had walked around the house searchingly peering in every available window and glass door with binoculars for signs of me and my life. All analysts would inquire as to the meaning of the analysand's behavior. We would vary greatly, however, as to our experience and understanding of the patient's behavior. One analyst would experience it as a sadistic attack, another as an effort to control, and a third as an effort to connect. The analyst's affective experience could range from anxiety, to anger, to tenderness and compassion. Partially based on the experience, each analyst would formulate a different working hypothesis. One analyst would think of a problem with boundaries, another would consider unrenounced infantile dependency longings, and a third would ponder a self-restorative search for a connection to the analyst. In addition to the patient's contribution, other central factors contributing to the analyst's experience are the analyst's theoretical models, organizing patterns, shifting motivations (Lichtenberg, 1989), momentary self-states (Lichtenberg, Lachmann, & Fosshage, 1992) and variable listening perspectives (to be delineated).

Patient's Contribution

The analysand enters analysis searching for the developmentally requisite experiences, protecting against the anticipated traumatic failures of responsiveness, organizing and constructing the analytic experience both according to the old and the new, and attempting to connect in those reliable ways established in past relationships (Fosshage, 1990, p. 613). In addition to the many subtle expressions and interactions, the analyst will experience powerful transferential pulls that emanate both from the patient's repetitious, pathological relational configurations and from the patient's developmental strivings for the needed vitalizing (selfobject) experience (Fosshage, 1994). Although technically our general guideline is to illuminate and interpret both the repetitively problematic and the developmental configurations, each analyst, depending on his or her subjectivity and models, will experience these transferential pulls differently, creating an unique intersubjective encounter. The complexity of the analyst's involvement, for example, is most notable when it comes to the selfobject experience seeking dimension, for the analyst, as Kohut (1977) noted (see p. 252), must resonate sufficiently at the deepest layers of his or her personality to be available for an analysand's developmental and self-regulatory needs. When the analysand, for example, is in need of and searching for a protector, the analyst must reciprocally feel somewhat protective. If the analyst cannot be affectively stirred, the analysis will remain lifeless.
For example, a psychoanalytic candidate in class once described shamefully and self-critically her rescuing fantasies of a deeply deprived patient. Her supervisor had reportedly told her that she was colluding with the patient's infantile demands for an omnipotent parent, that her grandiosity was getting the best of her, and that she should discuss it in her analysis. Instead, I experienced the candidate's rescuing fantasies as a resonance with the patient's profound need for an idealized figure. The analyst must be, and was, deeply touched by this powerful developmental pull of the patient in order to treat her successfully.

Listening Stances

Freud's breakthrough was to develop methods for an in-depth exploration of a patient's intrapsychic world. The exploration, however, was epistemologically framed within the positivistic science of the day and positioned the analyst as an objective observer. From today's perspective of relativistic science, the objective observational position is no longer a viable or even possible observational platform for psychoanalytic work, for as the analyst perceives, the analyst variably shapes and organizes. Nothing the multiple perspectives in the analytic arena, Kohut (1959/1978), updating psychoanalytic epistemology, formulated and proposed the consistent use of the empathic mode of observation, namely, to attempt to understand from within the vantage point of the analysand.

The analyst, however, can shift experientially into a number of listening perspectives. Lichtenberg (1984), for example, delineated three different listening stances: the outside observer, an interested companion, and a listener within. These are experientially different listening positions for the analyst, not different epistemological

positions. An outside observer, for example, is one who is making relatively more judgments from his or her vantage point rather than from the patient's. The psychoanalytic aim of the outside observer remains the same—that is, understanding what is going on within the patient.

For purposes of our discussion, I wish to consider two principle listening vantage points that profoundly impact the analyst's experience of the analysand. I propose that the analyst experientially can resonate with the patient's affect and experience from within the patient's vantage point—that is, the subject-centered listening perspective—self psychology's emphasis. The analyst can experience the patient from the vantage point of the other person in a relationship with the patient, what I call the other-centered listening perspective—frequently the emphasis in object relations and interpersonal approaches.3 (I am using the term subject-centered instead of the empathic mode of perception to definitively address an experiential listening stance and to keep it symmetrical with the term other-centered. Moreover, the empathic mode of perception, as Kohut, 1959/1978, delineated, is a more comprehensive term in that it addresses both a mode of listening and how that mode frames a fundamental psychoanalytic epistemology.) Countertransference discussions traditionally have involved listening from the othercentered perspective (e.g., the patient is provocative, controlling, manipulative, or seductive). Relationships in general entail a natural oscillation between these two perspectives as one listens to another person. In the analytic situation, I am proposing that the subject-centered and other-centered modes are two principle methods of listening to our analysands' experiences and that important data are gathered through each listening stance.

In the previous vignette involving my analysand's scrutiny of my home, listening from within the analysand's experiential world increases the potential (theoretical models notwithstanding) of hearing and understanding her feelings of desperation and search for a self-vitalizing connection. Listening from the other-centered perspective helps to illuminate (initially for the analyst) how the analysand might experience others (i.e., some others, keeping in mind that the other also shapes the experience) as feeling intruded upon within a relational scenario. When my analysand told me of her visual search of my home, I was initially taken aback and felt a twinge of intrusion. I thought of how her behavior could be experienced as intrusive, possibly evoking a dreaded aversive response from the other. These perceptions were emanating from the other-centered perspective. My deep fondness for the analysand, combined with a relative nondefensiveness about her seeing my home, enabled me in this instance to shift fairly quickly to a subject-centered perspective. I could then hear her expressions of need and could resonate with and understand her determined, even desperate, search for a self-vitalizing connection with me in my absence. Although a “within” perspective tends to decrease our reactions as the other person in relationship to the patient, an “as-the-other” perspective accentuates these reactions. For example, as a patient attacks us for not caring, the subject-centered mode helps us to “decenter” (Atwood & Stolorow, 1984; Piaget, 1970/1974) from our personal reactions as the other and to hone in on the patient's experience of not being cared for, whereas the other-centered perspective facilitates understanding a thematic relational scenario in which the patient's anger and attacks evoke an aversive reaction in the other, confirming the patient's expectancies and reinforcing the feeling of not being cared for.

How do these listening stances relate to Racker's (1968) description of two major countertransferences based on identifications? Racker termed the analyst's identification with the patient's ego and id, subsequently referred to as the patient's self, as a concordant identification and the identification with the patient's internal objects as a complementary identification. This emphasis is on the analyst's identification with aspects of the patient's internal object world and does not directly address the analyst's experience as the other person in a relationship with the patient. Sandler (1976) further delineated how the patient interacts casting himself or herself into a role and the analyst into a “complementary role” (p. 44). The analyst's complementary role-responsiveness is similar to Racker's complementary identification in its emphasis on the internal object world. I suggest that the subject-centered listening perspective may evoke an identification with the patient's self (i.e., a concordant identification), whereas the other-centered mode of listening may facilitate a complementary identification.

In recommending the exclusive use of listening from within the patient's vantage point, Schwaber (1992) viewed countertransference as a fundamental interference (resistance) in perceiving the legitimacy of another's perception. In contrast, I am proposing that both listening perspectives naturally emerge and are invaluable for a more comprehensive illumination of the patient's experience.

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Can the different listening stances be consciously employed? When listening to another person, I believe we naturally oscillate in a foreground-background configuration between a subject-centered to an other-centered listening perspective, especially when the here and now of the relationship is in the forefront. Either listening perspective may be triggered by the patient or by motivational and self-state shifts in the analyst that may be problematic or data providing. For example, a patient's deep sadness may trigger a subject-centered orientation, a resonance with the patient's affect that paves the way toward exploring and understanding its sources. If it triggers the analyst's personal sadness, the subject-centered listening will tend to be assimilated into one of the analyst's central issues, a problematic intersubjective conjunction. On the other hand, the depth of the sadness may also make the analyst aware of what it is like to be in a relationship with the patient, the other-centered perspective, that might illuminate some of the relationship difficulties previously described. The analyst, however, may experience the sadness as threatening, triggering an aversive reaction and the other-centered perspective. The more stressful interactions for the analyst tend to trigger the other-centered listening perspective, which can convey valuable information about patients and their relationships (or, of course, about the analyst). At these times, however, the analyst's capability of initially shifting into the subject-centered perspective can facilitate creating an observational platform (Lichtenberg et al., 1992) for both patient and analyst. Familiarity with these different listening stances increases conscious control and their flexible use for gaining a more comprehensive understanding of the patient.

HOW THE ANALYST USES HIS OR HER EXPERIENCE OF THE PATIENT

To note the listening perspective helps to clarify the varied uses of the analyst's experience and to provide guidelines for the point of entree in clinical interventions. Whereas one analyst begins exploration by sharing directly his or her other-centered experience with the patient (an approach within interpersonal psychoanalysis), another tends to deemphasize this experience to focus on an inquiry into the patient's subjective experience (self psychology's emphasis). Each listening perspective adds to our overall understanding of the patient. Exclusive use of either listening stance as the basis for our response entails a danger. To directly reveal the analyst's experience, especially when it is from the other-centered perspective, introduces to a greater degree the analyst's subjectivity and creates the potential danger of imposing the analyst's perceptions onto the patient and of derailing the patient's attempt to articulate his or her experience. Never directly sharing the analyst's experience as the other person in a relational occurrence, however, can foster a strained, isolated, and ultimately solipsistic world for the patient and deprive the patient of the relational experiences necessary for facilitating development.4

The analyst's affective experience of the patient centrally guides the analyst's inquiry and interventions. Although inquiry, in my judgment, needs to emanate primarily from a subject-centered perspective, I am proposing that the analyst's listening from within and without, 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 analysand's feeling via the subject-centered perspective, the focus on interpersonal consequences of the analysand's state and corresponding behavior via the other-centered perspective becomes useful in illuminating the patient's self and self-with-other experience. In contrast, to begin interpretively on the outside with the interpersonal consequences easily can be taken as criticism and an implicit demand to change. When the subject-centered access to the patient is blocked, however, the start of exploration with sharing the analyst's other-centered listening experience, making the analyst's listening perspective clear to the patient, can facilitate undoing the impasse.

For example, the analyst, listening from the other-centered perspective, experiences hostility from the patient. To use the experience directly (which, of course, is tempting for purposes of our self-regulation) requires the analyst to assume that his or her perception is an accurate reflection of the patient's experience and that the patient was the primary contributer to the perception. A more conservative approach is first to inquire about the patient's experience. If the patient acknowledges hostility, then we can proceed to illuminate its current and past origins. If the patient does not report experiencing anger or aversiveness, we are left with the need to address and explain our experience. Either the patient was unaware of the hostility or we momentarily were feeling vulnerable and sensitive and prone to experience the patient's expressions as attacking. If we feel the former is accurate, we may choose to introduce our contrasting subjective experience, garnered from the other-centered perspective, to be considered by both patient and analyst for its relevance and meaning for the patient with the possibility of opening up new pathways of exploration.

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CLINICAL VIGNETTES

While strongly supporting self psychology's emphasis on sustained empathic inquiry, what I have called the subject-centered perspective, I have proposed the important oscillation between two listening perspectives, making a case for the usefulness of the data gathered from both listening vantage points. I next present three vignettes: The first illustrates the usefulness of data acquired through the other-centered perspective to facilitate inquiry from within the patient's perspective. The second depicts the use of an enactment, revealing the analyst's experience emanating from the other-centered perspective, and its use in further illuminating the patient's inner world. The third illustrates the direct disclosure of the analyst's experience from the other-centered listening perspective that aids overcoming an impasse, deepening analytic exploration. These vignettes are not meant to be particularly remarkable, but they are common, everyday occurences.

Vignette 1

Barbara is a lawyer in her mid-30s. She had reached an impasse in a previous analysis. She felt the impasse was related to a singular focus on anger that was not aiding her in developing a deeper and more intimate relationship with a man. Her mannerisms and behavior expressed a shifting mixture of compliance and spunky rebellion.

Barbara had a habit of being late in all the areas of her life. Naturally, she was often late for her sessions. She would enter the room somewhat breathless, feeling guilty, apologetic, and self-critical. Although she admitted that it was a problem, she typically opted to proceed with other topics, for exploration of the lateness created more shame and self-criticism. Others would criticize her for her tardiness, particularly the man with whom she was romantically involved, and she expected the same of me.

Because Barbara made it clear that analytic exploration exacerbated her self-criticism, I typically did not comment on her lateness. Aided by the knowledge that this was typical behavior in a variety of relationships, I was able to shift from mild feelings of frustration (emanating from the other-centered mode) and to listen to her requests not to discuss it (hearing from the subject-centered mode). During the next 2 years, she commented on feeling less badly about it. At times, she even began to find pleasure in her lateness, and at times she purposely increased it. Her pleasure was related to a newfound freedom from demands and expectations. She would now and again comment to me that she really appreciated my not bringing the topic up and harping on it, unlike her previous analyst. We had connected her lateness to a theme of accomodation and rebellion against her very threatening and powerfully controlling father. One day she remarked: “My previous analyst said, you only have to pay, come on time and lie down on the couch. What if doing any one of those makes you a dead person. You're tolerant of me and I am more tolerant of myself. I am often feeling ‘What horrible thing have I done now?’ As you said, I have to be good and resent it like mad.”

More extreme behavior tends to trigger the other-centered listening perspective. Questions spontaneously arise: “How am I feeling in relationship to the patient?” “What is she doing to me?” In this instance, to share directly my experience as the other would have exacerbated and replicated the problematic relational theme. Instead, I was able to use this experience as one guide to further subject-centered exploration of Barbara's experience. In time, we were able to illuminate the relational scenario of her aversiveness to a controlling father, followed by guilt and a negative self-image.

Vignette 2

For the first 3 months of psychoanalytic treatment, Lisa had been riding the crest of an idealized selfobject transference that had vitalized her and pulled her out of a chronically episodic depression. A subsequent breakup of a romantic relationship with a married man, however, plunged Lisa into a major depressive episode. She felt terribly disillusioned by the fact that I had not prevented the breakup and could not readily mend the depressive episode. In the wake of this rupture, she began to search for another analyst through a series of consultations. Although I was initially accepting of these consultations and understood them as her search for a needed idealized tie, at one point I felt unusually frustrated and spontaneously erupted in a somewhat humorous melodramatic manner, “You and your 14 consultations!” She promptly shot back, “It was only two! And you're

angry at me!" I readily confirmed her perception. In the exploration of the origin of my anger, I realized that I had been deeply worried about Lisa. Although I was intensely involved in trying to help her through the depression, I kept experiencing her as disengaging from the analysis with me, as pulling out and seeking consultations, creating considerable frustration. Was she going to be engaged with me or not? She could identify with my experience of her as pulling out. We were then able to shift to her perspective and discovered that her pulling out was triggered by her current disappointment in me and, in addition, resonated deeply with a repetitive experiential theme established with her parents. When she was in desparate straits, she had learned that she could not rely on her parents for help. This organizing theme had become very alive in the analytic relationship with the onset of her depressive episode.

Retrospectively, I understood that a relational scenario was enacted and I had expressed my anger emanating from what it was like for me to be in a relationship with Lisa at that moment—that is, an experience anchored in the other-centered listening perspective (and undoubtedly influenced as well by my particular self-state that day). The further exploration of the direct expression of my experience as garnered from the other-centered mode enabled us to illuminate the relational scenario and its meaning from within the patient's vantage point.

Vignette 3

Several months after a mild heart attack at the age of 45, J., a highly articulate, good-looking man, began psychoanalysis sessions three times a week.5 The heart attack 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, he described how he often felt constricted and engaged in a performance. There were moments of freedom, primarily on vacations away from New York. Although he had a successful business, it did not bring him satisfaction. He had never married, and the heart attack accentuated his desires for an intimate relationship and family. He had dated one woman on and off for 6 years but could not bring himself to marry her because the relationship seemed lifeless. He kept searching for the perfect woman. His parents, coming from an aristocratic European background, worked tirelessly in the father's professional business. Apart from his father's violent rages primarily aimed toward his older siblings, the atmosphere was formal and unemotional, even "deadly." He was desperately afraid that he would end up on the "bus," a primary image where devitalized and unhappy people were traveling to and from work in a lifeless fashion.

Approximately 2 1/2 years into treatment, J. began speaking about dropping one of the three sessions because of the financial burden and because he was feeling considerably better. In the particular session on which I wish to focus, 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 nondisruptive, straightforward, and reasonable manner. After exploration, we agreed to proceed with the decrease the following week.

As he proceeded 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 deintensifying the process and our relationship. Was I picking up J.'s underlying missing of the relationship, against which he was defending? 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 wardedoff experience of deintensifying 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 subjectivities (Wolf, 1988) more directly in our explorations? After considerable internal debate as to whether 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 was unsure about their meaning (putting it this way was accurate and I hoped it would engage him in a collaborative inquiry). I then shared with him my profound sense of missing him. With his cutback, I felt that he was leaving, that he was deintensifying our relationship.

After I shared my experience to engage J. in analytic inquiry, he declared first how 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. In our 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." Although feeling freer and vitalized in our relationship, he was beginning to fear that, if he were to stay longer, he would be 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 transferential configuration emerging in the analytic relationship, we both concurred that it was not a time to cut back, and J. continued his sessions three times a week.

The technical issue here is that I directly used my subjective experience to further empathic exploration of the patient's experience. By not assuming the origins of my experience, I was able to introduce it to J. for mutual consideration. As it turned out, my subjective experience was predominately 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. Using directly my experience as the other facilitated the illumination of unrecognized aspects of the patient's subjective world.

To summarize, I propose that the analyst's experience of the patient, instead of the term countertransference, more fully captures the complexity of the analyst's involvement and correctly places it as a central guide for inquiry and interventions. Our moment-to-moment experience of the patient is shaped not only by the patient, but also by our listening perspective—be it a subject-centered or other-centered vantage point—our models, and our subjectivities. The analyst experientially can resonate with the patient's affect and experience from within the patient's vantage point—that is, the subject-centered listening perspective (self psychology's emphasis)—and the analyst can experience the patient from the vantage point of the other person in a relationship with the patient, called the other-centered listening perspective (frequently the emphasis of interpersonal and object relations approaches). I propose that the analyst's listening from within and without, oscillating in a background-foreground configuration, can illuminate more fully the patient's experience of self and of self in relation to others. Although the analyst's experience, in my view, should be used primarily to inform further empathic entry into the subjective experience of the patient (i.e., the subject-centered listening stance), direct sharing of the analyst's experience, as garnered from both subject-centered and other-centered listening perspectives, can facilitate the analytic process during the exploration.

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1 Stolorow, Brandchaft, and Atwood (1989) referred to the latter as the repetitive/conflictual/resistive dimension. Lachmann and Beebe's (1992) term, representational configurations, and my term, repetitive relational configurations, may not be necessarily conflictual or resistive and, therefore, tend to be broader designations.

2 While retaining the traditional usage of countertransference as referring to pathological reactions, Thomson (1980) differentiated and explored the important use of the analyst's subjective experience of the patient.

3 I believe Lichtenberg's "outside observer" and "interested companion" entail the use of a combination of the two principal listening perspectives delineated here. For example, as we listen to the patient's description of an interpersonal event, we alternate between listening within the patient's perspective and listening "as-the-other" to gain what appears to be our outside observer assessment.

4 Bear in mind that any intervention more or less reveals the analyst's subjectivity, ranging from an "uhuh," to a question, to an interpretation, to a self-disclosure—it is a matter of degree.

5 This illustration also appears in an article entitled "Interaction in Psychoanalysis: A Broadening Horizon" (Fosshage, 1995).

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