

Conflict Theory and Intersubjectivity

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Abstract

Subjectivity and intersubjectivity, like countertransference, are terms that now cut across theoretical paradigms. This paper explores intersubjectivity from the perspective of modern conflict theory and makes the case that there is much in common between Brenner and Arlow's ideas about how the analyst's mind works and our current discussions about subjectivity and intersubjectivity. Where the concept of intersubjectivity becomes polemical is when we draw implications regarding the claims the analyst can make about ever knowing the analysand's mind as a separate entity from his or her own.

The question of how psychoanalysis works touches on complex epistemological and ontological issues, which are intertwined. How do we know what we know? How do we come to know a patient? And what about the patient is indeed necessary for us to know, assuming that we can get at it? In an attempt to understand the patient more fully, the analyst pays attention not only to the patient's history, his/her transferences, unconscious fantasies, and the modes by which the person seeks to minimize anxiety and other unpleasurable affects; but, moreover the analyst pays attention to the complex feelings and thoughts that emerge in him or herself as vital sources of information. Countertransference, subjectivity and intersubjectivity are constructs that have come into their own and now cut across theoretical paradigms.

In this paper, I hope to bring some of the ideas of modern conflict theory in line with some ideas in contemporary psychoanalysis that have to do with subjectivity/intersubjectivity. First, I will address the irreducible subjectivity of the analyst expounded upon most clearly by Renik and how it is understood from the perspective of modern conflict theory; I will explore how the concept of subjectivity relates to the issue of countertransference; and finally, I will address the problems attendant on intersubjectivity when it is more narrowly understood as co-construction of mind.

Countertransference

Freud wrote little on the use of the analyst's countertransference. In a footnote in the *Interpretation of Dreams*, Freud (1900) quotes the French psychologist Joseph Delboeuf to justify the importance of analyzing oneself, stating: "Every psychologist is under an obligation to confess even his own weaknesses, if he thinks that it may throw light upon some obscure problem" (Freud, 1900, p. 105). And, in his oft-quoted metaphor of the phone receiver, as Arlow has noted, Freud was in fact focusing on the inner experience of the analyst as "the guidepost to the proper understanding of the analysand's

mental life” (Arlow, 1979, p. 197). Freud (1912) asserted that if the analyst had no resistance of his own to the analysand’s material, he would be able to reconstruct aspects of the patient’s unconscious as communicated in his free associations. In his recommendations for practicing psychoanalysis, Freud (1912) wrote:

Just as the patient must relate everything that his self-observation can detect, and keep back all the logical and affective objections that seek to induce him to make a selection from among them, so the doctor must put himself in a position to make use of everything he is told for the purposes of interpretation and of recognizing the concealed unconscious material without substituting a censorship of his own for the selection that the patient has forgone. To put it in a formula: he must turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient. He must adjust himself to the patient as a telephone receiver is adjusted to the transmitting microphone. Just as the receiver converts back into sound waves the electric oscillations in the telephone lines which were set up by sound waves, so the doctor’s unconscious is able, from the derivatives of the unconscious which are communicated to him, to reconstruct that unconscious, which has determined the analysand’s free associations (Freud, 1912, pp. 115-16).

Freud’s view of countertransference emphasized the problem that countertransference posed as a potential *block* to the analyst’s understanding of the analysand’s communications.

It would be some years later, with the development by Klein (1946) of constructs such as *projective identification*, specifically as the term was elaborated to represent a more interpersonal process (Bion, 1961, 1962); and with Isakower’s (1963) ideas about the analyzing instrument, when countertransference and a focus on the analyst’s inner experience would take a more prominent role in helping the analyst decipher the analysand’s unconscious fantasies and transference.

It is generally acknowledged that Melanie Klein objected to the equation of countertransference with projective identification. For Klein, projective identification was an intrapsychic process. That is to say, a process that takes place within the fantasy life of the child. Klein described how, in fantasy, the child puts parts of the self into the object represented internally and in fantasy. In her description, the “real” or external object was not affected. In *The New Dictionary of Kleinian Thought*, the editors write that according to Klein, if the “analyst’s work was affected by the patient’s projection, Klein thought that there was something wrong with the way the analyst was working. She definitely did not think that the analyst’s emotional response to the patient was a useful source of information about the patient” (Spillius, Milton, Garvey, Couve, and Steiner, 2011, p. 134). This brings to mind Segal’s (1982) classic anecdote of a candidate in supervision with Klein who attributed his state of confusion to the patient’s projection, to which Klein is said to have responded, “*No, dear, you are confused.*” (p.10).

It was in what Sandler (1987) has described as the second stage in the development of the concept of projective identification, with the work of Paula Heimann (1950), and Heinrich Racker (1968) among others, that Klein’s original concept was extended from representing an intrapsychic phenomenon that occurs in fantasy, to an interpersonal one that is tied in the clinical situation to countertransference. Notwithstanding how Klein conceptualized the relationship between countertransference and projective identification, subsequent developments would tie the concept to an interpersonal object relations. As Sandler points out, the relation of projective identification to countertransference would become “firmly established” (Sandler, 1993, p. 1105), and by now it is widely accepted that the analyst comes to understand the nature of the patient’s projective identification via his or her own countertransference.

As a consequence of these theoretical developments, and the influence of Kleinian concepts on other modes of treatment, countertransference would be given equal if not primary importance over transference.

Across theoretical perspectives, countertransference evolved from Freud's original formulation as representing specific blind spots having to do with the analyst's unresolved conflicts (Freud, 1912, 1915) to how the term is most commonly used today which typically refers to the *totalistic* reactions of the analyst to the analysand (cf Heimann, 1950; Racker, 1968; Kernberg, 1965, 1993). Analysts from every stripe have come to agree that countertransference is an important part of treatment, informing how the analyst understands a patient. Like its kin, transference, countertransference, rather than representing an obstacle to understanding the patient, was recognized as an important source of information. It has become commonplace and almost required that in the description of any case study the analyst say something about his or her countertransference. To *not* do so, is to be out of step with contemporary psychoanalysis. It is interesting to note how far we have come from Reik's (1948) quibble about the lack of the word "I" in clinical write-ups: "With what fear and avoidance," Reik complained, "does the analyst write about his own method of coming to conclusions, about his own thoughts and impressions!" (p. 147).

Eagle (2000, 2010), upon surveying the literature on the uses of countertransference, has drawn a helpful distinction between what he refers to as a strong and a weak definition of countertransference. The strong version suggests that countertransference "virtually always serves as a guide to knowledge about the patient's mental states" (Eagle, 2010, p. 220); while the weak version states that the analyst's countertransference may say something about the patient's mental states, leaving open the obvious possibility that it may not. Eagle (2010) challenges the idea that countertransference is, as Paula Heimann (1950) argued, always "the patient's creation" (p. 83). He makes the case that such a stance in

regards to the origins of a countertransference response represents a proverbial pendulum swing from a one-person psychology to a two-person psychology, and back again to a one-person psychology, where now the one person is the analyst or the analyst's mind as a blank screen, save for what the patient projects onto it. "This," Eagle writes, "is a blank screen with a vengeance (2010, p. 220).

Countertransference and Subjectivity

Although subjectivity and countertransference are terms that are sometimes used interchangeably, there has been considerable debate regarding the differences between the two terms. Renik (1993), for instance, contends that the term countertransference is misleading because it implies that the analyst can identify *moments* of countertransference, as different from the analyst's moments of 'technical functioning.' According to Renik (2006), every moment of an analyst's activity is saturated by what has been called countertransference and, thus, we analyze from a position of countertransference. Similarly, Benjamin (2010) views the term countertransference as problematic mainly because it is understood as something induced by the analysand "rather than embracing the whole of the engagement of the analyst's subjectivity" (p. 113). The notion of countertransference implies an asymmetry and separateness of two minds that, according to Benjamin (ibid), does not adequately capture the interactive field that she believes constitutes the analytic situation: mainly an intersubjective field. Aron (1991) similarly argued that the term countertransference remains problematic even when seen as the totalistic response of the analyst to the patient because it emphasizes the analyst's experience of the patient as merely reactive rather than emanating from the analyst's subjective experience. According to Aron (1991), the term *countertransference* "obscures the recognition that the analyst is often the initiator of the interactional sequences, and therefore the term minimizes the impact of the analyst's behavior on the transference" (p. 33). By contrast, Smith (1999) has observed that whereas the term subjectivity points to the uniqueness of the analyst,

countertransference points to how the analyst's uniqueness, or subjectivity, is brought to bear on the analytic process (Smith, 1999). According to Smith, subjectivity is

a general concept denoting an aspect of mind; countertransference is a specific application of that concept, the analyst's personal response to a particular patient.

Hence when an analyst speaks of disclosing his or her subjectivity, we know what is meant, though strictly speaking it makes no sense to disclose an abstract principle. One can in theory disclose an aspect of one's countertransference, but one cannot disclose one's subjectivity, any more than one can disclose one's objectivity (Smith, 1999, p. 474).

Modern Conflict Theory and Subjectivity

Modern conflict theory, a term that Abend coined to denote Brenner's important modifications of classical ego psychology, emphasizes the ubiquity of conflict, unconscious fantasy, and compromise formations as the essence of mental functioning, including that of the analyst. Yet, in his writings, Brenner gave little importance to the role of countertransference or subjectivity in the therapeutic process, and the term countertransference only comes up in five of over 90 publications in Brenner's corpus. Abend (1989), for his part, gave an ambiguous nod to countertransference, but worried about an excessive dwelling on countertransference. And, Richards (1999; Bachant, Lynch and Richards, 1995), another strong proponent of modern conflict theory, while acknowledging the inevitable impact of the analyst's subjectivity on the analysand, disagrees with the notion advanced by authors such as Hoffman (1983) and Aron (1991) that the analysis of countertransference and/or subjectivity is the primary vehicle for effecting therapeutic change.

Given the apparent reticence to find a common ground, it may come then as a surprise that when we examine countertransference from the angle of modern conflict theory, we find that Brenner's ideas

about conflict and compromise formation have much in common with contemporary views on subjectivity as purported, for example, by Renik (1993, 2006).

Most of what Brenner had to say on the subject of countertransference was contained in a brief but incisive paper titled, “Countertransference as Compromise Formation” (Brenner, 1985). The central argument in this paper, which emanates directly from Brenner’s ideas about transference, can be summarized as follows: Conflict and compromise formations are ubiquitous to mental functioning. Like the analysand, an analyst’s thoughts, behaviors, and even choice of profession are the products of conflict and compromise formations. When the balance in the components of the analyst’s compromise formations becomes disturbed in his clinical work, we refer to it as countertransference. As one might expect, some patients will upset this balance, at which point the analyst benefits from trying to understand how and why, using introspection, consultation with colleagues, and/or personal analysis. Brenner did not argue with the commonly held view that countertransference could inform treatment. However, he disagreed with the idea that countertransference is “the ego function that makes analysis possible” (Brenner, 1985, p. 156); or for that matter with those who make the concept *synonymous* with intuition or empathy.

Brenner argued that every thought and behavior is a compromise formation, without exception -- every conjecture the analyst forms; every interpretation that follows. As Brenner sees it, conflict and compromise formation are essentially how the mind works. Any product of the mind, therefore, reflects a compromise between a wish, some degrees of wish-fulfillment, anxiety, and defense. The compromise represents the means by which a person seeks to gratify a wish or deal with an objectionable thought, with the least amount of psychological discomfort. When the analyst’s compromise formations are working ‘well,’ they seem to operate in the background, without notable anxiety, depressive affects, or defense. They allow the analyst to carry out his work without much awareness of the elements of his

own conflicts and compromise formations. However, when in his work with a patient, the analyst's compromise formations are disturbed, as evidenced by an awareness of an increase in his anxiety, discomfort, unusual difficulties in processing or listening to the patient's material, undue distraction from the patient's narratives, then we would consider this to be a countertransference response. A response, parenthetically, that may say quite a bit about the patient's state of mind and the impact that it is having on the analyst's subjectivity. Conflict and compromise formations can operate seamlessly but are always present. There is no conflict-free sphere. And this, in essence, constitutes how modern conflict theory accounts for subjectivity.

Analytic Listening and the Uses of Subjectivity

The question becomes, are disturbances in the analyst's compromise formations the exception or the norm, and is attention to such disturbances the orienting principle for understanding the patient? In Brenner's writings, the analyst's subjectivity is represented in the inescapable influence of conflict and compromise formations. Disturbances in the analyst's compromise formations are likely to occur as part of every treatment, and understood as countertransference. Yet, much like Freud, Brenner viewed the emergence of countertransference more as an obstacle to understanding, and less so as a conduit. Arlow (1979), however, was explicit about the ubiquity of the analyst's use of her own subjectivity. The analyst lends an ear to her inner experience as a way of arriving at an understanding of the analysand's unconscious fantasies and conflicts, and developing interpretations to communicate such understanding. Arlow posited that as the analyst follows the flow of the patient's material, a change occurs whereby the analyst's attention is directed to something going on within herself. Arlow (1979) writes,

The thought that first appears in the analyst's mind rarely comes in the form of a well-formulated, logically consistent, theoretically articulated interpretation. More often what the analyst experiences takes the shape of some random thought, the memory of a patient with a

similar problem, a line of poetry, the words of a song, some joke he heard, some witty comment of his own, perhaps a paper he read the night before, or a presentation at the local society meeting some weeks back. The range of initial impressions or, more correctly, the analyst's associations to his analysand's material, is practically infinite, and it may or may not seem to pertain directly to what the patient has been saying. Either immediately or shortly thereafter, a connection can be and is made between what the analyst has been thinking and feeling and what the patient has been saying. It is at that point that the analyst's inner experience is transformed into an interpretation (p. 200).

Arlow (*ibid*) contends that unless there is some marked countertransference interference, such as when the analyst is ill, in pain or overwhelmed by personal problems of his own, the analyst's associations *always* represent a commentary to himself about the analysand's unconscious thought process. Arlow's ideas have much in common with Ogden's (1994) description of the *analytic third* (i.e., the interplay between subjectivity and intersubjectivity). Like Arlow, Ogden believes that the "self-absorbed ramblings of [the analyst's] mind, bodily sensations that seemingly have nothing to do with the analysand," are nonetheless related to something influenced by each participant of the clinical dyad.

In later writings, and perhaps in reaction to implications for technique attendant to the relational turn in psychoanalysis, Arlow (1995) would temper this view and warn of what he saw as a danger in the recommendation of Jacobs (1986), Schwaber (1992), Renik (1993) and Ogden (1994) that the analyst deliberately turn her attention during the session to her own experience as a way of understanding the analysand. The danger here, as Arlow saw it, was that by focusing on the analyst's "transient, personal anxieties" the analyst would be distracted from following the patient's flow of associations. "Under such circumstances, listening may become confused, overly theoretical, and intellectual in orientation" (Arlow, 1995, p. 226-227). In a posthumously published paper entitled

“Some Notes on Intersubjectivity,” Arlow (2002) reiterated that the analyst’s associations “serve as *signpost* leading to the direction of insight into the patient’s difficulties and the insight so achieved may be correct (p. 2).” But he cautioned against the idea that “simply by virtue of the fact that it occurred to the analyst’s mind, that fact alone was sufficient to substantiate the interpretation (Arlow, 2002, p. 2).”

Like Brenner, Arlow emphasized a stance in the analyst’s mode of listening that deviates from Freud’s (1912) recommendation of evenly suspended attention, in favor of close process attention to content and narrative flow. Special value is given to the analysand’s chain of associations undergirded by the premise that every thought is determined by a preceding one and influenced by underlying unconscious fantasies and *intrapsychic* conflicts. Inevitable shifts in content, the emergence of incongruent affect, and other subtle changes in the flow of associations allow the analyst to surmise something about the analysand’s unconscious conflicts that have altered the analysand’s narrative flow. Contiguity of words, thoughts and themes imply dynamic relevance (Arlow, 1979).

[I]n free associations connecting words, like "before," "after," "therefore," "because," are usually omitted. The connecting link has to be inferred from the contiguity of elements” (ibid, p.83).

Thus, Arlow likens the analyst’s mode of listening to the reading of a text with special attention to syntax, where the contiguity of elements indicates causal relatedness. In Arlow’s view, the analyst should strive for a “precision of comprehension” that can only come from paying close attention to what the analysand expresses verbally. The close methodical attention that Arlow (1979, 1985), as well as Brenner (1976), deem necessary for understanding the elements of conflict, leaves less room for the type of *reverie* that Ogden describes in his well know case of the *Purloined Letter*, where by necessity and by Ogden’s (1994) own account, the analyst inevitably finds himself catching up with the analysand because when returning from such reveries he has, as you might expect, fallen behind the patient’s narrative flow.

As Smith (1999) aptly summarizes his views on this dialectic, “Any form of looking or listening does to some extent preclude another, but to speak solely from a subjective or an objective perspective represents a regression in thinking to a form of naïve objectivism or naïve subjectivism” (p. 465). And Akthar (2012) more recently schematized the differences in how the analyst listens as follows: Whereas, objective listening is directed outward with focused attention to the quality of, and shifts in, the patient’s syntax; subjective listening may be said to stress a focus on shifts in the analyst’s inner experience. Both modes of listening are necessary and dependent on one another.

I believe that this hybrid of subjective and objective listening represents the position that most contemporary conflict theorists embrace (Abend, 1989; Richards, 1999; Smith, 1999). Below, I offer a brief description of a treatment that while falling under the general rubric of modern conflict theory, is nonetheless marked by the influence of my own countertransference in arriving at an understanding of key aspects of the analysand’s difficulties and an underlying unconscious fantasy.

Reflections on the *Recalcitrant* Patient

A single woman in her late 20s sought treatment for marked inhibitions, particularly around her aggression, which became most evident in her difficulties in advancing her career. The patient was offered psychoanalysis, which she accepted in principle but refused to use the couch for the first two months of the treatment. Within a two-week period, the patient produced a number of interesting dreams. In one dream, she is in a doctor’s office for a checkup. *‘I am sitting on the examination table and the doctor says that she (referring to the patient) needs that injection that they have been discussing. He’s holding a syringe. It is red and it looks like it’s made of plastic.’* She added that she was trying to postpone the procedure but that the doctor was only half listening. In her associations, she saw the dream as a comment on her refusing the couch. She said that the examination table must be a disguised reference to the couch; she related the color of the syringe to the color of my couch and then thought

about how the syringe also represented ‘something phallic.’ She then spoke of worries about sexual feelings that were associated with using the couch and revealed that part of her fear of letting go in an analysis was that she would fall in love and suffer when the analysis ended. I commented on her experience of me, as the doctor in the dream, not listening to her protests. She did not elaborate on this aspect of the dream and instead proceeded to assure me that in fact I listened carefully. In my associations to her dream, I likened my analysand to Irma, that famous recalcitrant patient of Freud, who refused his recommendations. It was this particular association, a joke to myself, with its underlying hubris, that made me aware of a particular type of pleasure that I was taking in my work. This represented a particular countertransference response, albeit one devoid of the storms that we tend to associate with countertransference. Through its recognition I came to realize how hard the patient was working to please me by the production of so many dreams; how much she wished to be the ideal patient even in defiance of the couch. Her dreams, which were like gifts, made for work that was going a little too well. And, yet, another part of my countertransference was to pay a blind eye to this aspect of her character that influenced her *need* to produce such rich material. It was the smooth sailing aspect of my countertransference that alerted me to what I was overlooking and that once recognized would take up the rest of her analysis. As a bit of context, the patient had a sibling who died when she was very young, after which point she took it upon herself to become a replacement child, working doubly hard to please her grieving parents.

In many respects, this simple illustration represents the mundane, almost imperceptible, influence of my countertransference in my understanding of a patient. The frequency with which these moments of recognition occur almost renders them unremarkable -- particularly when the feelings that are evoked in the analyst are ego-syntonic; such as feelings of pleasure, warmth, humor, hopefulness,

excitement; as opposed to more upsetting feelings that we typically associate with a countertransference response.

In this case, once we recognized the pressure that she felt to be a good patient and how this pressure had its determinants in childhood and the death of a sibling, we became aware of a second phenomenon that brought about a negative therapeutic reaction. During a prolonged period, the analysand became intent on being self-deprecating during her sessions, imagining with almost complete certainty that I had lost any interest in her, and that I would much rather be with the next patient, whom she often encountered in the waiting room. The next patient, she believed, must be entertaining, lively, and interesting.

In the midst of this period of self-deprecation, the patient recalled a memory from her adolescence of her father becoming inpatient with her sulkiness. She described a particularly distressing scene during a dinner, when the patient's sad mood led the father to an angry outburst, at which point he pounded on the dining room table, yelling "there will be no more crying in this house."

During the course of these recollections, I had become conscious of my own irritability and exasperation with the patient's self-deprecating attitude. It was as if the patient was telling me, "We must play this out between us." I believe that this countertransference response of irritability represented an identification with the father, who could no longer tolerate the patient's moods. This brought about an important variation in how we understood my patient's sadness. Rather than her depression representing simply survivor guilt, and self-punishment for infantile sibling rivalry, it was also meant to punish her father, who had preferred a boy to girls; to punish him for making her feel that she needed to work so hard to make up for the loss of his son. Her disavowed aggression then became evident to me, by recognition of my own sense of frustration with the case, one that had been so promising in the beginning with Irma-like dreams of injections. It was through the recognition and then interpretation of

this complimentary identification, whereby I could see and feel what I imagine the father felt, at least as far as the patient represented it, that I was able to help the patient become aware of the aggressive elements in her self-deprecation, first in the session as they related to complaints about me; and then tracing these aggressive elements to the episodes of depression in the presence of her father.

In this process of attending to the patient's transference, the analyst becomes aware of how he feels about being used as this particular type of transference object. In my case, my own experience with a volatile father got in the way of experiencing the full range of my anger and recognizing sooner my identification with the patient's rageful father and, to some degree, my own. For a period of time, instead of anger, I felt a diffused irritability; impatience that oscillated with sleepiness in my sessions with this patient. This, in turn, led to a prolonged enactment, whereby despite my best efforts, I must have confirmed to the patient that she had become uninteresting and boring.

The patient's experience of gradually going from the center of my attention to witnessing a dulling of my interest in her, surely represented a number of stages in her life, but most importantly, the time of her brother's arrival in the home as a second child, followed by a depressed household after his departure upon his death. As Freud (1919) so evocatively describes the birth of a sibling: "Many children who believed themselves securely enthroned in the unshakable affection of their parents have by a single blow been cast down from all the heavens of their imaginary omnipotence" (p. 187).

As the patient became aware of the aggression contained in her self-complaints, she became convinced that she needed to make some reparation. She decided that she would cancel her engagement to her fiancé so that she could move back home and take care of her father who had, after all, suffered so much with the loss of his son and whom she, moreover, must have hurt with her resentment spurred by her destructive envy. This solution was understood for its disavowed aggressive elements as well, insofar as with this fantasy of sacrificing her own wedding in order to take care of her father, the patient

would be making reparations for her aggression in the past, but continue to exact revenge upon her father in the present, by virtue of how she now deprived him of the satisfaction of seeing his daughter marry, and, I might add, the prospect of his daughter providing him with a grandson -- something that occurred to me in writing this piece.

The process that I have described above comprises most of the analyst's mode of working. In listening to the patient, the analyst can at times become aware of a *complementarity* (Racker, 1968) with objects in the patient's life. These transitory identifications (Fliess, 1942) with the patient's past objects are made conscious as the analyst attends to the feelings, thoughts, and reactions, being evoked in him, which have come to his attention because of some unusual intensity, quality, or disorienting effect. Once conscious of them, the analyst can come to understand how the quality of the patient's particular transference, pulls for the analyst to respond in a particular way. By allowing himself to be used in this complementary role that includes an element of relaxed listening, the analyst can come to appreciate how the patient felt in relation to important objects. The analyst can understand the patient's ways of not knowing certain aspects of her own thoughts and behaviors, and the motivations that the patient has for remaining unaware. The analyst facilitates this process through close attention to the patient's biographical narrative and ultimately sees to what extent his countertransference fits into the biographical narrative of the patient's history. And herein lies a dialectical tension between close process attention to the flow of the patient's material, as described by Arlow (1979), Gray (1994), and Busch (1997, 2004), and a more relaxed way of listening that allows a space for experiences from within and about the analyst.

This is not to say that the analyst needs to adopt too vigilant of a stance for evidence of how the patient's material relates to the analyst's own conflicts and compromise formations. The analyst need not go in search of countertransference. The fact is that countertransference, insofar as it represents an

unconscious process, should catch the analyst by surprise. Stepping into each session with a vigilant stance toward his or her own reactions becomes a willful attitude that is contrived, and restrains the fluidity that I believe is necessary in the analyst, which allows the analyst to go in and out of different states of mind in relation to him or herself and the other. A capacity to tolerate this type of regression and to suspend a willful attitude facilitates a *receptivity* to communications from the patient as well as from within the analyst.

Arlow (1979), in *The Genesis of an Interpretation*, has described the process by which we encourage the patient to relax his vigilant stance, and to dream during the session. At times, the analyst calls the analysand's attention to something in the analysand's material, as if waking him up from his sleep to say "look what you just said," "look what just happened." A similar process takes place in the analyst where he relaxes his attention and allows for messages to come from within, at which point he rouses himself from his semi-somber state to say "look what just happened" and from there develops some kind of interpretation. I believe that potentially damaging enactments result when the analyst does not wake up in time, either to his own or the patient's dream, so that patient and therapist play something out over an extended period of time without full conscious awareness.

In this process, the analyst listens to the patient, with the patient, and as I have shown, with the patient's objects, as they become known to the analyst by the impact they have on the analyst's own conflicts and compromise formations: or on his or her subjectivity, if you will.

Intersubjectivity

So far, the mode of listening for, and making use of, subjectivity that I have described above is deemed uncontroversial by most contemporary authors from a broad range of theoretical perspectives, who to varying degrees acknowledge the role that subjectivity plays in analytic listening. In a recent review of intersubjectivity, Bohleber (2013) points out that "nearly all psychoanalytical schools of

thought undergo a change towards a stronger intersubjective orientation” (p. 799). Yet, despite the growing acknowledgement of the analyst’s role in the process of psychoanalysis, the concept of intersubjectivity, especially as defined by some American relationists, has remained polemical. Before addressing some of these polemics, it is important to acknowledge that there is no monolithic definition of intersubjectivity.

Infant Research and Intersubjectivity

A number of researchers have used the term intersubjectivity to describe the earliest modes of communication between infant and mother (see Beebe, Sorter, Rustin and Knoblauch, 2003 for comprehensive review). Meltzoff (1977, 1994, 1998), for example, has developed sophisticated experiments by which he examined the matching of movement patterns between mother and infants. He found that infants orient themselves and respond more positively to movements in the other that match their own. Furthermore, he has shown that the infant has a capacity for deferred imitation of others, and that this capacity develops at a much earlier age (six weeks) than previously recognized (16 months; Piaget, 1954). The infant encodes events and representations of others. She can then access these representations even in the absence of the other. In addition, as Beebe et al, (1984) explain it, experiences that are encoded in one modality, such as the visual image of the experimenter; can be accessed via a different modality, such as through the sensations of the infant’s own facial movements that were matched during previous interactions. From these, and other studies, Meltzoff has argued that the correspondence between self and other that the infant registers is a form of pre-symbolic intersubjectivity (Meltzoff, 1985, 1990).

Trevarthen (1998), also interested in these behaviors, has added that intersubjectivity is an inborn capacity rather than being an acquired skill. According to Trevarthen (1998), “infants and their partners are thus in *immediate sympathetic contact*” (p. 8). Furthermore, the infant develops a sense of the

other's mind before the acquisition of language. The earliest forms of intersubjectivity are preverbal and reliant on what Trevarthen (1974, 1989, 1998) has described as *rhythmic patterns* of behaviors, vocal patterns and motoric concordance. This matching goes beyond simple body sensations and requires that the infant have a "cerebral representation of persons" (Trevarthen, 1998, p. 6).

From Infant Research to Psychoanalysis: Remaining Controversies

Infant research evolved from a focus on the infant as the unit of study to a focus on the mother/infant dyad. A number of relational theorists have drawn on studies of early infant/parent communication to describe the analytic process in work with adults. In such cases the assumption is that variations of the modes of preverbal communication, found to exist in the earliest form of mother – infant interaction, play an important role in nonverbal communication in adult treatment. Thus, from the dialogic development of the mind observed in infancy, it has been analogized that the adult's mind is also dialogic, and relational in nature. Not only can the analysand's inner state be communicated nonverbally, but it can also be registered nonverbally by the analyst in the form of somatic sensations, images, confused states of mind, and other subjective and highly idiosyncratic responses. By now the view of intersubjectivity as the interplay between verbal and nonverbal modes of communication between patient and analyst, and the interaction of transference and countertransference in the analytic couple, is a notion that has been widely accepted.

Where the construct of intersubjectivity becomes polemical, drawing a dividing line between our theories of therapeutic action, has to do with two related issues. One concern has to do with the objective claims that the analyst can make about the patient's state of mind given that the analyst's understanding of the patient is informed by his or her subjectivity. As Bohleber (2013) indicates "radical intersubjectivist-relational approaches not only stress the inevitability of a mutual, reciprocal influence but due to the ineluctable subjectivity of the subjects also exclude the possibility of an objective

awareness of the psychological reality of the analysand” (p. 799). The second polemical issue has to do with whether there is, in fact, a mind that can be understood as a separate entity from the relational dynamics between patient and analyst.

In regards to the first issue, critics from the hermeneutic tradition, such as Gill (1991), Hoffman (1983), and Mitchell (1998), argue that the analyst can never make claims to know whatever is in the patient’s mind because these contents “are knowable both to the analyst and to the patient *only* [italics added] through an active process of composing and arranging them” (Mitchell, 1998, p. 17). The mind, Mitchell (*ibid*) believes, is “understood only through a process of interpretive construction” (p. 16). As Eagle, Wakefield and Wolitzky (2003) point out, there is certainly value to Mitchell’s position to the extent that it challenges an authoritarian certitude that seemed prevalent in classical psychoanalysis, according to which the analyst was seen as having “virtually infallible access to the *Truth* about the patient’s mind” or that there was, in fact, “one canonical *Truth* to be arrived at” (p. 415). However, as Eagle *et al.* (*ibid*) elaborate, “it is one thing to reject the claims of infallible access to the truth about the patient’s mind and another thing to reject altogether the possibility that one can reliably infer certain truths about the patient’s mind as if there were no stable organization prior to and independent of these interactions [those between analysand and analyst]” (p. 416).

Brenner (1996) argued that the conjectures at which the analyst arrives are provisional and subject to revision as the available evidence supports their correctness or fails to do so. As Abend (1989) puts it “the clinical distinctions analysts reach are inevitably subjective, individualistic, variable, and hence far from perfectly reliable” (p. 386). How could it be otherwise? There is no doubt that biases in the analyst’s perception, understanding, and his interpretations color the clinical material, and even influence the material to be elicited according to one’s receptivity, in different ways and at different times, which can partly account for why analysis takes so long. Yet, the conjectures at which the analyst

arrives can be challenged or confirmed through the common methods that are familiar to us all: which include supporting or disconfirming evidence of our suppositions, introspection, self-analysis, supervision, consultation with colleagues, and not least of all, by the fact that some of our interpretations based on our conjectures are followed by an amelioration of the patient's symptoms and functional improvement over a short period of time, while others are not.

To acknowledge that our understanding of a patient, like any other mental activity, is determined by our own conflicts and compromise formations, that is, by our subjectivity, does not render such an understanding as inaccurate or incapable of reflecting certain unique aspects of the patient's conflicts and compromise formations, which are independent of our perception of them, predate our interaction with the patient, and are likely to manifest themselves across relationships in the patient's life. The impact of the patient on the analyst's subjectivity is one important source of information about the patient's intrapsychic conflicts. But, along the lines of Eagle's weak view of countertransference, the analyst's subjective experience is influenced by many sources and cannot be taken to represent solely the patient's contribution and as direct evidence of the patient's unconscious conflicts.

The second and more important challenge has to do with how we understand the emergence of disturbances of personality, conflict; and the impact of this conceptualization on how the analyst listens. From the perspective of classical ego psychology and modern conflict theory, personality is structured by core unconscious fantasies emerging early in life as the child negotiates his/her environment, traumas, relationship with caregivers, wishes, impulses, anxieties; and develops modes of dealing with these interpersonal and intrapsychic experiences. This perspective places a great deal of weight on the forces of *intrapsychic conflict* and the patient's best attempts at solutions. Psychoanalysis entails multiple levels of exploration that include understanding the patient's mode of relating and how these forces of conflict have been synthesized into personality styles (Shapiro, 1965). Insofar as these modes

of relating have been developed in the service of adaptation they resist change (Schlesinger, 2010). Of importance in the analytic setting is not only an understanding of the analysand's modes of relating, and this is crucial, but also the core fantasies that seek expression and the attendant fears that they elicit, which together underlie and give shape to the analysand's mode of relating. This is significant because these unconscious fantasies are not a relic of the past, stored in a static unconscious, but rather are part of a dynamic unconscious whereby they continue to influence the present. In the analytic situation, unconscious fantasies become manifest, among others ways, in the transference. In order to understand these forces of conflict, the analyst creates a space for, or a receptivity to, the patient's transference pulls, which inevitably generate states of countertransference in the analyst. When these countertransferential states are analyzed, they may provide important clues about the patient's state of mind and how his or her mind works.

However, as Benjamin (2010) has shown, the idea that subjectivity is part of the analyst's understanding of the patient, and the recognition that our subjectivity makes the analyst's observations fallible, is only one dimension of the challenge posed by intersubjectivity. The more profound claims made by relationists, such as Benjamin (1998, 2004) and Mitchell (1998), as well as Ogden (1994), have to do with a view of the mind as co-created and co-determined. According to Benjamin (2010), for example, the mind cannot be understood as a separate unitary entity, and the analyst's role is not to help the patient understand how his/her mind works. Benjamin argues that many analysts still leave untouched their conception of the patient's mind as a unitary entity, one that is separate from that of the analyst, and view the analysand's mind, rather than the relational dynamics, as the main object of understanding. Similarly, Ogden (1994) states, "I believe that, in an analytic context, there is no such thing as an analysand apart from the relationship with the analyst, and no such thing as an analyst apart from the relationship with the analysand" (p. 3). These ideas not only dispute the objectivity of the

analyst's observations, but more importantly, challenge what ought to be the appropriate object of observation, as well as what ought to be the central task of the analyst. According to Ogden (1994),

In both the relationship of mother and infant and of analyst and analysand, the task is not to tease apart the elements constituting the relationship in an effort to determine which qualities belong to each individual participating in it; rather, from the point of view of the interdependence of subject and object, the analytic task involves an attempt to describe as fully as possible the specific nature of the experience of the interplay of individual subjectivity and intersubjectivity (p. 4).

On the Use and Misuse of Developmental Metaphors

The idea that the analyst and patient have a shared mind, marked by mutual regulation, comes from infant observation - a metaphor used to denote how the mind develops interactively (intersubjectively). Yet, to use this analogy to describe the process of treatment with adults remains problematic for many reasons. Mayes (1994) has most cogently expressed a cautionary note against direct analogizing from infant research to psychoanalytic process:

Stated simply, the patient on the couch, unable to see the analyst and therefore deprived of access to body language and wholly dependent on verbal communication, is in quite a different position from the crawling and toddling infant who, exactly because he is maturationally cut off from lexical language, is wholly dependent on facial expression, affective response, body movement, and touching. (p. 790)

Furthermore, what is appropriate for one period of development outlives its utility as the infant develops and matures. The young infant, for instance, may rely on the mother for affect regulation, but does not remain dependent on the mother for this function. Otherwise, the term *self-regulation* would

have no meaning. Likewise, preverbal communication loses its predominant status as a mode of communication, once the capacity for language develops. As Mayes (1994) notes,

adult analysands, however impaired or distressed, are more likely than not capable of far more complex modes and fantasies of relatedness than when they were young children, and however regressed in that relatedness they may become, they nonetheless still have available to them these more mature functional capacities (p. 791).

Many common features of mother/infant interactions, which facilitate growth and maturation during infancy, such as touching, holding, cooing and nursing, would be completely out of place in psychoanalysis, notwithstanding the frequency with which many of these activities are used as metaphors for clinical work with adults. This is not to diminish the enormous contributions made by infant research to our understanding of how the mind develops, but rather to caution against the tendency to equate the mother-child relationship with that of patient and analyst. The aforementioned infant research on preverbal and nonverbal communication, matching, and imitation sensitizes us to latent manifestations of these processes in analysis.

Lastly, with regard to this ontological question about the presence of mental structures, a large body of research indirectly addresses the issue by pointing to the stability of such structures and representations in adults. This includes Luborsky's (1989, 1990, 1993) research on core conflictual relationship themes (CCRT), with which he has demonstrated that wishes can be reliably identified from patients' narratives, and that such wishes remain stable over the course of even successful treatments. In another study using the CCRT researchers (Tishby and Vared, 2011) measured the CCRT of therapists and found that across stories about their patients, therapists show components of CCRT that related to their parents. That is to say, that the therapists' core conflictual relationship themes were not unique to their interactions with their patients, but rather, were stable structures with which therapists entered each

treatment. Sampson and Weiss' (1977, 1986, 1994) work on control mastery theory points to the presence of stable pathogenic beliefs that emerge in treatment and can be traced to early life experiences. And, finally, there's an exhaustive body of attachment research that shows not only that early attachment styles are relatively stable over time (Ainsworth, Blehar, Waters, and Wall, 1978; Sroufe, 2005), influencing adult relationships, but that they can reliably predict the attachment style of a parent's offspring (Fonagy, Steele, Moran, Steele, and Higgin, 1993). Mother's attachment pattern in the third trimester, for example, has been found to predict the child's attachment patterns at age one, at a rate of about 70 percent or higher.

Conclusions

By its very definition, modern conflict theory places special emphasis on subjectivity, which is defined in terms of the ubiquity of conflict and compromise formations. Conflict and compromise formation inform everything that the analyst thinks, does, feels, how he listens, and what and when he interprets. When the analyst's own conflicts and compromise formations come to his attention, maybe in the form of a signal affect, a memory, a distraction from the patient's content, the analyst does well not only to listen for what they may indicate about the analyst's state of mind but also listen for what these reactions may say about the patient's conflicts and compromise formations. In this regard, Brenner's ideas about the ubiquity of conflict and compromise formation speak to a ubiquitous subjective perspective (Rothstein, 2005).

Today, most conflict theorists hold a tempered view of intersubjectivity -- they are what Held (2007) calls *middle ground theorists* -- acknowledging the role that their subjectivity plays in their understanding of the patient's mind, where the patient's mind, nonetheless, remains the subject of clinical inquiry. Awareness of the influence of our own subjectivity represents an important, salutary shift in tone -- a certain humility in regards to our capacity to ever fully understand another person. It

represents a legitimate challenge to presumed universals, and unmask the illusory certainty behind some of our most dogmatic claims, whether they are at the level of diagnoses or our metapsychologies. They keep us aware of the multiplicity of possible meanings and help resist a tendency to premature foreclosure. They encourage us to keep some of our ideas at the level of conjectures for longer periods of time, as the unfolding material supports or fails to support their goodness of fit, that is, to use Freud's terms, as our ideas "tally with what is real" in the patient (Freud, 1917, p. 452).

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