Analytic Interaction: Conceptualizing Technique in Light of the Analyst's Irreducible Subjectivity

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ABSTRACT

Every aspect of an analyst's clinical activity is determined in part by his or her personal psychology. The implications for our theory of technique of taking the analyst's subjectivity fully into account—which we have tended not to do—are discussed.

Contemporary analysts acknowledge that every psychoanalysis inevitably consists of an interaction between the patient, with all his or her values, assumptions, and psychological idiosyncrasies, and the analyst, with all his or hers. When we refer to a psychoanalytic interaction, we mean an interaction between two complete psyches, and the realization that this is so has been exerting an increasing influence on the way we think about what actually takes place in treatment: various basic psychoanalytic concepts are currently coming up for reconsideration in light of the understanding that an analyst is a participant-observer. For example, Boesky (1990) recently proposed that each analytic couple negotiates its own unique forms of resistance—a valid and useful formulation, in my opinion, and one that shows just how far we have come from the image of the analyst as detached psychic surgeon, dissecting the patient's mental operations in an antiseptic field.

Yet, having said this, I would add that even our most up-to-date conceptions of the psychoanalytic process (the sequence of events that characterizes a successful clinical analysis) tend not to acknowledge fully the fact that clinical analysis is an interaction, in the sense just described. I think that despite our new understanding in principle, we retain an implicit obsolete theory of technique, evident in the model that most of us strive toward as we make moment-to-moment choices about whether and how to intervene with patients.

Let's consider the action that is involved in psychoanalytic interaction. A patient's expressions of his or her personal motivations in action during analytic sessions are expected and welcomed: speech is a form of action, and the things a patient says that proceed from his or her most intimate wishes, fears, and concerns, rational and irrational, make up the desired text that allows analysis of transference to take place.

What about actions on an analyst's part during sessions that proceed from his or her personal motivations? What role in the psychoanalytic process is played by the things an analyst says that proceed from his or her most intimate wishes, fears, and concerns, rational and irrational? Our conception of the analytic couple is clearly not symmetrical in this regard. According to the prevailing view, while an analyst's awareness of his or her personal motivations is certainly seen as useful, expression of them in action is not. Countertransference fantasies are considered a rich source of information, but countertransference enactment is generally understood to be, in principle, a hindrance to analytic work.

An analyst is supposed to try to become aware of his or her emotionally determined urges before they get translated into speech or any other form of behavior. The goal is for the analyst to imagine how he or she might wish to act on an impulse before acting on it. Of course, recognizing human fallibility, an analyst expects to fail significantly in this endeavor; but concern about failure is ameliorated by the analyst's further expectation of being able to learn from his or her lapses and the patient's reaction to them. Our literature contains many accounts of how a countertransference enactment, once it occurs, can be put to

1 To use the conveniently familiar term without, for the moment, discussing its disadvantages.

use. It is important to note that such a turn of events, commonplace enough, is conceptualized as the productive exploitation *post facto* of a departure from model technique—the skillful recovery of an error. This is the conceptualization that is implicit, for example, even in Jacobs's *(1986)* beautifully evocative portrayals of the ubiquity and subtlety of countertransference enactment, the ways countertransference enactment can coincide with appropriate and generally accepted psychoanalytic procedure, and the yield of analytic work when the analyst becomes aware of countertransference enactments and their determinants.

According to the current consensual theory of psychoanalytic technique, as I understand it, countertransference awareness ideally takes the place of countertransference enactment, and it is toward the ideal of self-analysis forestalling personally motivated actions that an analyst continually strives. The principle of *awareness instead of action* guides analytic technique, though that principle is never, in practice, realized.

Thus, the fundamental conception we hold is of psychoanalysis as an interaction between two complete psyches, *but regrettably so*: our theory of technique directs the analyst to eliminate personally motivated action as much as he or she can. The current state of affairs is therefore a bit confusing: on one hand, tolerance for and interest in the intensely personal nature of an analyst's participation in clinical work has gained an increasing place in our thinking about psychoanalytic process and technique; but on the other hand, the theory we retain still conceptualizes the patient's psyche as a specimen to be held apart for examination in a field as free as possible from contamination by elements of the analyst's personal psychology.

Today's analysts readily acknowledge that dispassionate analytic technique is only an ideal, a goal approached but never perfectly achieved. However, this acknowledgment has the effect of helping us accommodate and perpetuate what is really a significant problem with our theory: we admit the fact that an analyst's individual psychology constantly determines his or her activity in analysis without taking systematic account of that fact in our conception of technique.

Everything I know about my own work and that of my colleagues leads me to the conclusion that an analyst's awareness of his or her emotional responses as they arise in the course of an analysis *necessarily* follows translation of those responses into action—i.e., awareness of countertransference is always retrospective, preceded by countertransference enactment. It is my impression that those instances in which we find ourselves able to profit from subsequent exploration of technical errors committed on the basis of the analyst's emotional involvement simply show us with unusual vividness what in fact is *invariably* the case; these "errors" differ from the rest of our preliminary countertransference enactments only in that circumstances conspire to bring them explicitly and dramatically to our attention.

Here is an everyday clinical sequence. A patient is describing her joyless marriage. As I listen, I am aware of a sense of immobility—I am sitting absolutely motionless in my chair, and my limbs feel heavy. Possible interventions come to mind, but I decide against them, one after the other; I have the feeling each time that what I might say just would not lead to anything useful. I note that the remarks I keep thinking of making all aim at a rather active investigation of my patient's situation—questions about her attitudes toward her husband and the future of their relationship, how she regards her options. I realize I have an urge to rescue her from her marriage and end her distress. The feeling is a familiar one to me, reminiscent of, among other things, my childhood wish to be my mother's savior.

We could summarize this vignette by saying that a piece of self-analysis led me to become aware of an omnipotent rescue fantasy generated by my own psychology, a fantasy that was not appropriate to my actual task as an analyst and my responsibilities toward my patient. The insight I gained was quite useful: keeping it in mind allowed me to avoid embarking on a mission of my own I might otherwise have pursued at my patient's expense. Thus, in this instance it was true that self-analysis forestalled.
analytically unproductive, personally motivated behavior on my part; awareness of a countertransference urge took the place of enactment of it, with beneficial results.

However, it was also true that before I became aware of it, the countertransference urge in question had already been determining my activity, my technique. The posture and the physical sensations I observed in myself were manifestations of an inhibition I was employing to guard against anxieties generated by my impulse to rescue my patient, and this driven passivity on my part was exerting a very significant influence on how I was listening to what my patient said, as well as on my interpretive efforts. The possible interventions that were coming to mind I rejected one after another, not because I had thought through the issue of their analytic utility, but because they carried a forbidden meaning for me. In fact, once I became more fully aware of my state of mind and some of its personal historical determinants, I allowed myself to facilitate more actively my patient's exploration of how she was dealing with her husband. The outcome of this line of investigation was analytically quite fruitful, too. Eventually, as you might expect, we even came to look into my patient's need to elicit rescue by me and her difficulty initiating her own efforts to extricate herself from her marital problems.

It seems to me that when we can look closely enough, we always see that an analyst's awareness of a personal motivation in the clinical situation has its origins in self-observation of a behavioral manifestation, in some form or other, of that motivation. Sometimes what the analyst notices about himself or herself can be an activity on the very finest scale of magnitude—a subtle kinesthetic tension, for example. It is tempting to believe that such microactivity remains essentially private and has no significant impact on the treatment relationship, so that, for all practical purposes, countertransference awareness can precede countertransference enactment. However, experience indicates otherwise. Even the slightest nuance of disposition influences how an analyst hears material, influences whether the

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analyst decides to remain silent or to intervene, influences how the analyst chooses his or her words and in what tone they are spoken if the analyst does make a comment, etc., all of which is of the greatest importance, as we know.

I would say that the data of introspection favor Darwin's (1872) conclusion that a motor behavior lies at the core of every affect. In the same vein, William James (1890) proposed that our awareness of emotion arises from observation of our actions—which was the case for me in the clinical experience I just recounted. I think James was right, and I believe the only reason that psychoanalysts look at things differently is that we have perpetuated, without realizing it, what is really an unsubstantiated and incorrect theory Freud put forward early in his thinking, as part of his beginning effort to account for dreams and hallucinations.

In The Interpretation of Dreams (1900), Freud developed a model of mental function based on the spinal reflex-arc (as the reflex-arc was understood by late nineteenth century neurology). According to that model, motivations are conceptualized as impulses that can take either one of two quite separate paths: the efferent, leading to motor activity, or the afferent, leading to fantasy formation via stimulation of the sensory apparatus from within. From this conceptualization, it follows that thought and motor behavior are mutually exclusive alternatives: to the extent that one acts, one will not think, and vice versa. Hence the notion that a patient's "acting out" should be blocked, so that his or her motivations will be made available for analysis in the form of fantasy, and hence the notion that an analyst should become aware of countertransference by imagining how he or she might behave in the clinical situation, not by observing how he or she actually has been behaving.

So far as I know, there has never been any empirical corroboration of this early protoneurological conceptualization of Freud's. Certainly, if one becomes aware of an unrealistic fantasy and of the irrational motivations that produce it, awareness often puts an end to enactment of the fantasy; and, if one remains

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determinedly unaware of an unrealistic fantasy and of the irrational motivations that produce it, enactment of the fantasy is more likely to continue. However, these observations, which every clinical analyst has had the opportunity to confirm, in no way support the premise that thought and motor action are mutually exclusive alternatives. Rather, there is every reason to believe that thought is a trial form of behavior involving highly attenuated motor activity. Freud in effect superseded his early reflex-arc model of mental function when he began to develop a sophisticated ego psychology (in Inhibitions, Symptoms and Anxiety [1926], Freud agreed with Darwin's view of emotion), though Freud never specifically
reviewed and discarded his early model. In practice, we have increasingly gotten away from the assumption that a patient needs to frustrate his or her urges in order to think about them, but we have not gone as far in considering how an analyst's self-analysis takes place.

If we accept that an analyst's activity—including how an analyst listens and all the various moment-to-moment technical decisions an analyst makes—is constantly determined by his or her individual psychology in ways of which the analyst can become aware only after the fact, then we acknowledge the necessary subjectivity of even ideal analytic technique. Many authors have pointed to the participation of an analyst's individual psychology in analytic work. Atwood and Stolorow (1984), for example, define psychoanalysis as the "science of the intersubjective," stating: "Patient and analyst together form an indissoluble psychological system, and it is this system that constitutes the domain of psychoanalytic inquiry" (p. 64). Any number of analysts have written similarly.

Our difficulty has been in moving from broad epistemological assertions to a practical theory of analytic technique that takes account of the inherent subjectivity of every aspect of an analyst's activity. Just the fact that we still use the term interpretation would seem to indicate the extent to which we retain a conception of analytic technique as potentially objective, rather than inherently subjective—the extent to which we implicitly see the

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...an analyst trying to transcend his or her own psychology in order to deal with the patient's psyche "out there." The term interpretation dates from a conception of the psychoanalytic process that is now generally criticized, a conception in which the analyst decodes the patient's thoughts to reveal the unconscious, decides what hidden meanings lie beneath the manifest content of the patient's verbalizations—like the well-traveled railway conductor of Freud's famous analogy who tells the ignorant passenger where he is. In ordinary speech, interpretation refers to translation from one language to another, to exegesis of a religious text, to giving meaning to a work of art, etc. (see Dimon, 1992). The interpreter is always better informed than the recipient of the interpretation. In psychoanalysis, if we speak of an analyst making interpretations, our implication is that the analyst is better informed—despite the fact that the patient's psychic reality is the subject of investigation.

Schwaber (1992) has directly engaged the problem of the analyst's subjectivity in her extensive study of modes of analytic listening. Here is a clear statement by Schwaber of the way she sees the dilemma: "As analysts, we may agree with certain basic tenets: we should not impose our truths, whether or not theory-laden; we should maintain our focus on the patient's inner reality... But again and again, we fail to adhere to these precepts. Despite our best intentions, we seem to have a fundamental disinclination to maintaining these positions" (pp. 359-360).

I think that Schwaber articulates here, as she says, the generally agreed-upon basic conception of analytic technique. My own conclusion about subjectivity and analytic technique goes a bit farther, as will have been obvious from what I have already presented. Instead of saying that is it difficult for an analyst to maintain a position in which his or her analytic activity objectively focuses on a patient's inner reality, I would say that it is impossible for an analyst to be in that position even for an instant: since we are constantly acting in the analytic situation on the basis of personal motivations of which we cannot be aware until after the fact, our technique, listening included, is inescapably subjective.

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Although I very much agree with the intent of Schwaber's recommendations, it seems to me pointless to ask an analyst to set aside personal values and views of reality when listening or interpreting. Everything an analyst does in the analytic situation is based upon his or her personal psychology. This limitation cannot be reduced, let alone done away with; we have only the choice of admitting it or denying it. I think we tend to give lip service to the important truth that an analyst cannot, ultimately, know a patient's point of view; an analyst can only know his or her own point of view. Thus, Schwaber has entitled her latest paper "Countertransference as a Retreat from the Patient's Vantage Point," and in it she urges the analyst, through attentiveness and humility, to reverse the retreat. If we are to take seriously the fact of an analyst's subjectivity, we need to question the concept of countertransference used as Schwaber has, the assumption that an analyst's personal responses can be isolated and subtracted from the rest of his or her analytic activity. It has been said, justifiably, that one person's countertransference is another person's empathy; I think we could equally add that one person's countertransference enactment is another person's good interpretation.

It is commonly asserted nowadays that an analyst is not and should not think of himself or herself as simply a
reflecting mirror. Yet our usual underlying conception of technique asks the analyst to aspire to be a reflecting mirror, inasmuch as we encourage the analyst to be maximally objective by minimizing the influence of his or her individual psychology. This pursuit of a technical ideal that departs entirely from the true nature of clinical events, like the related effort to be aware of personal motivations before acting on them, can never be a successful strategy.

The unavoidable fact of the analyst's subjectivity is the psychoanalytic version of a universal and familiar scientific problem: the influence of the observing instrument on the thing observed. Consider an analogy from physics. Let us say that we want to ascertain the exact temperature of a glass of water. As

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soon as we introduce a thermometer into the water, we alter the temperature we want to measure. The change may be tiny, but it is certain. There is no way to eliminate this effect; but neither is there any need to. We only have to study it and take account of it. We establish the temperature, volume, and specific heat of the thermometer, use it to take the temperature of the water, the volume and specific heat of which are known, and calculate what the heat transfer must have been. We then use this information to obtain from our reading the true temperature of the water prior to introduction of the thermometer.

Analogously, in the analytic situation an analyst cannot eliminate, or even diminish, his or her subjectivity. However, an analyst can acknowledge his or her irreducible subjectivity and study its effects. Objectivity, in the Einsteinian rather than the Newtonian sense, requires that we do so. Our inclination is to think that the subjectivity of technique is a quantitative matter: that we become more or less emotionally involved at various moments, and that we can try to detect the extent to which we are acting on the basis of subjective considerations by noting our deviations from established baselines. It seems to me that, on the contrary, we are always completely personally involved in our judgments and decisions, and it is precisely at those moments when we believe that we are able to be objective-as-opposed-to-subjective that we are in the greatest danger of self-deception and departure from sound methodology.

What are the practical implications of a conception of analytic technique that accepts the analyst's constant subjectivity? For one thing, it means we discard a widely accepted principle of technique which holds that countertransference enactment, so called, is to be avoided. While emotional satisfaction for the analyst is clearly not an objective to be pursued, in and of itself, in making technical decisions, neither does recognition that a given course of action will serve the analyst's personal purposes constitute a contraindication to going forward. What distinguishes good technique from bad technique is not whether the analyst is gratified or reassured, consciously or unconsciously, by what he or she does; good technique can be gratifying or reassuring to the analyst, and bad technique frustrating or anxiety-provoking for the analyst, or vice versa.

Actually, analysts by and large tend to be quite conscientious, in my experience, so that interferences with optimal technique arise from constraining inhibitions and reaction formations designed to prevent satisfaction of some urge or another at least as often as from the direct pursuit of satisfaction per se. This was so for me with respect to my wish to rescue my patient in the vignette I presented. Elsewhere (Renik, 1993), I described how acting unself-consciously on a wish to compete with and punish a patient was the basis for a very effective analytic intervention. I find, all in all, that the technique of beginning analysts tends to suffer more from stiffness than from an excess of spontaneity; and it seems to me that veteran analysts become more effective and comfortable not because they reduce the extent to which they act out of personal motivation, but because they become less defensive about it and more confident about being able to explore their patients' reactions to expressions of the analyst's personality.

An analyst can aim for maximum awareness of the personal motivations that determine his or her analytic activity without assuming that acting in a way that satisfies personal motivations will necessarily oppose the analytic process. Sometimes it is useful for an analyst to accept the need to act under the influence of personal motivations of which he or she has become aware before those motivations can be thoroughly investigated. I think this is the conclusion we reach if we follow, for example, Sandler's (1976) concept of "free-floating behavioral responsiveness" to its ultimate implications.

In this same vein, Jacobs (1991) makes the following assertion: "Reacting spontaneously with responses that inevitably include a mix of some personal as well as objective elements, the analyst uses his intuitive understanding of
the patient's state of mind and character to make unconscious adjustments in his technique" (p. 12). Now, we may ask, why are these adjustments

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unconscious? Freud's (1915, p. 194) often-quoted comment, "It is a very remarkable thing that the Ucs of one human being can react upon that of another, without passing through the Cs," tends to mystify and glamorize the phenomenon a bit, I think, and distract us from considering that if the analyst's responses and technical "adjustments" are made unconsciously, it is likely because the analyst is motivated to remain unconscious of them—not a remarkable situation at all, but a very common and familiar one.

This brings us to a second implication of a theory of technique that accepts the analyst's constant subjectivity, namely, that unconscious personal motivations expressed in action by the analyst are not only unavoidable, but necessary to the analytic process. Here we enter into a crucial subject that deserves more extensive discussion than I can give it without departing from the immediate purposes of my presentation (for a fuller discussion, see Renik, 1993). For the moment, I will only suggest that it is precisely because of the analyst's capacity for self-deception, the analyst's willingness to be self-deceived, that he or she is able to enter spontaneously and sincerely into corrective emotional experiences with the patient without the presumption and hypocrisy of deliberate role-playing. These interactions provide a crucial series of gratifications and frustrations to the analysand that form the basis for a successful analytic process. Continuous examination of them as they occur, and the retrospective understanding continuously reached and refined, is what we usually refer to as the analysis of the transference. We can emphatically agree with Boesky (1990) when he observes, "If the analyst does not get emotionally involved sooner or later in a manner that he had not intended, the analysis will not proceed to a successful conclusion" (p. 573).

We come to a problematic third implication of a theory of technique that accepts the analyst's constant subjectivity. Since an analyst acting on his or her personal motivations is inherent in productive technique, how are we to say where analytic work leaves off and exploitation of the analytic situation by the analyst

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begins? There is no avoiding this very disconcerting question. In struggling to answer it, we cannot afford to deny the fact of an analyst's personal involvement.

What we have been used to calling countertransference, in the widest sense of the term, is the ever-present raw material of technique. We need to learn more about what combines with it in order to distinguish helpful analytic treatment from exploitation. We do not profit, ultimately, from the comforting but misconceived ideal of what is essentially an impersonal use of the self of the analyst in clinical analysis.

Instead of the analyst as surgeon or reflecting mirror, our guiding metaphor might be the analyst as skier or surfer—someone who allows himself or herself to be acted upon by powerful forces, knowing that they are to be managed and harnessed, rather than completely controlled. Of course, the forces with which an analyst contends in his or her work are internal ones. In this sense, perhaps we should think of effective clinical psychoanalytic practice as not unlike good sex, in that it is impossible to arrive at the desired outcome without, in some measure, relinquishing self-control as a goal. In making this analogy, of course, I am suggesting that interferences in both arenas may arise from the same causes.

By granting that the analyst's personally motivated behavior plays a constructive role in the analytic process, it might seem that we are opening the way for an "anything goes" attitude in analysis; but this is not really the case. Our traditional ideals of abstinence and transcendent objectivity provide no real protection at all against exploitation of the analytic situation by the analyst (as we have ample reason to know) because they advocate pursuit of an illusion. The notion that an analyst can minimize the personal involvement and subjectivity of his or her participation in clinical work offers only a false and dangerous complacency. An analyst's use of the clinical setting for personal gain is in fact more easily rationalized, and effective self-analysis impeded, by maintenance of the belief that countertransference is separate from technique.

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We have no reason to believe that our prevailing theories about the analyst's personal motivations in relation to technique have helped us avoid exploiting our patients. Every effective clinician learns that appropriate gratifications for analyst and analysand are an essential feature of the successful analytic process; thus, the principle of abstinence is obviously flawed and does not provide an effective safeguard. In practice we struggle to determine which gratifications are effective and appropriate and which are counterproductive and exploitative, and in this context abuse can easily be excused as therapeutic. Actually, it is the ethical norms we establish and maintain in our analytic communities, rather than our theories, that prevent us from taking advantage of our patients. We do not have sex with our patients or borrow money from them for the same reasons that internists and surgeons refrain from doing these things with their patients (because responsible caregivers do not want to trade on the hopes and fears of people who rely upon them), not because we conceptualize that enactment of fantasies interferes with the analysis of transference.

Another implication of a conception of technique that accepts the analyst's subjectivity is that communication to the patient of even an implicit pretense of objectivity on the analyst's part is to be avoided. In this regard, perhaps we can look upon our continued use of the term *interpretation* as helpful in a way, since it constitutes an admission, really, that the analyst is always imposing his or her truth.

Hoffman (1983), in his paper "The Patient as Interpreter of the Analyst's Experience," cautions against the error of responding to a patient's speculations about the analyst's psychology as if their possible accuracy were not relevant. In issuing his warning, Hoffman joins those who emphasize that the analyst's interpretation of reality is not authoritative. I definitely agree, and I think it is also most important to add and to emphasize that neither is the patient's interpretation of reality authoritative. Surely there can be no privileged interpreter of reality within the analytic couple. Analyst and patient each develop their own interpretations of reality and operate on the basis of them. Progress in analysis occurs through the interaction between two individual interpretations; and though I think we generally find the interaction to be dialectical, it is by no means necessary for consensus to be achieved between patient and analyst on every point. In fact, I have the impression that when analytic work goes well, there are usually some matters about which analyst and patient agree to disagree, or to consider impossible to determine.

I would therefore take some issue with Schwaber's (1992) suggestion that the analyst focus on the patient's vantage point instead of the analyst's own. Certainly, the patient's exploration of his or her psychic reality is the objective of clinical analysis. However, sometimes the best way to facilitate a patient's self-exploration can be for an analyst to present his or her own, different interpretation of reality for the patient's consideration—even to present it as persuasively as possible, in order to be sure that the patient has taken full account of it. When an analyst feels constrained against doing this, an important tool is lost. Lipton (1977), for example, has discussed times when it is necessary for an analyst to introduce perspectives to which the patient will not come of his or her own accord, and I have suggested that the analyst communicating his or her own construction of reality is central to the analysis of certain fetishistic transference phenomena (Renik, 1992). I very much concur with Hoffman's (1992) view that if "analysts embrace the uncertainty that derives from knowing that their subjectivity can never be fully transcended ... analysts can ... 'speak their minds,' including expressing conviction about their points of view, even sometimes when they clash with those of their patients" (p. 287).

It seems to me a fundamental principle of analytic collaboration that an analyst's aim in offering an interpretation is not to have it accepted by the patient, but rather to have the patient consider it in making up his or her own mind. If the analyst is clear about this, then respect for the patient's autonomy—we

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might even say insistence on the patient's autonomy—comes through, and it can be useful for the analyst to communicate a definite point of view, even a sense of conviction about his or her own inferences. If, on the contrary, an analyst is not clear about the patient's autonomy, if an analyst holds persuading the patient to the analyst's own view as the goal of interpretation, then no amount of ostensible focus on the patient's vantage point will help—it can even act to keep the analyst's subjectivity covert, and therefore all the more insidious. An analyst is much more disposed to being
 inadvertently coercive toward agreement with his or her underlying assumptions when the analyst believes that he or she has been successful in putting aside subjectivity and allowing the patient's inner reality to determine the investigation.

To look at it from a slightly different angle, the problem with an analyst believing that he or she can transcend subjectivity and focus on the patient's inner reality is that it can promote idealization of the analyst. If an analyst communicates a feeling of being able to offer interpretations concerning the patient's psychic reality not as that reality appears to the analyst through the lens of his or her own constructions, but from the patient's vantage point, then the patient and analyst together become susceptible to colluding in a disavowal of the distinction between developing one's own meanings and accepting the meanings implicitly communicated by another. The analytic work relationship may be experienced like the relationship between mother and infant, in which giving meaning encourages development. So the analyst, like the good mother of early infancy, "understands" perfectly. While this is perhaps a necessary and useful illusion for a time in some treatments, if it persists the patient's autonomy is coopted in the name of empathy or analytic humility.

Psychoanalysis has frequently been criticized from without for being a clinical method that cultivates the patient's reliance on an idealized analyst, and analysts themselves have recognized this difficulty as a limiting factor, for example, in training analyses. I think we have much to learn on this score, in particular

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from French analysts, who are especially sensitive to the issue of subjectivity and its implications for technique. The French do not speak of analytic "training" (éducation, in French) because training means subordination of the trainee to the purposes of the trainer, e.g., what one does with a horse; they refer instead to the "formation" (formation) of the student analyst.

Although he may not have been successful himself in overcoming the problem, Lacan (1975) did repeatedly call attention to the ease with which an analyst is cast in the clinical situation as le sujet supposé savoir, the one who is supposed to know; and, partly as a result of contending with Lacan's assertion, French analysts tend to operate with a particular mindfulness of the epistemological privacy of the patient's psychic reality. Interpretations are considered more as stimuli to the patient's self-investigation than as truths about the patient's mental life to be communicated to him or her. I have the impression that this helpful perspective on interpretation is one we too easily lose track of in the United States. It seems to me that the most effective way to avoid danger of an analyst imposing his or her own subjective constructions upon a patient is not for the analyst to try to abandon those constructions, but rather for the analyst to acknowledge them and to make every effort to identify and question ways in which the analyst is idealized and his or her constructions given undeserved authority by the patient.

When we accept the subjectivity of analytic technique, we admit the role of suggestion in a successful analytic process, inasmuch as suggestion consists of the imposition by an analyst, wittingly or unwittingly, of his or her own views upon a patient. Many papers have been written about the fate of suggestion in clinical analysis. Since earliest days psychoanalysts have been at pains to distinguish psychoanalysis from other therapeutic modalities explicitly based on suggestion—at first from hypnotism and faith healing, then from the technical innovations recommended by Alexander and French, and more recently from systematic desensitization, cognitive therapy, and various other psychotherapies. It seems to me that this concern to preserve a

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psychoanalytic identity, so to speak, has occasioned a certain defensiveness. Analysts have often felt the need to deny the role of suggestion in analytic technique, whereas the truly scientific approach is to study the role of suggestion in effective analytic technique (see also Gill, 1991); (Stolorow, 1990).

In our clinical lore, we have a group of maxims designed to counteract suggestion by reducing the analyst's subjective biases. We are cautioned to be modest, to remain open to surprise, to see ourselves as students who learn from our patients, to focus on the patient's inner psychic reality. I think all of these recommendations are well intended, and useful, as far as they go; but I also think it is very important that we realize that they are all double-edged swords—as I have already tried to point out with regard to some of Schwaber's suggestions—principles that can be inhibiting instead of liberating, if they are followed categorically. The reason that this is so, in my opinion, is that these recommendations substitute for a systematic, comprehensive theoretical conception of analytic technique that takes into
account the unavoidable, pervasive subjectivity of the analyst. The more a theory of technique places the analyst in a position of authority as the privileged interpreter of reality, the greater the need to compensate by exhorting the analyst to humility. The more the theory of technique denies the inevitable subjectivity of technique, the stronger the call for objectivity on the part of the analyst. It has been my purpose to propose that we aim toward a revision in our basic theory of technique that will make it unnecessary for us to ask ourselves, in vain, not to be passionately and irrationally involved in our everyday clinical work.

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