

mous terminology. We hope that analysts will strive to cultivate new ways of describing old and new that do justice to a richer, more nuanced way of characterizing affective/transferential experience in the analytic situation.

## References

- Cooper, S. (2004), State of the hope: The new bad object and the therapeutic action of psychoanalysis. *Psychoanal. Dial.*, 14: 527-551.
- Davies, J. (2003), Whose bad objects are these anyway? Repetition and our elusive love affair with evil. Presented at conference of International Association for Relational Psychoanalysis and Psychotherapy, Toronto, January.
- Fairbairn, R. (1952), *Psychoanalytic Studies of the Personality*. London: Routledge, 1981.
- Greenberg, J. (1986), Theoretical models and the analyst's neutrality. *Contemp. Psychoanal.*, 6:87-106.
- Mendelson, E. (2002), The analyst's bad enough participation. *Psychoanal. Dial.*, 12:331-358.
- Mitchell, S. (1988), *Relational Concepts in Psychoanalysis*. Cambridge, MA: Harvard University Press.
- (2002), *Can Love Last? The Fate of Romance over Time*. New York: Norton.

in, RELATIONAL PSYCHOANALYSIS

eds., Aron, L. & Harris, A.

Vol. II

(2005)

Analytic Press

## Why the Analyst Needs to Change: Toward a Theory of Conflict, Negotiation, and Mutual Influence in the Therapeutic Process

(1998)

Malcolm Owen Slavin  
Daniel Kriegman

### Editors' Introduction

In this fascinating article, Slavin and Kriegman build on their coauthored book, *The Adaptive Design of the Human Psyche* (1992), in which they introduced evolutionary issues and concepts as they relate to the question of what is primary about the human mind and the relational world in which it functions. Slavin and Kriegman drew on contemporary evolutionary biological theory and its overall dynamic theory of human motivation in order to revise modern psychoanalysis.

In that book, Slavin and Kriegman described how our intricate inner psychodynamic system may have evolved to guide the ongoing negotiation and renegotiation of the self in the ambiguous, inherently conflicted relational world. In that world our minds are powerfully constructed within the family and the larger culture by others whose interests inevitably diverge from our own. Within this model of the

evolution of mind, dealing with conflict, mutuality, and deception is part of the normal family matrix.

In the chapter "Why the Analyst Needs to Change," the authors extend their ideas to demonstrate why it is essential to the patient that the analyst be open to change within him- or herself as part of the analytic process. In contemporary evolutionary theory, the overall dynamic system of human motivation is adaptively designed to operate in a self-interested fashion. For these authors, self-interest is a natural organizer of human motivation and the patient's skepticism is a natural evolutionary adaptive capacity. It functions in the service of evaluating the degree of overlap and divergence of interests of the patient and the analyst. This perspective places internal conflict and interpersonal conflict center stage. Resistance is viewed as an essential adaptive function that protects one from influence by someone whose interests conflict with one's own. Patients are therefore highly motivated to observe therapists' ways of dealing with their own inevitable internal conflicts as well as with conflicts of interest between themselves and their patients.

It is inevitable that the subjective worlds and personal interests of patient and analyst will conflict. These inevitable conflicts of interest between patient and analyst are regularly hidden within all versions of psychoanalytic technique. Slavin and Kriegman persuasively argue that it would not make sense for patients to surrender to analysts' influence unless and until the patients were convinced that, in spite of these inevitable conflicts, the analyst's interests were sufficiently aligned with his or her own. From this point of view, ongoing mutual influence in analysis is generated by the need to test these conflicts of interest. Since "the power to influence" is generally granted only to those with whom we experience real, long-term, stable reciprocity, it is the patients' experience of the analysts changing that convinces each patient that there is a genuine working negotiation occurring.

In the course of developing their argument, Slavin and Kriegman take up and revise many fundamentals of psychoanalysis, including empathy, authenticity, conflict, resistance, and the therapeutic action of psychoanalysis. The crux of the matter is that, from a relational point of view, therapeutic action requires mutuality—we can expect our patients to reorganize their identities only if we are open to revising our own.

## Why the Analyst Needs to Change: Toward a Theory of Conflict, Negotiation, and Mutual Influence in the Therapeutic Process\*

As we thread our way through the patient's brambles, we trip over the big feet of our self interest, then stumble to those same feet to resume the quest for the other (McLaughlin, 1995).

This essay addresses a basic dimension of the therapeutic process, something that lies at the very core of it and is a central feature of all human relating: the experience and role of conflict—inner conflict (within both patient and analyst), and interactive (interpersonal) conflict. We cannot talk about conflict without addressing, simultaneously, what we believe is a realm of experience that is inextricably linked with it, namely, the ubiquity of deception and self-deception.

We are going to try to discuss conflict, deception, and self-deception in a fairly generic way, by which we mean a way that cuts across the specific languages of particular psychoanalytic traditions. Our views will be most familiar and compatible with readers who have moved away from the classical assumption that all conflict and defense derives from drive/defense structures—away from viewing transference and resistance as necessarily or primarily equated with individual intrapsychic distortions of reality. Yet from this relational and intersubjective springboard we propose some assumptions about the nature of conflict that differ from the customary focus of theorists working in the relational, intersubjective, and constructivist paradigms. Specifically, we develop a way of talking about conflict in the therapeutic relationship as deriving from the inherently *diverging interests* (identities and needs) of analyst and patient. We shall describe the deceptions and self-deceptions surrounding the conflicts of interest and the complex negotiation process that is often required to deal with it.

### Conflict as an Essential Constituent of Relating

Consider Winnicott's (1950) incredible assertion, "The mother hates her infant from the word go" (p. 201). Winnicott was not talking about bad

\* Originally published in *Psychoanalytic Dialogues*, 8:247–284. © 1998 The Analytic Press, Inc.

or less than adequate mothers. He was talking about all "good-enough," devoted mothers. We don't think Winnicott was even talking simply about "hate" (the affect, or affective state) *per se*; certainly nor primarily about the manifestation of a destructive instinct" pressing for expression. We believe he was alluding to the affective dimension of something broader and more fundamental in the nature of human relating: the absolutely inescapable, major conflicts of interest that exist in the background between *even* the two individuals who share in the closest, most mutualistic relationship on earth—the relationship in which, without question, a natural empathy and love normally constitute the predominant affective bond.<sup>1</sup>

Consider what Winnicott says:

The baby is not [the mother's] own (mental) conception. . . .  
 The baby is a danger to her body in pregnancy and at birth. . . .  
 To a greater or lesser extent [she] feels that her own mother demands a baby, so that her own baby is produced to placate her mother. . . .  
 He tries to hurt her, periodically bites her, all in love. . . .  
 He is ruthless, treats her as scum, an unpaid servant, a slave.  
 He shows disillusionment about her.  
 [After] having got what he wants he throws her away like an orange peel. . . .  
 He is suspicious, refuses her good food, and makes her doubt herself, but eats well with his aunt. . . .  
 She must not be anxious when holding him. . . .  
 If she fails him at the start, she knows he will pay her out forever [p. 201].

The paper in which Winnicott wrote these lines, "Hate in the Countertransference," is, of course, *not* about mothers and infants (although

<sup>1</sup> The reader can basically interpret "conflict of interest" and "self-interest" in terms of the familiar, social meanings of these terms. Psychoanalytic readers may assume that self-interest as a motivational principle implies goals that are more conscious, calculated, and rational than those we observe in analytic work. We *make no such assumption*. The framework in which we understand self-interest as an overarching organizer of human motivation ultimately derives from contemporary evolutionary theory, in which the *overall dynamic system of human motivation*—not necessarily particular needs, wishes, or affects—is adaptively designed to operate, as much as possible, in a self-interested fashion (Slavin and Kriegman, 1992). The reader may also wish to see Trivers (1974) for a fascinating discussion of the biology of conflicts of interest (parent-offspring conflict) in human development and the wider world of nature and Slavin (1985) for a discussion of the function of repression in the context of parent-offspring conflict.

they are never far from Winnicott's mind). Immediately following the foregoing list of observations about mother and infant, Winnicott states, "The analyst must find himself in a position comparable to that of the mother of a newborn baby" (p. 202). Winnicott then introduces his notion of an "objective countertransference"—by which he means those aspects of the therapist's feelings about the patient that derive not from pathology in the therapist, nor from pathology in the patient, nor even from the specific character and style of the therapist as it interacts with the character and style of the patient.

Rather, the so-called objective countertransference seems to refer simply to a level of feelings, often fear and hate, that coexist with love. The fear and hate that Winnicott finds central to human relating seem to arise from what we see as the "psychic undertow" that operates between any two distinct beings who are attempting to interact in an intimate way. In an overarching, often unconscious way, each attempts to use the other, to pull the other into his or her subjective world, and to *resist* the pull, the undertow, in the *opposite* direction. Simultaneously, though, each needs to "use" the other to construct his or her own identity and thus wants—must want—to take in aspects of the other's subjectivity. Each tries to redefine the other in his or her own terms (and both to accept and to resist redefinition in the terms of the other). We call these universal relational tensions an undertow because they operate inexorably beneath whatever crashing of waves and ebbing and flowing of behaviors catch our attention on the surface.

Beginning with Winnicott's mother, "who hates her infant from the word go," we are also, as Havens (1997) puts it, confronted with the fact that "we stare forth from individually shaped and genetically different nervous systems onto a world seen from this time and place by no one else" (p. 526).

This innate individuality is not simply a function of having different histories (although it is, of course, immensely elaborated and developed by different sets of experiences). From the word go, as it were, our individuality derives, in part, from the fact that each of us must have access to inner signals that will prompt and guide us to construct and reconstruct our individual world in accord with our self-interest (including most prominently inner signals that guide the actual process of constructing a viable subjective sense of what constitutes our own self-interest in relation to the interests of others).

As Winnicott (1963) observed, "There is a core of the personality that never communicates with the world of perceived objects and that the individual knows . . . must never be communicated with or be influenced by external reality" (p. 187).

This "core" can be seen as not only referring to an inevitable effort to protect the vulnerable aspects of the self, but also as signifying an *adaptive capacity to create and sustain the self in face of the average, expectable conflict, bias and deception that comes along with communication and influence in a relational world that, despite considerable mutuality, always includes significant competing interests*. There is a continuing tension, a web of conflicting and coinciding aims in the normal relational world that are sustained and amplified by our human capacity, as Havens (1993) notes, to use speech (not only to convey and communicate but also, regularly) for the purpose of concealing our thoughts, shaping them according to one or another prejudice. "Every human encounter is therefore a collision of viewpoints in which language both connects and conceals differences in outlook (Havens, 1997, p. 526).

Winnicott (1963) went on to say, "Although healthy persons communicate and enjoy communicating, the other fact is equally true that *each individual is an isolate, permanently non-communicating, permanently unknown, in fact unfound*" (p. 187).

Again, we read Winnicott (and Havens) as attempting to capture a very basic human tendency to construct our communications unconsciously in complex ways that, despite genuinely shared aims, are nevertheless inevitably biased toward our own interests; we naturally anticipate that the communications we receive from others will be similarly biased.

Winnicott's "core" is thus not a mute, defensively shut-off fortress but an adaptive aspect of how the self is configured, an aspect that serves as an innate, inner reminder that prompts us with something like the following message: monitor every communication, every relationship, that exerts a potential influence; despite significant overlap, my self-interest is unique and only partly shared by others; and even if they love me, they will often tend to act more in their own interests than in mine.

The core (as we see it) is not a "thing," or set of contents that exists in a fixed, immutable way within us; it is a metaphor that captures the essence of a process by which we organize all interactive experience, selectively coding outgoing and decoding incoming communication. This process limits the vast shaping potential, the influence, that interactive (social) experience can have on the highly plastic human psyche. The core reflects our inner design for managing the paradoxical nature of the human adaptation to the relational world: namely, in order to create and maintain a sense of self—including a sense of our own self-interest—we must continually learn from and incorporate aspects of the relational world. We must be influenced and feel this influence to become ourselves. Yet the intrinsically ambiguous relational world will, in even the best of

circumstances, be biased toward its own interests, will tend naturally to represent its constructions as "reality" and its aims and ties as more closely and altruistically aligned with our own aims and interests than can ever, in fact, be the case.

Winnicott's observations about the "hate" that is present "from the word go" and the "core that must never be communicated with or be influenced by external reality" relate to fundamental aspects of our psychological being, *vital constituents of relating*. As we see it, Winnicott was not referring to an attunement to the realities of conflict that is reducible to "endogenous drives that need discharge" in the Freudian or Kleinian sense (although his Kleinian training certainly sensitized him to the existence of inherent conflict "from the word go"). Nor was he referring to hateful and defensive responses to environmental failures as self-psychological or intersubjective perspectives stress (Kohut, 1972; Stolorow, Brandchaft, and Atwood, 1987). Nor was he simply referring to reactions to the inevitable vicissitudes and disappointments in relating as other relational perspectives would emphasize (Mitchell, 1988). We believe he was talking about a universal *dialectic* between all individuals and the relational world, a dialectic that a) is rooted in the existence of implicit conflicts of interest, b) is represented innately in basic affects like hate and the existence of a private core of the self, and c) is vitally linked to the complex innate strategies we employ to "use" the relational world in order to create and maintain our individuality.

Clinically, this dialectical conflict within and between individuals involved in intimate forms of relating will also operate "from the word go" (see Benjamin, 1988). In myriad forms and innumerable deceptive ways, our subjective worlds and our interests will conflict with those of our patients. The crucial dimension of conflict we are referring to is intertwined with yet does *not* derive from and is not fully graspable or understandable in terms of a) the patient's *pathology*, projected or displaced onto a blank screen neutral, or even an affectively resonating therapist (as traditional analytic theorists and contemporary classical theorists might hold); b) the therapist's countertransference response to the patient's pathology, the experience evoked by a projective identification into the roles of others who were in conflictual relationships with the patient in the past (as many object relations and interpersonalist theorists might hold); or c) the failures of therapists to adequately empathize or sustain an attunement with the patient's subjective reality (as the self psychologists would have it).

What we are saying is that—like any two individuals (strangers, close relatives, intimate friends, lovers, parent and child)—therapist and patient operate through subjective worlds, needs, agendas, ultimately

interests, that, to some extent, always diverge. At times their interests will inevitably clash. Woven into the most loving and cooperative motives (over and above the influence of professional roles) every individual organizes—really must organize—his or her subjective world to communicate and promote his or her own interests. From birth onward our subjectivities are naturally and inherently biased toward our own vital agendas. This bias is basically adaptive; it underlies the meaning of human individuality in a world of conflicting interests; and it may operate consciously or unconsciously.

### The Adaptive Resistance to Influence in the Analytic Relationship

We develop here a perspective in which the centrality of the conflict between the patient's and analyst's needs and identities leads to continuing efforts to break down each other's identity: to reveal and examine each other's biases (identities, loyalties, agendas) and the inevitable conflicts between them. Patient and analyst continuously experience each other doing this. They experience and evaluate the integrity of each other's effort to engage in this process. The process is highly mutual and reciprocal (Ferenczi, 1932) although not symmetrical (see Aron, 1992; Hoffman, 1994; Beebe and Lachmann, 1988). Indeed the substantially different roles of patient and analyst invariably heighten certain aspects of the inevitable conflicts between them and what they ultimately need to negotiate (Slavin, 1996a; Kriegman, 1998).

The analytic literature grapples with facets of this negotiation process using the technical frameworks of transference, countertransference, empathy, holding, affective resonance, role responsiveness, projective identification, enactment, resistance, and so on. But all these clinical conceptualizations lead to discussions of conflict in the therapeutic relationship in ways that, we believe, often obscure crucial aspects of how and why conflict is central to human relationships, how it operates inexorably within every thoroughly "good-enough" therapeutic encounter and is integrally tied to the therapeutic action.

Most of our clinical conceptualizations of conflict (over the whole spectrum from classical to object relational, interpersonal and self-psychological/intersubjective perspectives) exaggerate the difference between the therapeutic relationship and other intimate human interactions (Bromberg, 1991). Our concepts tend to restrict us to viewing conflict in the therapeutic relationship as arising from the patient's pathology, from the analyst's pathology (countertransference), from fail-

ures in technique, or simply from differing individual, subjective organizing principles (Stolorow and Atwood, 1992), interpersonal patterns (Aron, 1992), or the complexity of human relating (Mitchell, 1988).

We believe that all analytic traditions overemphasize the extent to which differences in the subjectivities of patient and analyst result from either instinctual clashes, relational failures, or the accidents of an imperfect world. Rather, intersubjective disjunctions are often ultimately rooted in genuine conflicts of interest. In a variety of ways, it is conflicting interests that generate the continuing (self-interested) efforts at *mutual* influence that can be found within most therapeutic communications, and these conflicting interests are, inevitably, deceptively hidden within all versions of analytic technique. Consider the following kinds of clinical situations that, in one form or other, most of us have encountered.

### Nancy and the Analyst's Newborn Child

Nancy was a very troubled young woman who had been characterized by many other therapists as "very primitive." She became agitated and depressed in response to hearing that her current therapist was about to have a child. Her therapist responded warmly to her, yet tried to articulate what he felt was idiosyncratic in her perspective on the situation. He conveyed something like the following thought: "We've seen how much you tend to feel that there is a limit to the amount of love and concern available in the world; so what I give to my child will reduce what is available for you."

The implication was that the most significant dimension of Nancy's current experience was a set of internalized assumptions carried over from a childhood during which she suffered enormous deprivation and frequently felt intensely envious, jealous, and rivalrous with her siblings. The emphasis on her past—although communicated in a compassionate way without any direct implication of "distortion"—implied that her views did not fit the reality of the current situation. Nancy seemed to contemplate the therapist's words. But, following this session, she became more distraught and angry (in his view she regressed further) and became suicidal!

A careful continuing look at this case revealed that the therapist was deeply invested in his assumption that Nancy's fear, rage, and regression came predominantly from her pathology, that is, that the threat to her emerged essentially from her characteristic way of organizing experience and was fundamentally at variance with his own basic sense of the world. He knew, too, that, to some degree, his experience of Nancy also arose from his analytic identity. He sensed that his analytic training and theory were biased toward his interests, geared to developing and

protecting his therapeutic identity, his healthy need as a professional to feel that he had adequate, valuable resources to give.

For example, in supervision on this case, he was reassured that, of course, he would have enough to give and that the crucial therapeutic question was why Nancy could not experience his caring. He was encouraged to look at how she had even managed to project her doubts and anxiety into him—managing to enlist him emotionally in the reenactment of her relationship with her rejecting parents—making him feel as though he were abandoning her. It was also pointed out that this was, simultaneously, a reversed side of the enactment: Nancy was now in the role of her abandoning parents (with whom she was identified) engaged in a rejection of the vulnerable child (projected into the therapist).

The analyst recognized that Nancy's characteristic readiness to experience changes as threatening was clearly at play in the disruption that had occurred in the treatment. Yet the very power of Nancy's "regression"—her intense transference—had set in motion an interactive process that led (with the help of further consultation) to a deeper reappraisal by the analyst of his own beliefs, specifically, of the way in which his views of Nancy shielded him from recognizing the elements of self-deception and self-protection in his own initial response to her. During this process, he also had the opportunity to experience the birth of his child—his own joyful preoccupation with it and the very real drain it created on his resources.

In subsequent meetings the analyst found himself needing to acknowledge the vital, inherent truth that Nancy's "transference anxiety" had ultimately brought him to hear: that, of course, his life energies were and would be significantly absorbed by a child of his own flesh and that his relationship with his child did represent a different—in many ways, far more powerful—investment than his bond with her. He acknowledged and discussed the reality of these conflicts, including his own struggle to recognize and articulate them. Nancy seemed to experience something in these discussions as genuine. She began, as she put it, to feel "real" again; she no longer felt that her therapist had "disappeared." She became less afraid and—in her inimitable way—quipped that "maybe her analyst would actually learn something about nurturing that might be of use to her." As she recompensated, they went on to explore many of the additional, painful, and highly defended personal meanings that his becoming a father held for her.

### *Tanya: Paying to Be Cared About*

Consider another familiar therapeutic conflict. Tanya was experiencing recurrent, extreme distress at "having to pay to be cared about" by her

analyst. Very careful attempts to use the analyst's empathic understanding to clarify the personal meanings of Tanya's distress in terms of either her ongoing experience in the analysis—or prior painful disappointments in her life—were met with doubt, sometimes by withdrawal, sometimes with an understanding that ultimately seemed compliant. The analyst thought he had already reached a workable resolution regarding the complex meanings of money through his own personal treatment, supervision, and extensive clinical experience. He also seemed to be closely attuned to the painful way in which paying for therapy replicated Tanya's individual history of being taken from and used by others, of never having experienced a generous and genuine giving.

Yet, Tanya's persistent "transference anxiety" over the meanings of the fee eventually evoked a broader range of thoughts and self-confrontations in her analyst. Tanya's persistent distress eventually compelled him to confront his sense that the disappointment, shame, and rage associated with paying for treatment could be analyzed in a way that would essentially transcend the painful sense of their differing investment in the therapeutic relationship, that understanding the individual subjective meanings of paying could somehow allow them to override the way in which these real differences in participation signaled the existence of their painfully conflicting interests. The analyst ultimately conveyed to her that he could see that money was an indication of one of the ways in which their interests did, in fact, diverge. In charging her, he acknowledged, he could see that he was clearly pursuing his own interests—which, in this respect, were quite different from and actually in conflict with hers.

The analyst's earlier attempts to explore the issue of money with Tanya were cast in what he believed were the meanings that historically had shaped her subjective world. That her analyst did not initially grasp the inherently conflicting interests that pervaded their relationship lent weight to the implication that her reactions to the rules of exchange in the analytic situation were rooted in her idiosyncratic unconscious organizing principles. As carryovers from her past, this old set of meanings undoubtedly needed to be explored empathically in the present therapeutic relationship.

Yet Tanya needed more than to have the analyst empathically acknowledge and help her articulate her painful distress about "paying to be cared for" and her suspiciousness about the genuine character of the caring thus received. She seemed to need him to recognize that her feelings were, in part, responses to certain real implications of paying him for maintaining their current relationship. That is, she needed to have a firmer sense that her analyst was going to be able to acknowledge the



existence and potential implications of the existential dilemmas created by inherent conflicts of interest. She seemed to benefit not only from a sense that her analyst could become aware of how these existential dilemmas were woven into their relationship, but from a sense that he could grasp how her sensitivity to this conflict represented an essential adaptive capacity on her part.

We believe that Tanya essentially used this aspect of her transference (her capacity to mobilize and express her anxiety and suspiciousness) to probe the therapist's capacity to become more aware of the inevitable "background of conflict" that formed the context for their mutual work together. She seemed to need to see if he could face the ways in which his interests were clearly different from hers and, in fact, were naturally biased toward himself. She initiated (and he engaged in) what we would call a transferential dialogue about it, a dialogue in which she compelled some real change in his views (see Slavin and Kriegman, 1992; Slavin, 1994).

The cases of Nancy and Tanya illustrate two of the most common clinical arenas in which the analyst's interests clearly diverge from those of the patient: the existence of the analyst's real kinship ties and the exchange of money for the analyst's attention. As a function of the real, conflicting interests that pervade these arenas, interactions within them are fraught with significant deception and self-deception. The relational conflict and deception seen in the cases of Nancy and Tanya go well beyond the idiosyncratic aspects of these particular analysts' and patients' subjectivities. Beyond the recognition that we inevitably "trip over the big feet of our self interest" (McLaughlin, 1995, p. 435) and ultimately encounter the "hate" in our countertransference (Winnicott, 1950), we need to understand (in much broader, more basic terms) *why* these dimensions of the treatment relationship universally arise.

These cases illustrate the operation of a deep, natural, human sensitivity to the ways in which our needs and identities conflict with those of others. This universal awareness forms a context in which a range of other personal, historical, and intersubjective meanings take shape. While the existence of these conflicting interests is a painful reality that must slowly be grasped and lived with over the course of treatment, the process of arriving at a relatively less deceptive and self-deceptive discourse about such conflicting interests is fundamental to the viability of the analytic relationship. Beyond the obvious and direct acknowledgment of the conflicts experienced during mini- "crunches" (Russell, 1973) like those with Nancy and Tanya—in virtually all long-term, intensive therapeutic work, there is a subtle process by which analyst and patient struggle with seeing and acknowledging the real conflicts in their needs and identities. This process is central to the therapeutic action.

## How the Analytic Situation Heightens the Experience of Conflict and Deception

Analytically oriented treatment is designed to be a process by which an unrelated person (someone without the depth of commitment of a family member or a close friend) is given extraordinarily privileged access (and power potentially to influence) very deep layers of the mind. Given the view of the relational world we have been presenting, an inherent, "adaptive skepticism" is likely to exist between any two individuals—including a patient and an analyst—concerning a new situation where an unrelated person invites the establishment of an intense transference and potential renegotiation of identity. As we see it, a patient's skepticism is a crucial adaptive capacity. It balances the equally vital capacity for a "willing suspension of disbelief." It serves as a means of evaluating the particular texture of the overlap and divergence of the interests (the identities) of patient and therapist. That is, patients must assess the likelihood that the potential activation of archaic longings and other repressed or disavowed aspects of themselves will be occurring in the context of a truly safe and promising relationship. Patients are likely to call into question only what they experience as their essential, ongoing sense of self (and self-interest)—likely to allow themselves to "use" (be influenced by) their analyst only when they experience the analyst as genuinely allied with their interests (see Weiss and Sampson, 1986).

Yet, as Nancy's and Tanya's analysts repeatedly discovered, there exist a range of ways in which the interests of patient and analyst regularly clash. The inherent tendency of both to construct their experiences and communicate in a biased fashion means that a patient's sense that the analyst is fundamentally allied with the patient's interests can be achieved only in an elusive, intermittent way. We think a crucial aspect of the therapeutic action lies in an ongoing, two-way negotiation process by which patients come to experience—then inevitably doubt, lose, search for, and repeatedly re-create with the analyst—the vital sense that the analyst is willing and able to become sufficiently allied with their interests.

Quite apart from individual, pathological mistrust carried into the analytic relationship by the patient, the fact is that, in all naturally occurring human relationships, the "power to influence" that we grant to persons outside our closest family relationships normally depends on our tangibly experiencing real, long-term, stable reciprocity in our interactions with them. We may significantly change in the context of marriage, intimate, enduring friendships, and, occasionally, some mentor, collegial, and business relationships. Yet, in each of these relationships, the other partner makes major tangible investments or takes close to equally large risks. In virtually every sphere of our lives, we humans

basically operate through such experienced, carefully monitored and evaluated reciprocity (Trivers, 1971).

Yet the analyst is an unrelated individual who asks the patient to pay (sometimes dearly) for what is always experienced (at times by even the most grateful patients) as a relatively small investment in terms of visible costs to the analyst. With an analyst there is little tangible, reciprocal sharing or exchange and—for long periods of time—usually ambiguous and subtle results.

In this light, consider the implicit message we deliver to our patients:

Though I, as analyst, give you little that is tangible in return—and, in fact, insist that you pay me—I expect you to trust me, open yourself up to my influence, and give free reign to powerful fantasies and wishes. I imply that the interpersonal negotiating power, as it were, that the activation of these forces within you confers upon me will ultimately lead us to reorganize you in ways that are more aligned with your real interests than you can at this point even imagine (and that, right now, either of us can actually know).<sup>2</sup>

### The Therapeutic Transference as a "Mimicry" of the Parent-Child Relationship

Consider also some of the larger meanings of the analysts interest in evoking an intense transference attachment and potential regression. We expect a therapeutic transference to develop: we create a setting and a way of relating designed to revive aspects of early experiences in the context of which the patient constructed basic conclusions about who he or she is and what can be expected from interactions with others. The analytic relationship is essentially designed to mimic, as it were, the unique emotional power and influence that early familial ties naturally hold for the child in the human life cycle. Through this mimicry, the transference creates a highly emotional human situation in which it may be possible to revise some of one's fundamental conclusions about oneself and the world.

Because we live and breathe the life-cyclical realities of our species every instant of our lives, we should not take for granted (absurd as it may seem to question it) the fact that children "allow" their parents and the familial environment to develop the degree of influence, the power as internalized presences (introjects) that they normally exercise in con-

structing the child's self organization, that is, in molding the child's basic definition of self and self-interest. Yet, despite the mother's "hate for her infant from the word go"—the very real conflicting interests and psychic undertow that operate between parent and child—the fact is that in a natural environment parents can be expected intrinsically to share their child's interests very deeply and to invest in them (more than anyone else) over a long period of time (Trivers, 1974). This seems to mean that the child's "core personality" (in Winnicott's [1963] sense) is, in fact, predisposed to allow more communication and influence (to modulate its innate skepticism to a greater degree) in early interactions with related individuals than at any other time in the life cycle. The therapeutic transference relationship essentially mimics these formative, developmental relationships in which there is a far different form of investment than in the analytic situation. It is thus inconceivable that our patients would not have an underlying sense that the experience of heightened transference expectations and longings exposes them to a dangerous deception and invites them to engage in a perilous self-deception.

However we conceive of the meaning and function of the transference, patients are apt to feel within it the potential for a tangible, reciprocal investment in their self-interest that is seductively similar to what natural, formative relationships could entail. And, yet—despite much in the analytic relationship that is as heartfelt and genuine as in any relationship—this therapeutic version is not the same as what occurs in most other reciprocal relationships that give rise to such powerful emotions. The pain of paying for concern, the constant reminder at the end of each hour of the limits of the therapist's involvement, all signal a much broader and more basic reality of the analytic situation: the therapeutic relationship does not carry with it the inherent investment in the patient's interests that kin and other natural, reciprocal relationships regularly entail. Patient and therapist must negotiate ways by which the patient may come to experience that, despite its painful "unrealness," the treatment relationship is, in fact, real enough to justify the patient's fully engaging himself or herself with its potential power and influence (Slavin, 1996b).

Just what is the analyst's investment in the patient? How far reaching is it in comparison with the natural context of familial hate and love in which the child's "core personality" may be designed to allow relatively greater communication and influence? Analysts tend not to define their core self-interests in a fashion that includes the self (and self-interest) of a specific patient to a great degree. Indeed, many of the *rules* of therapy are structured precisely to ensure that, the analyst's self-definition does *not* include the patient's self-interest to an overly great degree.

<sup>2</sup> Also see Kindler's (1995) references to the therapist's "entitlement to intimacy" and Friedman's (1991) notion of the intrinsic "seductiveness" of the analytic situation.



Consider the relative experience of a therapist and patient if, for some unavoidable reason, the relationship is prematurely lost. Given the risks the patient is asked to assume and given the analyst's relative safety and comfort, it is hard to imagine any human situation more likely to elicit a vigilant readiness to detect signs of potential conflict and deception. Beyond this imbalance in risk and safety, the analyst often tends to equate his or her subjectivity with reality; what is tilted toward the analyst's interests is often subtly conveyed as really in the patient's benefit.

### The Patient's "Innate Skepticism"

Like Tanya and Nancy, all patients tend ultimately to compel us to face the fact that there is something fundamental in the relational structure of the analytic relationship, which, in a real sense, should make the patient suspicious. In the thick of the struggle with the unique transference-countertransference complexities of our relationship with a particular patient, we tend to ignore the fact that the therapeutic negotiation process probably carries the natural human capacity for self-revision (in the context of a powerful relationship) to an unusual—perhaps, in some ways, unnatural—extreme. This is why something tantamount to an "innate skepticism" is activated in most patients concerning this almost unparalleled new situation in which an unrelated person deliberately offers him- or herself as a vehicle for profoundly influencing and altering a patient's identity. This adaptive skepticism is, for us, a kind of backdrop to all discussions of "resistance." It refers to a general, adaptive core in all forms of resistance. This core is distinct from (although perhaps intertwined with) the "dread to repeat" (Ornstein, 1974) particular, painful relational scenarios that have thwarted development in the past.

As we see it, a patient's innate skepticism is the adaptive phenomenon that Winnicott was trying to describe when he struggled to articulate what he experienced as a "core that must never be influenced." It signifies a fundamental, universal form of "resistance to influence"—one that by no means aims to bar all influence, but, rather, subjects all potential influence to the scrutiny of a basic relational test: what is the texture, the subjective feel, of the overlap and divergence of this other person's interests and my own? Is this relationship actually sufficiently geared to my interests to (re)awaken my deepest longings? Is there enough of a sense that the analyst is willing and able to gear this relationship to the enhancement of my genuine interests—and consistently maintain that biased focus in my favor—for me to open up those aspects of my inner experience and desire that I long ago concluded were not

safe to expose to relational influence? In a way that both analyst and patient dimly sense, because the analyst is an Other, whatever the analyst can offer will come wrapped in who he or she is—his or her needs, identity, biases. And, therefore, the patient is going to have to lose parts of him- or herself, compromise his or her interests, be hurt in the inevitable adaptation to the analyst.

### Transference as an Adaptive Probe

The human capacity to develop and interactively use transferences may actually be geared, in significant part, to expressing and probing the potential for recognizing and negotiating the ambiguous mixture of real conflict and mutuality in human relatedness. Tanya repeatedly used her sense of the unreality of the "paid-for caring" in the treatment relationship to find out whether her analyst could see and accept his own needs as distinct from—even, at times, inimical to—hers. The analyst's recognition of his need to use her for his own ends did not diminish her longing to be cared for without reciprocating financially—indeed to be given more unconditional love than probably even a very good parent would provide. Yet the greater clarity about their conflicting interests significantly diminished the deceptive and self-deceptive blurring of their interests—the "insult added to injury"—that made the "unreality" of the analytic relationship, with its painfully real limits on the expression of love and investment, even more painful and dangerous than it needed to be.

Nancy also responded intensely to her sense of this potential deceptiveness in the transference. She was not part of the analyst's life in a way that permitted her to observe or directly influence his investment in her even to the extent that a child can affect the relative investment in a sibling. She thus needed to mobilize fantasy and emotion within her transference as a way of probing the analyst's capacity for candid reflection on their conflicting interests over the investment in his own child. Tanya reacted to one of the most thorny areas of conflicting interest and potential deception in the analytic situation: that, in the early part of the analytic work, there may be, for some patients, a strong sense of the situation as tilted toward the fulfillment of the analyst's needs—financial, certainly, and also in terms of professional identity. If treatment is successful, the balance in the exchange is restored in the (very) long run. But, meanwhile, the painful experience of adapting to a relationship that is, indeed, structured in the short run to benefit the other person is one major way in which the "asymmetry" of the treatment relationship becomes experienced as problematic. Real diverging interests and the

accompanying potential for deception and self-deception are amplified by the analytic context.

In many respects therapists must sustain an exquisite alertness to self-deception and avoidance of deception. For not only is the analytic relationship basically prone to the same complex web of conflict and deception as are other human ties, but the analytic relationship must ultimately justify its potential influence without making the same kind of real investment in the patient's life that is often found in other, naturally occurring reciprocal bonds. The negotiation between analyst and patient must continuously transform the deceptive part of the relationship, the unreality, into its benign form, something that is experienced as play and creative illusion (Winnicott, 1969). Ultimately, it must be real-enough on its own terms and in its own way (Greenberg, 1986) to justify the patient's using it effectively to question and revise fundamental conclusions about, and ways of interacting with, the relational world.

As Tanya, Nancy, and the case we are about to present compelled their analysts to recognize, one of the major ways in which therapists fail their patients revolves around the therapist's use of self-deceptive strategies for protecting or enhancing his or her interests in a fashion that is cast in terms of the interests of the patient. In our view, the danger that many patients sense in such a "confusion of interests" is not simply the dread of a repeated traumatic experience of major boundary confusions in their past. Within many ordinary enough, everyday deceptions lies the potential for further loss and erosion of the vital capacity to define, know, and promote one's own interests. *We believe that this tendency to engender a confusion of interests is the central feature of many less than good-enough, traumatizing, pathogenic family environments.*<sup>3</sup> And it is not uncommonly replicated in many therapies woven into what therapists codify as "technique."

By focusing on relatively isolated moments during a long, complex treatment process, the brief vignettes of Nancy and Tanya may suggest that we believe there can exist a clarity and simplicity in such analytic negotiations. There are, of course, many dimensions to the process of mutual adaptation that signal to patient and analyst alike that a genuine negotiation is taking place. In the following case example, we hope to

<sup>3</sup> This "confusion of interests" can be very destructive to the child, and we would probably tend to call its effect "traumatic." However, it can operate in subtle ways over a long period of time and can lead to a very familiar event: our dealing with very troubled and confused patients who continually exclaim, "What's my problem? I had a good family/childhood. Nothing *really* bad happened to me."

convey a bit more of the enormous complexity in this process of negotiation and mutual adaptation.

## Edward and His Analyst

Edward was the most intensely and tenaciously depressed person his analyst had ever known. Trials of virtually every known medication had been almost totally ineffective. After a few years of treatment, on occasion the analyst felt that there were small, momentary brightenings in Edward's mood, brief periods of improved concentration, and, from time to time, moments of interest, intense passion, and insight. To his analyst, Edward seemed in these moments to be noticeably more alive.

The positive moments, the flickerings of hope and passion, were linked to the analyst's highly consistent efforts to remain closely attuned to Edward's subjective world, to remind herself that, more than anything else, he needed to establish (and continually restore) the sense that someone could grasp his experience of deadness and impossibility in which he constantly lived. They had come to construct a picture of his having grown up as an unwanted child—a child of a removed, depressed mother and a distant, critical father—who felt that he existed only insofar as he corresponded to and validated everyone else's expectations for him. He was tortured by an unresolvable dilemma: although he craved intimacy, attempts at closely relating with other people invariably left him feeling lost, trapped in what he called "the black hole." There he was bereft of meaning, lived only for the other person, and virtually lost all sense of himself as a real, living being.

Although in some ways the treatment relationship had become a kind of sustaining bond through which he seemed to feel more understood than he had ever felt in any other relationship, Edward's intense, deadening hopelessness always returned. He felt that he could never have the sense of aliveness that other people felt. Nor could he tolerate the deceptiveness, the hypocrisy, the self-deceiving "mechanical social ritual" that he astutely observed in the lives of others. Yet the more he removed himself from "meaningless social contacts," the lonelier he became.

Over time, Edward's analyst became regularly aware of living with a powerful, anticipatory dread within herself, a dread of what felt to her like the repeated undercutting and undermining of all good feelings. Early on in one session, Edward seemed to be fighting off the horrible tug of another slide into hopelessness. For an instant, the analyst was aware of silently siding with what she sensed as Edward's effort not to lapse, once again, into a state of angry despair. She attempted to remain closely attuned to the story he was telling about a perennially frustrating

problem at work. As the hour proceeded, however, it became clear, that Edward's despair was gaining the upper hand. Nothing was helping. Whatever they might come to understand, he still had no life.

"Can't you see," he said, "I am dying more each day. This is futile."

In the midst of this hopelessness, it seemed as if something inside her began to talk. She heard herself saying, "At times like this, I sometimes feel that all I can do is to be here with you in your despair." And then, as she realized it, she added, "Yes, there is something more, maybe more important. I, I have to try to deal with the part of me that really doesn't want to feel it."

In the next session, Edward said that something "sort of strange" had happened: "That image of you had a different sense to it. Different from the ways I think about this . . . you as a person who's enduring the despair . . . it puts you inside the image rather than outside it. Do you know what I mean?"

"I think so."

"As opposed to me being desperate, and you trying to know what to do about it. And me convinced that you can't do anything about it—enduring the desperation together. I think it's probably the only real comfort you can give me."

In many moments like that, it became clear to the analyst that her arduous and careful effort to remain attuned to Edward's subjective world clashed painfully with her own sense of life and hope. At a very profound level, her sense of hope for Edward was rooted in her own need to maintain a basically positive view of herself and of life, as well as her need to feel hopeful about the analysis itself. To the extent that Edward seemed to sense this conflict between them—and particularly that he sensed any tendency in her to deceive herself about whom the hope was really for—his despair and rage intensified.

Note that "whom the hope was for" was often quite ambiguous, even paradoxical. Edward's analyst felt a need to be hopeful about the analysis in a way that she felt compelled to acknowledge was *for her*, after all, analysis was part of her identity. Yet she also felt an ethical demand that she not fall prey to some projective identification (or pull toward an enactment) and allow Edward's despair and hopelessness to tell her: wouldn't she be failing her patient if she lost hope? The powerful, emotionally charged, paradoxical ambiguity threatened her identity in a destabilizing manner that added significantly to her simpler defense against despair and hopelessness about aspects of human existence. Thus, the conflict between Edward's need to have her "decenter" and experience the legitimacy of his subjectivity (his despair) and her need to find ways to stand outside the hopelessness was quite complex.

When she allowed his experience to move her to confront these aspects of the real conflicts between their identities (and her own need to keep the conflict out of her awareness) she could "hear herself" saying something to him that had a very different feel to her than her usual, careful, consistent empathic inquiry had. In a way that pathologized neither him nor herself, she communicated her own struggle to join him. Her response was spontaneous and authentic because it reflected her direct struggle with the conflict between them; and she conveyed something crucial about her ongoing capacity and willingness to be moved, changed, by him, despite countervailing pressures within herself.

She essentially demonstrated her willingness to experience her own internal struggle over hope and despair, an inner conflict that was induced, in part, by the conflict between them. She needed to reopen her own efforts to come to terms with some of the grief and despair she had felt in her own life. Having a genuine relationship with Edward required her to reimmerge herself in painful realities for which she had successfully and adaptively found a working resolution. It seemed as though she conveyed something crucial about her ongoing capacity and willingness to be moved away from something that had been provisionally settled in her own identity.

## Deepening Conflicts with the Analyst's Identity

Despite these moments in which they negotiated a greater psychological "realness" in their relationship, Edward felt that the closer they became, the more he was condemned to live with a bitter, frustrated longing to be a real part of his analyst's life, her real life, like the "real" people in her life, her family and friends. Most painful was that while they could recognize and talk about his need to be held, she could never really hold him.

His earliest memory was of being in his mother's arms but sensing that she was vague and distracted. Mother didn't put him down, yet it felt as though she didn't really want to hold him. The analyst's closeness now only makes him more painfully convinced that, as in every relationship he has ever had, he is being tortured by getting something but not getting what he really needs. He clings to her while she pursues her real life; he stands on the sidelines.

If she actually (physically) held him, he believes it would destroy her life. So the only way he can feel held by her is if she admits and accepts his hopelessness, their hopelessness together—that is, the hopelessness of analysis and of life itself. They must accept that they have to stop engaging in a futile process. What can analytic understanding accomplish? He

has no life. Can't she see, he is dying more each day? He wants to die. He realizes (when she points it out) that this Catch 22 is the essential dilemma he experiences at every turn, the "black hole" of relationships: he desperately needs to feel that she is genuinely with him, yet he can feel her to be genuinely with him only if she accepts his reality, his belief that analysis is futile. And if she does, their relationship must end.

She knows that in some way it is a Catch 22: a paradox that ultimately derives from the fact that their needs are in conflict. And his need for her to feel his despair profoundly conflicts with his desperate need for her to sustain her—and his—hope. She must recognize his inner conflict. But she has come to realize that, first and foremost, she must wrestle with the real conflict between them, not gloss over the ways in which analysis is, in a real sense, a seduction, a tease, bringing him to experience his needs intensely yet not providing the real loving holding that he ultimately needs.

Over the years, the analyst became increasingly aware that their relationship entailed enormous risks, risks for which, when it came down to it, she was not prepared by her training or her own long and productive analysis. Sometimes the risks and dangers were felt as largely external: when Edward seemed more desperate and suicidal, she feared being accused of driving him crazy by doing analytic treatment with a man who could not tolerate it. Frightening images of Margaret Bean-Bayog (and the personal and professional catastrophe that had befallen her in her "regression" treatment of Paul Lozano) drifted through her mind.<sup>4</sup> She knew that some of her valued colleagues and teachers might well fault her for pursuing an intensive analytic treatment with a man so disturbed. The conflict felt like disloyalty (her abandonment of them and their teaching) as well as like a direct danger to her interests (her professional reputation and livelihood). Not only might she fail to help him, she might hurt him. She might also deeply hurt herself in the process.

With countless reiterations of this theme, the analyst came to a wrenching, emotionally complex appreciation of what Edward was compelling her to see. On numerous occasions, she began to try to communicate her grasp of this to him. Indeed, in many ways, she would not (analysis, as she practiced it, could not) give him what he needed: to be held, to be a "real" part of her life. Nor could she fully accept the legitimacy of his despair and fully decenter into a complete empathic union with his hopelessness; as long as she was functioning as his analyst, she

could never fully accept that psychoanalysis with him was futile. Yes, these were, in significant ways, limitations of her method, not simply his inability to adapt to the limitations, or her failure to attune herself thoroughly and consistently enough to him. The realities of her own life and her way of working created the limits in their relationship. These limitations might be more than he could take. His life might not improve; and the heightened longings stimulated by the analysis might be so unbearable that he would kill himself.

Then, on several occasions, she conveyed to him that she knew he would feel acceptance and relief if she acknowledged the hopelessness and futility of their work: "It would even bring me real relief from the feeling that I am engaging you in something that benefits me while it perhaps endangers you and brings you (and me) more pain and little gain. But, at many moments, I feel a life within you, something that responds to me and stirs a feeling of life in me; and when I feel this, the hopelessness and futility is not the only thing in the picture. I can't ignore that life, despite my own uncertainty about the ultimate outcome."

These clearly painful realizations on her part were conveyed to him as she understood them. They seemed to make him feel that she was less deceptive with herself, and that was of some importance to him. Soon after this, the analyst saw an uncharacteristic flicker of a smile on his face at the beginning of an hour, a smile that he quickly aborted. When she asked about it, he said, "I come in the door and look in your eyes and see you smile and it's like I'm inside it, inside the smile. If I don't 'stay in your smile' I'll have nothing to say. If I stay in it and smile back, I'll begin to lose myself in you. But if I don't see you smile I'm completely alone and lost."

Through all these episodes, the analyst came to appreciate further that, beyond the frustrations produced by her maintaining professional and personal limits, it was, in many ways, her life itself—her feelings, hope, needs—that was dangerous to him. He desperately needed to feel her life, but, simultaneously, it threatened to rob him of himself, to kill him. Ultimately, it seemed to be her continuing, inevitable self-deceptions (that is, her unwitting tendency to confuse their interests) that drove him into a quietly raging despair. And it was her open revelation to him, each time, of her dawning realizations about her need to remain hopeful (*for herself* as well as for him) that restored the sense of realness and authenticity to their relationship.

Near the seventh year of treatment, Edward commented that he thought she had begun to move her hands a lot more. Only when he said this did she become aware that she had, in fact, been dimly aware of feeling this shift herself.

<sup>4</sup> The widely publicized Boston case of a psychiatrist whose career was destroyed over her work with a severely disturbed man who eventually killed himself.

"Is it true?" he asked.

"Yes. As you say it, I can see it."

"What does it mean?" Edward asked.

She said she feels as if she were groping toward him and groping around herself, searching in the dark. She had, she told him, begun to try to express things with him that she didn't really understand but was trying anyway.

Soon he began to question her frequently whenever he felt that she might be holding back. He said he wished she could "push him more."

"Do you even know what to do to push me anyway?"

"I feel as if I'm pushing you when I respond in some way that you'll feel is for me, not for you. You know, based on my belief in analysis, my agenda."

Surprisingly, he now seemed genuinely *unconcerned* about this major issue.

"Look," the analyst said. "It often feels as if there is one kind of pushing that feels as if it is for you but that I realize is for me. And another kind that feels as if I'm taking some kind of risk for myself."

"You? What do you mean, risk?"

Moving her hands helped a lot here. Edward averted his eyes, as though he could not stand to see her make a false step.

"Sometimes," she said, "I start to worry that we're doing things here that are really my agenda—that it is going too far for you. It can feel essentially cruel, that it will hurt you, make you 'regress,' less able to work and function. The risk for me often comes when I say to myself, 'Don't let this fear control you. You know you believe more and more that what you're trying to do is basically right. Be more active with him, go ahead, put it in words, try whatever it is out.' I think it's when I take this risk of hurting you that something feels like a good kind of pushing."

Edward's face opened gradually as she spoke. He nodded. Something was clearly getting through, but it often did. After a pause, he burst out, "So all these years I've been thinking you're sitting there thinking about me—and you're actually thinking about you!"

They both laughed very hard.

"This is such a strange relationship," he said. "We're here to understand me, but we have to understand you in order to understand me."

Slowly, over much time, through this kind of negotiated understanding, Edward began to develop a sense of realness in the relationship with his analyst that, for the first time, seemed to endure despite the annihilating pull of the "black hole." He reported that he felt somehow that something more solid had come into his experience and that he thought he had perhaps chosen to live.

The relationship between Edward and his analyst was fraught with deepening experiences of conflict and the continuing uncovering of a web of unwitting deceptions and self-deceptions. No doubt Edward's pathology—the tenuousness of his self-organization and his entrenched, unrelenting beliefs in the danger and hopelessness of relationships—contributed heavily to the extreme complexity of negotiating a greater closeness with him. Equally, aspects of his analyst's struggle derived from rigidities and blind spots within her self-organization. Yet we believe a very significant dimension of this conflict, deception, and self-deception was not attributable to his pathology or to idiosyncratic countertransference obstacles or to significant technical failures on the part of his analyst.

In the course of the negotiation process, Edward and his analyst challenged each other's identity on many different levels. His primitive transference (in both its pathological and adaptive elements) served to create and sustain a relentless series of challenges to his analyst's identity.<sup>5</sup> But these challenges were—had to be—quite real to her; they entailed a deep and consistent questioning, and revising, of the way she organized aspects of her personal world. Yet only in the course of her sustained negotiation with Edward did these features of her identity take on meaning as "countertransference obstacles" that needed to be overcome. In other words, aspects of her personal and analytic identity needed to be reopened in order to negotiate an authentic relationship with Edward, not because they were especially problematic in her own personal or professional life.

At the same time, the challenge and negotiation were not simply an "enactment," a replay of pathological relational scenarios induced or recruited (by projective identification) into the mind of the analyst. The negotiation was over real conflicts between Edward's identity and the analyst's personal and professional identity, conflicts that were clearly intensified by the tremendous natural seduction (Friedman, 1991) and potential for deception in the analytic situation. Yet this conflict served as an indispensable vehicle for creating a meaningful negotiation process.

<sup>5</sup> Pizer (1992, 1996) has developed an interesting perspective in which negotiation and "mutual adjustment" are central to the analytic process. His emphasis is on the process of negotiation of many of the paradoxical aspects of the patient-analyst experience. Although a full discussion of his concept is beyond the scope of this paper, we believe that the "negotiation of paradox" invariably takes place within the context of the negotiation of conflicts interest and may represent a clinical emphasis that is potentially complementary to our own.

## Implications

In the first section of this article, we presented a view of internal and intersubjective conflict as fundamentally rooted in a *normal, adaptive bias that pervades our subjectivity*—a bias that will inevitably clash with the subjectivities of others. The existence of such “evolved, existential conflict” is an ancient, enduring aspect of human development and adult life. It accounts for the existence of a *concomitant, evolved tendency to disguise (from others and ourselves) aspects of our subjective bias while anticipating and evaluating the motivated biases in the subjectivities of others*. We are, in effect, designed to open ourselves (but only partially and selectively) to the influence—the enormous shaping power—of an engagement with the relational world.

We talked about conflict, deception, and self-deception from a vantage point that lies a bit *outside* of the customary language and frameworks of transference-countertransference, enactment, affective resonance, projective identification, and so on, in which contemporary analysts customarily discuss the complex intersections of the subjective worlds of analyst and patient. From this broader perspective we raised very fundamental questions about the therapeutic relationship as a human endeavor. These questions are touched on in much contemporary relational and intersubjective writing, yet, the language of our usual clinical-theoretical narratives keeps us from getting at this broader relational reality.

Now the question is, how do we relate what we have been describing in somewhat new language to more familiar analytic concepts and ways of talking about some of these same clinical phenomena?

Our view of conflict and deception—self-deception takes us far from what we believe is the classical analytic emphasis on conflict emanating from (ultimately drive-based) motivated *distortions* of reality. Yet we move well beyond the tendency of relational, intersubjective models to attribute conflict exclusively to the unfortunate vicissitudes of an individual's particular, problematic (or less than adequate) relational experience. Our perspective allows us to bring into focus a very important arena of inevitable, *motivated* conflict and deception within all relationships, including the treatment relationship. We focus on an aspect of conflict that is a function of *both* the therapist's and the patient's biased subjectivity. And while always intertwined with meanings derived from past experience (transference) and countertransference, a crucial element in this very real, ongoing conflict and deception is lost when it is reduced to either a) a “role-responsive” (Sandler, 1997) enactment of the patient's old pathogenic reality (through the necessary enlistment of inevitable countertransference); or b) the complexity and difficulty of the

therapist's dealing with his or her own selfobject needs (Bacal and Thomson, 1996; Stolorow and Atwood, 1992) in the effort to sustain a sufficiently other-oriented, empathic stance. Let us look at some of the implications of viewing the familiar, analytic notions of projective identification, enactment, empathy, and authenticity from the point of view of the universal mixture of conflict, deception, and self-deception that we call evolved existential conflict.

## Projective Identification and Enactments

In speaking of relational dynamics in which conflict is induced within the other, people often use the term projective identification. For us, this term is problematic when it refers to a process by which certain versions of self-experience, or of inner conflict, are somehow seen as “put into” the therapist or even simply as eliciting an affective resonance in the therapist's personal life. Such “induced” experience and role responsiveness (Sandler, 1976; Ogden, 1985) may well occur but do not capture the interactive and internal negotiation process to which we are referring. The related notion of enactment can be talked about in the same way: as though the transference-countertransference mix that is enacted (and, it is to be hoped, eventually understood) were a kind of as-if scenario in which the participants emotionally relive the *patient's* fantasy world—not the therapist's real (and fantasy) world—as it is activated by their relationship (Bollas, 1987; Jacobs, 1991).

We are referring to a more interactive process that is closer to those processes described in discussions about the patient's evocation of—and attunement to—the real inner life of the therapist (Searles, 1975; Hoffman, 1983, 1991; Aron, 1991; Blechner, 1992; Lichtenberg, Lachmann, and Fosshage, 1992; Pizer, 1992, 1996; Davies, 1994; Rogers, 1995). We are proposing that such interactive processes can be understood as operating within a broader “evolutionary biological” understanding of the inevitability of conflict in all human relationships. The experience of negotiation in the treatment relationship is activated by an adaptive striving by patient and analyst to engage real conflicts—real multiplicity and inner dividedness—within the therapist in the treatment relationship. The evocation of conflict within the analyst and the recognition of the clash between the analyst's identity and that of the patient serves to create the necessary conditions for a genuine renegotiation of internal representations (beliefs, introjects, expected interactional patterns) that were forged in the context of mutuality, conflict, and deception within earlier formative relationships. Patients are highly attuned to the therapist's ways of dealing with the inevitable conflicts of interest experienced



*within* his or her identity and *between* his or her identity and that of the patient. We believe that we are all equipped with an evolved, intuitive sensitivity to the natural self-deceptions and deceptions in which we all engage and (especially in the clinical setting) must tease out in ourselves and each other. Let us consider how this natural, adaptive sensitivity relates to the use of empathy as an analytic stance.

### *The Intrinsic Ambiguities of Empathy*

Edward's analyst made a skillful effort to grasp consistently his experience—to maintain a consistently empathic stance (Ornstein, 1979; Kohut, 1984) or a "sustained empathic inquiry," as the intersubjectivists put it (Stolorow et al., 1987). This stance was crucial to keeping the conflict within tolerable limits for both of them by minimizing Edward's experience of the divergence of their subjective worlds. But, contrary to the impression given in much of the self-psychological literature, on many occasions the empathic grasp of Edward's experience, though crucial, was of limited effectiveness. We think the reason for this is that a consistent attunement to Edward's subjective world did not, in itself, go far enough as a genuine signal of the analyst's capacity to ally with Edward's interests. And at moments it even exacerbated his sense that she was deceptively evading the conflict that he knew existed between them.

If we understand the meaning of empathy in the context of the background of expectable conflict and deception in the therapeutic relationship (that is, beyond the self-psychological/intersubjective frameworks in which it is often embedded), we can see why an empathic stance is a vital, effective communication of the analyst's position regarding the patient's real interests. Yet, at the same time, we can see how the very sources of empathy's effectiveness as an interpersonal communication generate problems that necessitate *other* ways of relating.

Empathy is a fundamental interpersonal signal that lets patients know that a genuine alliance with their interests is a real possibility. Sustained empathic communication signals that the therapist is more likely than most perhaps to be willing to decenter from his or her own personally adaptive bias (and to be emotionally capable of doing so) in order to join in viewing things from the subjective point of view of the patient. The therapist's consistent decentering, or abandoning of his or her own (personally more adaptive) subjective view, even though only temporary and never fully achieved, signals the potential for a genuine investment that might be emotionally equated with the type of investment experienced outside of the analytic setting only with a true friend or close relative.

Yet no therapist can achieve a consistently empathic immersion in another's experience. Essentially the design of our psyche—the nature of human relating—mitigates against it. Even a largely consistent empathic stance is very hard to achieve.

In a discussion of the highly disciplined, consistently empathic inquiry written about and practiced by the analyst Evelyne Schwaber, Lawrence Friedman (1992) noted that in Dr. Schwaber's persistent struggle to share her patient's point of view, she

shows us something that we might not see as clearly in Kohut: it is not just empathy that is powerful, but the wish and effort to empathize. Dr. Schwaber puts the spotlight on what is in the shadow of Kohut's theory: the negative aspect of empathizing is as important as the positive; the empathizer's willingness to give up his own investment. . . . The analyst is frustrating her own natural thinking style in order to . . . come close to the patient. Recognizing the magnitude of the sacrifice, the patient can probably feel the analyst's urge toward closeness almost physically. Ordinarily, only an unusually dedicated love would produce such a self-sacrificing devotion. . . . Most analysts want to know their patients well. But they are not all equally willing to discomfort themselves in the process, and not all theories encourage such discomfort.

We think Friedman has accurately captured some of the enormous meaning communicated within the struggle (see Schwaber, 1983) to maintain an empathic stance. We also suggest that Kohut and the self psychologists have, as Friedman notes, left the meaning of this struggle in the shadows. There has been a tendency in self psychology to discuss the empathic stance in ways that imply that it is largely a technical maneuver.

Attributing failures of empathy to individual countertransference or faulty technique (and successes to proper techniques and a lack of countertransference interference) can be very misleading; it is only one version of the story, a limited version that leaves out the fact that we experience consistently empathic responsiveness as a (usually very welcome) deviation from what is normative in virtually all human relationships—not simply from those relationships that have significantly failed us. Every child is prepared (from the moment of conception onward) to expect that the relational world will be filled with hard-to-recognize conflict, conflict that is likely to be hidden behind rules and views that are represented as more tailored to the child's own interests than in fact they are.

A consistently empathic stance is, in this sense, simply unnatural. A highly consistent attempt to communicate to the patient exclusively from a vantage point within the patient's subjective world (although absolutely crucial) will tend to be only cautiously accepted by some patients and,

for others, will become suspect as a strategy for hiding the therapist's self. Some therapists may, in fact, use the empathic stance to remain defensively hidden from their patients. Over and above any particular individual defensiveness that may be attributed to the therapist, the overly consistent use of the empathic mode will, for some patients, be sensed as the therapist's hiding some aspect of himself or herself, possibly in the pursuit of his or her own interests. Often, an immersion in the patient's subjective world must be complemented by what is, in effect, the visible expression of the therapist's reality (Ehrenberg, 1992; Fosshage, 1995).

As Modell (1991) notes, there is an enduring set of paradoxes here: the therapist cares and listens deeply, and yet, when the hour ends, the therapist summarily dismisses the patient. The patient must believe in the reality of the powerful feelings that arise in the relationship and yet tolerate that, at the very same time, to a degree, there are limits and boundaries on the expression of these feelings that would be inconceivable in a naturally occurring relationship. A patient once referred to this as an ongoing sense that one lives with a "taboo" in therapy, a certain taboo of the real. Many aspects of a real relationship are there but never fully touchable. Like all taboos, the forbidden fruit of the real heightens the power of the situation and also makes the situation quite precarious. For some patients, this particular heightened longing is unbearable. For most patients (and therapists) there are times when it is barely bearable. It is always a background tension.

### *"Throwing Away the Book," Self-Interest, and the Process of Achieving "Authenticity"*

There are inevitably times when, as Hoffman (1994) says, the therapist must "throw away the book" in order to demonstrate a genuine willingness to place the patient before some of the rules of therapy. Patients can feel the therapist's move away from a loyalty to teachers, belief systems, the hiding places afforded by rules and rituals. There is a palpable satisfaction—perhaps a corrective emotional experience—in the sense of "spontaneous deviation . . . shared by patient and therapist . . . when they depart from an internalized convention of some kind." The "taboo of the real" is broken, and the validity of the therapeutic relationship is affirmed when the therapist's struggle to engage with a particular patient calls into question some of the rituals, rules, and beliefs important to the therapist (in this case encoded in a whole style and tone of relating). It becomes a more real relationship as the "one size fits all" structures, rules, and expectations set in place before the two parties even met are renegotiated in the specific relationship between two individuals.

Throwing away the book, however, can and has, in some circles, "become the book" (Hoffman, 1994)! A certain idealization of therapeutic spontaneity or self-disclosure tends to emerge in which this behavior itself becomes a new agenda, an agenda that, as we see it, *will inevitably become biased toward the needs and views of those who come to advocate it*. As any new therapeutic approach (any new stance and version of technique, regardless of its content) emerges, it will often represent, in part, a movement away from the therapist's traditional preconceptions and loyalties toward the patient's subjective reality. Then, as the new approach becomes codified, it will tend to become more and more invested with the therapist's own personal identity and agenda as well as the collective agenda of the members of a new faction or school.

With a bit more historical perspective than analysts are accustomed to adopting, we can see how virtually any codified analytic approach will almost certainly come to yield a new set of rituals. In other words, the reason that "throwing out the book becomes the book" lies precisely in the ongoing, natural tendency of therapists to *bias* the process toward their own ends. Hoffman seems to be addressing some of the problems introduced by this tendency toward bias when he recommends the maintenance of a "dialectic" between the therapist's acceptance of ritual authority and anonymity, on one hand, and "spontaneous deviation" (including self-revelations) from those rituals on the other. Out of this dialectical tension and acknowledgment of the paradoxical realness and unrealness of the analytic situation a more genuine "authenticity" in the therapist's participation is expected to emerge.

We believe that, if we appreciate Hoffman's paradoxical dialectic, we are likely to practice with a new sensibility rather than a new set of rules and technical guidelines. Such a sensibility represents a higher level principle concerning the necessary struggle with (deviation from) authority with which each therapeutic relationship compels us to engage. Thus, Hoffman's views probably encourage the sort of grappling with inner and interpersonal conflict that enhances the therapist's authenticity. Though such a higher principle is less likely to become codified and ritualized into a "new book," we suspect that, over time, even such a broad dialectical principle is not likely to transcend the deeply rooted tendency (in the therapist, his culture, his therapeutic "school") to translate and ritualize the meaning of the principle in ways that are biased toward his own subjective ends. Thus, ultimately, we would expect that this very dialectical principle would come to be concretized and practiced in a way that, itself, would need to be "deviated from" and negotiated.

The natural and universal tendency to bias technique (often self-deceptively) toward the analyst's interests is an important aspect of why

consistent attempts to apply many specific analytic, technical prescriptions are of limited value (see Greenberg, 1995). Any stance or set of techniques that is formulated prior to the engagement of specific individuals in a particular psychoanalytic relationship—be it neutrality, sustained empathic inquiry, relational authenticity (or even a broad appreciation of the dialectic between ritual authority and spontaneity)—may tend to become deceptive, a deception that is usually rooted in self-deception. In this sense, “authenticity” in our responses as analysts is a quality that can only gradually be achieved, or created, through our struggle with our patients’ influence on us: the struggle to reopen aspects of our own identity (including our therapeutic frame), with minimal deception and self-deception, in areas that are elicited by and relate to our patients’ conflicts.

Sometimes the changes, the needed deviations, are “spontaneous,” as Hoffman (1992) put it, only *after* the therapists’ prolonged immersions in their own subjective world as it is influenced by their struggle to relate intimately with their patients. Consider Ogden’s (1994) description of the coming to life of an analysis that had seemed correct but lifeless:

In retrospect, my analytic work with Mrs B to this point had sometimes felt to me to involve an excessively dutiful identification with my own analyst (the ‘old man’). I had not only used phrases that he had regularly used, but also at times spoke with an intonation that I associated with him. . . . My experience in the analytic work . . . had “compelled me” to experience the unconscious fantasy that the full realization of myself as an analyst could occur only at the cost of the death of another part of myself (the death of an internal object analyst/father) [p. 16].

At the outset of an analysis, the analyst may start out as a “new object,” a person whom the patient can experience as having views, needs, and responsiveness different from the patient’s familial objects (Greenberg, 1986). We also know, however, that usually the analyst simultaneously starts out as an “old object”; both patient and analyst will, from the outset, reenact old relational patterns. Only through a prolonged interpersonal and internal negotiation with the challenge and influence of the patient can the analyst, cumulatively, *become* for the patient a more fully usable “new object,” new to the patient because the analyst is—through the negotiation process—new to him- or herself!

From this point of view, it is the experience of the process of negotiating the real conflicts between the analyst’s and patient’s “otherness”—their differing needs and identities—that constitutes “what is new.” It is the patient’s experience of the analyst’s changing—of the analyst struggling to come to terms with something new—that pro-

vides the crucial knowledge that there is a genuine working negotiation occurring. Because the relationship between analyst and patient entails real conflicts between their identities, the negotiation process, ultimately involving real changes in the analyst, provides the crucial experience for the patient to reopen and rework old conclusions about his or her self and the potential for effective negotiations with the relational world.

### Some Concluding Thoughts

As our patients try to raise questions about their own entrenched, debilitating ways of experiencing themselves, they use the transference to ferret out and activate within the current therapeutic relationship precisely those areas of relational conflict and (failed) interpersonal negotiation in which old conclusions about themselves were formed. The transference may begin by creating an “as-if” reality, if you will, a “potential space” for activating and exploring the past in the present. But, although this reliving of the patient’s transference is crucial, it *cannot* be an end in itself. Such analytic “play” leads, in turn, to a call for the opening up of real, often unseen but inevitable, conflicts within the analyst and the conflicting needs of analyst and patient. In this sense, transference is a vehicle, a means to arrive at an arena in which the therapist’s own identity, own real strivings and interests, become deeply engaged in the negotiation process. Transference (or projective identification) brings the analyst into a realm in which the past is not simply enacted (or affectively resonated with by the analyst) in the present. The past is, in fact, rediscovered by the patient in the present in a very profound way—in the analyst’s identity and the realities of being with the analyst. As Edward put it, after years of intensely confusing negotiation, “This is such a strange relationship . . . We’re here to understand me, but we have to understand you in order to understand me.” Here is where the process of interpersonal, intersubjective negotiation becomes most difficult—and most genuine.

From the word go, the therapeutic relationship is filled with many moments—from mini-“crunches” (Russell, 1973) like those illustrated in the cases of Nancy and Tanya to vast, conflictual landscapes like that described between Edward and his analyst. This is the arena in which patients look for and enable us to see some of the divisions and tensions in our identity, the multiplicity and bias in us. Wittingly and unwittingly, we let them raise questions about who we are. Through such adaptive probing, patients may palpably sense how they can influence us (“deconstruct” us). They can sense how, when faced with this challenge, we put

ourselves back together (in a somewhat different way) in the context of our particular relationship with them.

A genuine renegotiation, reintegration (an increased experience of "realness") is far more likely to occur when our patients see what happens when—tapping into the fault lines in our identity, our conflicts—they take us someplace that is obviously hard for us to go. But we go there and often change in the process, because having a relationship with them requires it. They are worth it. All the time, our patients provoke in us (and read) the quality of *our* inner dialectic, our ways of experiencing and resolving internal and interpersonal conflict. And they assess its implications for renegotiating or reintegrating *their* selves in the context of inducing us to adapt to them—and them to us.

## References

- Aron, L. (1991), The patient's experience of the analyst's subjectivity. *Psychoanal. Dial.*, 1:29–51.
- (1992), Interpretation as an expression of the analyst's subjectivity. *Psychoanal. Dial.*, 2:475–507.
- Bacal, H. & Thomson, P. G. (1996), The psychoanalyst's selfobject needs and the effects of their frustration on the treatment: A new view of countertransference. In: *Basic Ideas Reconsidered: Progress in Self Psychology*, Vol. 12, ed. A. Goldberg. Hillsdale, NJ: The Analytic Press, pp. 17–35.
- Beebe, B. & Lachmann, F. (1988), Mother–infant mutual influence and precursors of psychic structure. In: *Frontiers in Self Psychology: Progress in Self Psychology*, Vol. 3, ed. A. Goldberg. Hillsdale, NJ: The Analytic Press, pp. 3–25.
- Benjamin, J. (1988), *The Bonds of Love: Psychoanalysis, Feminism, and the Problem of Domination*. New York: Pantheon Books.
- Blechner, M. (1992), Working in the countertransference. *Psychoanal. Dial.*, 2:161–179.
- Bollas, C. (1987), *The Shadow of the Object: Psychoanalysis of the Unthought Known*. New York: Columbia University Press.
- Bromberg, P. (1991), Introduction to symposium on reality and the analytic relationship. *Psychoanal. Dial.*, 1:8–12.
- Davies, J. M. (1994), Love in the afternoon: A relational reconsideration of desire and dread in the countertransference. *Psychoanal. Dial.*, 4:153–170.
- Ehrenberg, D. B. (1992), *The Intimate Edge*. New York: Norton.
- Ferenczi, S. (1932), *The Clinical Diary of Sandor Ferenczi*, ed. J. Dupont (trans. M. Balint & N. Z. Jackson). Cambridge, MA: Harvard University Press, 1988.
- Fosshage, J. (1995), Interaction in psychoanalysis: A broadening horizon. *Psychoanal. Dial.*, 5:459–478.
- Friedman, L. (1991), Address to the American Psychoanalytic Association.
- (1992), Discussion of Evelyn Schwaber's paper, "Psychoanalytic Theory and its Relation to Clinical Work." Presented at Scientific Meeting of the Psychoanalytic Society of New England, East, October 24.
- Greenberg, J. (1986), Theoretical models and the analyst's neutrality. *Contemp. Psychoanal.*, 22:87–10.
- (1995), Self-disclosure: Is it psychoanalytic? *Contemp. Psychoanal.*, 31:193–205.
- Havens, L. (1993), *Coming to Life*. Cambridge, MA: Harvard University Press.
- (1997), A linguistic contribution to psychoanalysis: The concept of performative constructions. *Psychoanal. Dial.*, 7:523–534.
- Hoffman, I. Z. (1983), The patient as interpreter of the analyst's experience. *Contemp. Psychoanal.*, 19:389–442.
- (1991), Toward a social constructivist view of the psychoanalytic situation. *Psychoanal. Dial.*, 1:74–105.
- (1992), Some practical consequences of a social constructivist view of the psychoanalytic situation. *Psychoanal. Dial.*, 2:287–304.
- (1994), Dialectical thinking and therapeutic action in the psychoanalytic process. *Psychoanal. Quart.*, 63:187–218.
- Jacobs, T. (1991), *The Use of the Self*. New York: International Universities Press.
- Kindler, A. (1995), Discussion of A. Ornstein's "The Rocky Road Toward a New Beginning." Presented at 18th Annual Conference on the Psychology of the Self, October 21, San Francisco.
- Kohut, H. (1972), Thoughts on narcissism and narcissistic rage. *The Psychoanalytic Study of the Child*, 27:360–400. New Haven, CT: Yale University Press.
- (1984), *How Does Analysis Cure?* ed. A. Goldberg & P. Stepansky. Chicago: University of Chicago Press.
- Kriegman, D. (1998), Interpretation, the unconscious and analytic authority: Toward an evolutionary biological integration of the empirical scientific method with the field defining empathic stance. In: *Empirical Perspectives on the Psychoanalytic Unconscious*, ed. M. Bornstein & J. M. Masling. Washington, DC: American Psychological Association.
- & Slavin, M. (1990), On the resistance to self psychology: Clues from evolutionary biology. In: *The Realities of Transference: Progress in Self Psychology*, Vol. 6, ed. A. Goldberg. Hillsdale, NJ: The Analytic Press, pp. 217–250.
- Lichtenberg, J., Lachmann, F. & Fosshage, J. (1992), *Self and Motivational Systems*. Hillsdale, NJ: The Analytic Press.
- McLaughlin, J. T. (1995), Touching limits in the analytic dyad. *Psychoanal. Quart.*, 64:433–465.
- Mitchell, S. (1988), *Relational Concepts in Psychoanalysis: An Integration*. Cambridge, MA: Harvard University Press.
- Modell, A. H. (1991), The therapeutic relationship as a paradoxical experience. *Psychoanal. Dial.*, 1:13–28.
- Ogden, T. H. (1985), *The Matrix of the Mind*. New York: Aronson.
- (1994), The analytic third: Working with intersubjective clinical facts. *Internat. J. Psycho-Anal.*, 75:3–19.
- Ornstein, A. (1974), The dread to repeat and the new beginning: A contribution to the psychoanalysis of narcissistic personality disorders. *The Annual of Psychoanalysis*, Vol. 2:231–248. New York: International Universities Press.
- Ornstein, P. (1979), Remarks on the central position of empathy in psychoanalysis. *Bull. Assn. Psychoanal. Med.*, 18:95–108.

- Pizer, S. (1992), The negotiation of conflict in the analytic process. *Psychoanal. Dial.*, 2:215-240.
- (1996). Negotiating potential space: Illusion, play, metaphor and the subjunctive. *Psychoanal. Dial.*, 6:689-712.
- Rogers, A. (1995), *A Shining Affliction: A Story of Harm and Healing in Psychotherapy*. New York: Viking.
- Russell, P. (1973), Crises of emotional growth (a.k.a. the theory of the crunch). Unpublished manuscript.
- Sandler, J. (1976), Countertransference and role-responsiveness. *Internat. Rev. Psychoanal.*, 3:43-47.
- Schwaber, E. (1983), Psychoanalytic listening and psychic reality. *Internat. Rev. Psychoanal.*, 10:379-392.
- Searles, H. F. (1975), The patient as therapist to his analyst. In: *Tactics and Techniques in Psychoanalytic Theory*, Vol. 2: *Countertransference*, ed. P. Giovacchini. New York: Aronson, pp. 95-151.
- Slavin, J. H. (1994), On making rules: Toward a reformulation of the dynamics of transference in psychoanalytic treatment. *Psychoanal. Dial.*, 4:253-274.
- Slavin, J. H. (1985), The origins of psychic conflict and the adaptive function of repression: An evolutionary biological view. *Psychoanal. Contemp. Thought*, 8:407-440.
- Slavin, J. H. (1996a), Is one self enough? Multiplicity in self organization and the capacity to negotiate relational conflict. *Contemp. Psychoanal.*, 32:615-625.
- Slavin, J. H. (1996b), Analytic re-parenting (and parenting) as negotiated achievements. Presented to Annual Spring Meeting of Division 39 of the American Psychological Association, New York City, April.
- Slavin, M. O. & Kriegman, D. (1992), *The Adaptive Design of the Human Psyche: Psychoanalysis, Evolutionary Biology, and the Therapeutic Process*. New York: Guilford Press.
- Stolorow, R. & Atwood, G. (1992), *Contexts of Being*. Hillsdale, NJ: The Analytic Press.
- Brandchaft, B. & Atwood, G. (1987), *Psychoanalytic Treatment: An Inter-subjective Approach*. Hillsdale, NJ: The Analytic Press.
- Trivers, R. (1971), The evolution of reciprocal altruism. *Quart. Rev. Biol.*, 46:35-57.
- (1974), Parent-offspring conflict. *Amer. Zoolog.*, 14:249-264.
- Weiss, J. & Sampson, H. (1986), *The Psychoanalytic Process: Theory, Clinical Observation, and Empirical Research*. New York: Guilford Press.
- Winnicott, D. W. (1950), Hate in the countertransference. In: *Collected Papers: Through Paediatrics to Psychoanalysis*. New York: Basic Books, 1975, pp. 194-203.
- (1963), Communicating and not communicating leading to a study of certain opposites. In: *The Maturation Processes and the Facilitating Environment*. New York: International Universities Press, 1965.
- (1969), The use of an object and relating through identifications. In: *Playing and Reality*. Middlesex, England: Penguin.

## Afterword

Malcolm Owen Slavin

On many occasions when I have presented later versions of some of the ideas in this paper a few people (often newer analysts) remark that "hardly anybody talks like you and Kriegman do about the clashes between the needs of analysts and patients—about the patient's skepticism concerning the *unnaturalness* of the analytic frame and the meanings of its *lack* of reciprocity. You talk about these things as, well, facts of life, without pathologizing, without faulting either participant. It's a relief," they sometimes add, "to put this aspect of the work on the table theoretically and, especially, to be able to think about our own experiences with patients in these terms."

Yet other colleagues—responding to the same emphasis on the ever-present role of the analyst's self-interest as well as to the inherent realism we attribute to our patients' wariness about our influence—are more disturbed by what they believe are the implications of our stance. Sometimes they confide that they are having a hard time with what they call a harshness or darkness in our view of human motives. Or they worry that our emphasis on a certain *universality* in our patients' "adaptive skepticism" about being influenced by us will lead away from an appreciation of the idiosyncratic, transferenceal meanings of resistance, rooted largely in individual fantasy or trauma; or that our focus on the multiple, *deceptive potentials* inherent in the analytic frame will detract from an appreciation of analysis as a unique, magical potential space, a cherished theater for psychic change. A bit sheepishly, others confess a puzzlement over what to them seems like a contradiction between the paper's emphasis on the ubiquity of conflict—its repeated references to the "dark side," as Irwin Hoffman (2001) puts it, of the analytic frame—and the fact, say these colleagues, that they perceive me as a basically empathic, hopeful guy.

So, for six years, my own thinking about this paper has developed in spontaneous as well as formal, often quite candid, interaction with a very wide range of audiences in which I am the discussed or the discussant. It has developed through many intense, sustained relationships with supervisees and patients whose experience and response have tested the paper's assumptions about analysts and patients and challenged and extended the whole notion that "the analyst needs to change." Because this ongoing dialogue is the main source of whatever changes have taken place in "this analyst" regarding the paper, I present here my reflections as responses to the kinds of questions that have animated me over these years.

*Where did the notion of the "analyst needing to change" originally come from? And why are there several footnoted allusions—but no direct arguments—connecting the analytic process to evolutionary biology and to the book you and Dan had just recently written about analytic models from that broad perspective?*

Frankly, putting "needs to change" in the title was partially chosen for the obvious hyperbole in it. Over time the scope and importance of change in the analyst has become increasingly apparent. Beyond dramatizing the need to appreciate the reciprocal aspects of the analytic relationship, we teasingly implied that change comes about *only* if, in some fashion, the analyst changes. Something, we felt, had to help shake us analysts out of our relentless tendency to diagnose quickly the tensions in the relationship between analyst and patient into a set of eagerly waiting, familiar categories—transference, countertransference, empathic or selfobject breaks, resistance, enactment, projective identification, and so on. As illuminating as these technical categories may be at many stages of our work—and as necessary as some of them seem to our identities as analysts—we felt that constructing analytic experience in those familiar terms actually takes on far greater meaning when a strong, ongoing sense of dialectical tension is preserved between the human realness of the relationship and its various transference or technical dimensions. We set out to bolster what we saw as the weaker pole of this "analytic versus broadly human" dialectic in the minds of most analysts *without*, we ardently prayed, relying on any new version of the ever-proliferating technical jargon that, itself, often undercut the vital tensions analysts experience in this realm.

How Dan and I came to construct a different picture of human motives and relating—a bit different sense of what's real—on this issue is, of course, linked to our book. We had spent many years looking at our clinical experience in part with eyes conditioned by thinking broadly about human nature in terms of contemporary evolutionary biological theory, an emerging viewpoint captured in a series of papers through the late 80s and culminating in our book (Slavin and Kriegman, 1992). It was this weaving inside and outside analysis—the impossible task of standing in both places at the same time—that made it look as though *all* analytic clinical models had very seriously underestimated how much the tensions between analyst and patient are rooted in the existential facts of their naturally differing, individual human perspectives. In the initial setting-up and ongoing maintenance of a good-enough working analytic relationship—ironically, perhaps especially in the strongest working relationships—analyst and patient continuously negotiate their own somewhat differing

conscious and unconscious agendas and (however they subjectively define them) their own individual needs.

Yet in this paper the influence of evolutionary theory on our thinking was almost entirely acknowledged in footnotes on the advice of a friendly *Psychoanalytic Dialogues* editor who was interested in our analytic views. The editor cautioned that, at that time, the aversion of some postmodernist, relational analysts to anything that seemed universalizing and linked to biology—albeit simultaneously constructivist—could create roadblocks to publication.

*Is the evolutionary theory linked to the fact that some colleagues feel there is something unduly harsh and dark about your emphasis on the pursuit of self-interest in human relating, on potentials for deception in the treatment relationship?*

What stands out in contemporary evolutionary theory is that *two* contrasting motivational currents, self-interested and altruistic, evolved into a kind of innate dialectical tension in the human heart—a stark contrast to earlier, one-sided, social Darwinist views of human competitiveness and aggression that perhaps overly influenced Freud. In our book, we tried to make it clear that, from an evolutionary perspective, there is absolutely nothing deeper (more primary or innate) about self-interested motives than there is about the inherently prosocial, cooperative, human concern for related individuals. Both are equally ancient parts of us, if you will.

So it isn't that the "dark side" is writ so large. It's not. Rather, it is precisely the immense interdependence and mutuality in a good analytic relationship—as in most basically good-enough families—that, paradoxically, makes the interwoven threads of self-interest and bias stand out as incredibly significant, sometimes as problematic. But, on the other side, the painful and poignant tensions with self-interest give far greater meaning to the kinds of mutuality and love that can emerge. For me, the ironies here are actually what is quite hopeful. But some of our colleagues, of course, view this broader tragic side of an evolutionary worldview as if it were more one-sided than I believe it is.

*But what about that whole other reaction, especially of younger colleagues, who feel more directly relieved in some way by what they hear in your perspective on their motives?*

Yes, the main reaction to our normalizing or naturalizing narration of conflict in the analytic relationship has been that it is "freeing" in that it openly recognizes a substantial, self-interested side of doing analytic work that most analysts seem very well to know they experience. Analytic candidates, especially, find it useful to have a way to



conceive of the legitimate, adaptive role of the analyst's self-interested motives as they try to negotiate that complicated, uncertainty-racked transition from what they have been calling psychotherapy to an analysis with their first controls. Deeply questioning their own legitimacy as analysts, many find it liberating not to have to hide or soften the sense that—however useful the analysis may eventually turn out to be for the patient—it is not difficult to recognize that, in the shorter run, many of the benefits to the *candidate* (the major professional and professional identity gains) are palpably real.

Ironically, the frank recognition of this realness about the tangible, shorter term benefits to the analyst often argues initially for acknowledging the ways in which good-enough, self-interested analysts *do not* need to change—they do not have to disavow their sense of the often disproportionately self-interested short-term benefits to them of the move to the couch. Except, of course, that reorienting themselves to the self-interested realities of the analytic enterprise in this way initially entails a kind of de-idealizing of themselves and of the altruistic nature of analytic practice. Though initially this experience may seem freeing, I am repeatedly struck by the way in which de-idealizing the analytic process while struggling to retain hope and confidence in it is one of the most telling processes of “change” that analysts in training undergo. I think the occurrence of change within many candidates in supervision has a real effect on their relationships with their patients. Perhaps that accounts for some of what some see as the surprising success of some control analyses despite the inexperience of the analyst.

*So there seems to be something a bit more ironic about the notion that “the analyst needs to change” than you realized. Have you shifted and changed as an analyst—let’s say in your view of what “the analyst needs to change” means? And of the therapeutic action?*

Yes, the whole analytic enterprise—especially the process of negotiating change—looks more ironic, more paradoxical, sometimes more blatant, sometimes more subtle, more “right there” and couched in endless guises, than we could recognize when we wrote the paper. Several astute writers who have commented on our work (Benjamin, 1998, 2003; Ringstrom, 1998; Pizer, 1999) have led me to see how—interwoven with the negotiation of real conflicting interests—the subjective experiences through which we know and wrestle with those conflicts are often organized centrally around human developmental and intersubjective paradoxes. For me, though, appreciating the subjective paradoxes of development and object-relating ultimately remains most useful—feels most grounded and honest—when it is rooted in an awareness, and emotional acceptance, of the

background tensions, indeed the real limits and dangers of conflicting interests in all intimate relating.

If you look at your own work and extend that work with “data” from the (sometimes strikingly) different work of supervisees, you continually see that patients ask us to try to go somewhere—emotionally, imaginatively, ethically—somewhere beyond where, in virtually any other relationship, we are ready to go. The analytic frame serves us and protects us for sure, but in a way that also puts us in greater emotional jeopardy. We must sometimes bear more, or differently, than what we bear in any other intersubjective context. Whether this burden creates crunchlike impasses or simply subtle, long-term shifts in the building of a relationship, I keep finding myself struck by just how much, and in how many different ways, analysts are called on to revisit their own basic, internal, existential issues in order to relate deeply to a given patient despite the fact that analysts may well have resolved those issues sufficiently to function in the rest of their own lives. Moreover, in the process of doing this, it seems to me that often the analysis itself (or the working frame of a given analysis) also needs to change as part of the therapeutic action.

For my supervisees, me, and several creative analysts whose work I have studied and discussed these challenges can sometimes be incredibly agonizing and confusing—fraught with contradictions (see my discussions [Slavin, 2002, 2003] of Atwood, Stolorow, and Orange [2001] and Davies [2003]). They are moments when the analyst's reality is pushed and challenged. In one form or other we end up being asked for something we *cannot* refuse yet, often, *must* refuse. Perhaps it is joining a patient's ultimate despair or madness in ways that simply defy any simple empathic recognition. If we *do not* find a visible way to join the patient, we abandon him or her. Yet it *seems* that, for long periods, if we *do* join them we must somehow violate something connected to our own beliefs, impose unacceptably on our lives, even seem to abandon some key aspect of our therapeutic identity.

As I see it, these are the moments when many contemporary analysts increasingly call on constructs derived from Kleinian theory because they promise to narrate these moments in ways that seem to capture some of their mysterious, bigger-than-both-of-us projective qualities. In these accounts, the story seems inevitably to entail patients' evacuating unbearable affect and conflict from themselves by putting it into us. Doing this compels us to feel their pain and coerces us into reenactments of *their* old relational scenarios.

In a small but very significant variation on this story, I have come to see these moments far less as patients' aiming to colonize us with their (pathological) stories and far more in the larger adaptive context

in which the projections occur—that is, patients' vital human need to see who we are and what kind of potentially "new" experience they can have with us (Aron, 1996). Basically what we call projections usually look to me as though they are in part designed to serve as communicative probes, or vehicles, tactics, for compelling us analysts to experience *ourselves* more fully—and, if we are capable—to confront and struggle with real tensions within ourselves. These aspects of ourselves, as I view it, represent the *analyst's own versions* of the same human dilemmas (over what is real, over love and hate, self and other, self-esteem, meaning and despair) that prove overwhelming for our patients (and are, for all of us, ongoing, lifelong human adaptive challenges with which we never cease to grapple).

This kind of negotiation is essentially what goes on around key developmental issues between parents and children as parents inevitably struggle with (and defend against struggling with) the reopening of what are their own inner working solutions to the same issues faced by their children. The personal realness of this mutual challenge in analysis is what replicates the interactive context in which the patient's maladaptive solutions were shaped. The very realness of it for the analyst is, paradoxically, what allows the patient to develop deep, intense transference meanings as the issue is relived, for real, with the analyst.

In other words, my sense is that I have become a usable, transference version of a parent when, in some measure, I have allowed myself to become a bit lost at my version of that parenting place where a patient's earlier experience in the family failed. Together we may refind and revise something old in them, in part through my willingness to reopen and, I'll say it, *to suffer anew something old* in myself.

Though it is much clearer to me now than when the paper was written that there is a lot of basic healing of the analyst that goes on when we engage in this way, I still think that Searles (1975) too narrowly construed this process as therapeutic rather than more broadly, as two individuals engaged in an adult developmental process (P. Crastopol, personal communication). Sometimes what seems key is the particular kind of love that is signaled by our willingness to suffer alongside the patient for stretches of time creating a more a level playing field—a field of two fellow sufferers—each dealing with their own version of the same human dilemmas.

*So where in all this, as you said, does the analytic frame itself need to change?*

What I am referring to is something that closely complements the analyst's very real, very personal willingness to struggle internally for

and with the patient. In tension with the elements of intimate human relationships, all analytic approaches probably need to include some degree of ritualized authority (Hoffman, 1998)—a certain heightened dramatic structure that is intertwined with basic boundaries, rules, and roles but, in a sense, goes beyond rational technique into the realm of something that conjures a bit more mystery.

Set strictly apart from other relationships and deliberately wrapped (even by very open, interactive relational analysts) in a transference-inducing ambiguity, this aspect of the treatment relationship is particularly prone to being (and being experienced as) *deceptive*. Put bluntly, because the analyst's interests and belief system naturally infuse the design of the analytic frame, the patient needs to probe, explore, and establish how much and in what way the more mysterious qualities of the ritual and frame are, in this case, useful illusions versus well-meaning, but deceptive, hocus pocus.

In most of the successful analyses I have seen (and markedly not in the unsuccessful ones), there is a flexible process of negotiation over aspects of the analytic frame and process itself—aspects that, at first, were assumed by both analyst and patient to be in some way integral, sacred, essential to the analytic process. Just as our personal openness to reexperiencing our versions of the issues with which patients struggle enables them to trust that we truly grasp their interests, so our readiness to reopen, examine and alter our relationship with some sacred aspects of the analytic process (to which we have been wedded) often seems indispensable to generating a sense that the analytic process is aligned with who they are.

Sometimes it is literally impossible for very fine, otherwise flexible analysts to move far enough within the timeframe of the analysis. I recently heard of two analysts who were able to do so *after* the analysis and were lucky enough to have second chances when, later on, the patients returned (Cooper, 2003; Pizer, 2004). I hope it is clear that I am *not* advocating an automatic, unreflective "giving in" to our patients' views or accommodation to their pressures for changes in the frame. Remember, Dan and I strongly emphasize analysts' need to look out for their own interests, and their interests are often embedded in, and protected by, the analytic frame. Indeed, as Glen Gabbard (personal communication) has said, a clear understanding that there are inherently differing, sometimes conflicting, needs of patient and analyst may ultimately be our best protection against regressive pulls toward boundary blurring, even boundary violation.

*I am* advocating that—after struggling to grasp deeply the differences between our experiential world and that of our patients—we make

many of our complex decisions about what to preserve or modify in the frame in terms of what we ultimately believe is essential for *us* at this moment as well as for *our* broader way of working—not in terms of various abstractions about analytic authority. The frank recognition and expression of our own interests, combined with our understanding that our needs will sometimes strongly conflict as well as coincide with those of our patients, preserves a vital kind of tension and realness in our work. We believe that this stance inclines us toward an overall analytic sensibility (and way of negotiating) that differs from most efforts to preserve the frame based primarily on particular, theoretically rooted understandings of what kind of limits, containment, selfobject needs, spontaneous disclosures, and so forth are presumed to be in the *patient's* interest.

Six years after publication, it seems clearer that the vital role of flexibility and change in the frame—like change in the analyst—must emanate from an acute awareness of how our own investment in the analytic frame is, itself, a very complex human commitment, tied to some of our own needs, to our professional identity and beliefs, as well as to our attachment, empathy, understanding—growing intimacy with—a particular patient. We must allow the multiple, sometimes contradictory, strands in our commitment to be challenged and *partially disassembled*. Each strand shifts in relative weight and meaning, yielding new experience for the analyst and patient, as well as a revised version of the frame. The analytic process comes to tap the power of an ancient, evolved human imperative—the yearning for genuine reciprocity. What is inevitably a generic, off-the-shelf analysis at the start is partially dismantled and, with luck, within a time period both parties can tolerate, changed into a novel, idiosyncratic engagement.

## References

- Aron, L. (1996), *A Meeting of Minds: Mutuality in Psychoanalysis*. Hillsdale, NJ: The Analytic Press.
- Atwood, G., Stolorow, R. & Orange, D. (2001), Shattered worlds/psychotic states: A post-Cartesian view of the experience of personal annihilation. *Psychoanal. Psychol.*, 19(2).
- Benjamin, J. (1998), Finding the way out: Commentary on papers by Slavin and Kriegman and Ringstrom. *Psychoanal. Dial.*, 8:589–598.
- (2003), Discussion of "The analyst's otherness as a source of hope" by M. O. Slavin. Presented at spring meeting, Division 39, American Psychological Association, Minneapolis, MN, April.
- Cooper, S. (2003), The new bad object and the therapeutic action of psychoanalysis. Keynote address, Division 39, American Psychological Association, Minneapolis, MN, April.

- Davies, J. M. (2003), Whose bad objects are these anyway? Repetition and our elusive love affair with evil. Presented at conference of International Association for Relational Psychoanalysis and Psychotherapy, Toronto, January.
- Hoffman, I. Z. (1998), *Ritual and Spontaneity in the Psychoanalytic Process*. Hillsdale, NJ: The Analytic Press.
- Pizer, S. (1999), *Building Bridges: The Negotiation of Paradox in Psychoanalysis*. Hillsdale, NJ: The Analytic Press.
- (2004), Impasse recollected in tranquility: Love, dissociation, and discipline in the analytic process. *Psychoanal. Dial.*, 14:289–312.
- Ringstrom, P. (1998), Therapeutic impasses in contemporary psychoanalytic treatment. *Psychoanal. Dial.*, 8:297–315.
- Searles, H. F. (1975), The patient as therapist to his analyst. In: *Tactics and Techniques in Psychoanalytic Theory. Volume II: Countertransference*, ed. P. Giovacchini. New York: Aronson, pp. 95–151.
- & Kriegman, D. (1992), *The Adaptive Design of the Human Psyche: Psychoanalysis, Evolutionary Biology, and the Therapeutic Process*. New York: Guilford Press.
- Slavin, M. (2002), Post-Cartesian thinking and the dialectic of doubt and belief in the treatment relationship: A discussion of "Shattered worlds/psychotic states: A post-Cartesian view of the experience of personal annihilation" by G. Atwood, D. Orange, and R. Stolorow. *Psychoanal. Psychol.*, 19(2).
- (2003), How we struggle to become "new objects." Discussion of Jody Messler Davies's "Whose bad objects are these anyway? Repetition and our elusive love affair with evil." Presented at conference of International Association for Relational Psychoanalysis and Psychotherapy, Toronto, January.