**THE ANALYST'S WAY OF BEING**

Recognizing separable subjectivities and the pendulum's swing

*Whether the analyst finds the patient's emerging transference affectively tolerable or intolerable plays an important role in the analytic couple's negotiation of the configuration the transference-countertransference relationship ultimately assumes. If the analyst is deeply repelled by transference-related roles, attributions or projections he may react violently in protest, engaging in enactments that say more about his separable subjectivity than it says about the intersubjective situation. While enactments are seen by some as the psychoanalytic technique par excellence, this trend risks overlooking the way in which the analyst's way of being comes into play in the treatment.*

The psychoanalyst's way of being—his personality, characteristic style of relating to others, unresolved transferences, etc.—helps determine his response to, and his clinical interventions with a given patient. In turn, how he intervenes in treatment can significantly contribute to the way in which the patient’s transference manifests. This paper aims to explore these two subjects—the range of possible ways in which different analysts might theoretically respond to a given patient as a function of their way of being and how these varied responses help determine the way in which the transference ultimately gets expressed. This paper also questions current trends in certain quarters to overvalue countertransference enactments as an indispensable clinical tool in the absence of which, some claim, little psychic change will occur.

It is helpful having terms that single out a phenomenon by which the analyst's way of being contributes to the creation of the patient's "*manifest transference*," which is distinct from what the patient brings to the treatment--his *core transference.* The core transference refers to a range of ways a given patient's transference *could* manifest; the manifest transference refers to the *particular* way—one amongst many—transference ultimately ends up manifesting. Unlike the manifest transference that to whatever extent is co-constructed in the process of analysis, the patient’s *core* transference issues are neither of the analyst’s making nor a product of the intersubjective field. According to such thinking, transference is both *essential and invariant at its core* while, at the same time is *context-specific and variable in its surface presentation.* The terms "core transference" and "manifest transference" are being introduced to drive home the point that a given patient's manifest transference may differ as a function of how the analyst relates to the patient.

The analyst's way of being readies him or her to engage in countertransference enactments, some of which are chiefly *of the analyst's own making*--a reflection of a one-person psychological perspective (Ghent 1989, Aron 1990). This assertion conflicts with the position taken by those who believe enactments are universally co-constructed in accordance with a two-person psychological perspective. Though some countertransference enactments develop as a result of the patient's conscious or unconscious efforts, for example, to draw the analyst into acting out an assigned role, believing this invariably to be the case, as some seem to do, disallows for each party's *separable subjectivities* in accordance with a one-person psychological perspective that is reflected in Benjamin's (1995) brand of intersubjectivity that leaves room for "the other who is truly perceived as outside, distinct from our own mental field of operation" (p. 29). Countertransference reactions that lead to such enactments aren't always the result of the patient's efforts to *provoke* the analyst into assuming a role coincident with the patients expectations or needs and may primarily be the manifestation of the analyst's unresolved issues that have been *evoked* in him by the patient's transference behavior.

Aside from the analyst's way of being, another topic explored in this paper has to do with current trends in our thinking about *countertransference reactions*. In particular, we'll explore two issues: 1) the fallacy that countertransference awareness invariably follows enactment and can only be known after the fact (Renik 1996), and 2) current trends that overemphasize the clinical value of countertransference enactments, leading some to believe that successful analysis invariably hinges on the development of enactments (Boesky 1990, Renik 1993 Chessick 1999). Some analysts celebrate countertransference enactments as *the* quintessential psychoanalytic intervention--reflected in Boesky's (1990) often-quoted declaration[[1]](#footnote-1), which has gone on to become a sort of rallying cry for those who insist on the desirability, even necessity of enactments[[2]](#footnote-2): "If the analyst does not get emotionally involved sooner or later in a manner that he had not intended, the analysis *will not proceed* to a successful conclusion" (p. 573 italics added). Hirsch (1998) reiterates how most read Boesky's proclamation: "He [Boesky] is not simply speaking of emotional involvement with the patient in the form of caring about the patient or becoming aware of countertransference feelings . . . He is saying that the analyst's countertransference, in the form of enactment, must become an actualization of the transference resistance in order for the analysis to be truly and profoundly effective" (p. 87). I believe the current trend that overemphasizes the centrality and indispensability of countertransference reactions in general, and countertransference enactments in particular, has carried us too far afield into territory that strikes some as absurd--for example, by declaring countertransference reactions and enactments to not only be extraordinarily helpful but the very essence of the entire psychoanalytic enterprise (Renik 1996).

**TED JACOBS VIGNETTE**

The first clinical material to be considered is a published vignette (Jacobs 1993), one of the many Ted Jacobs presents to illustrate his thesis--how his own personal dynamics sensitize him to react in a particular fashion to how patients go about relating to him:

*It is 7:55 a.m. on a Monday. I am in the new office to which I have moved over the weekend, waiting for Mr. V. to arrive. He is 38, single, an attorney, slim, handsome and polished. . . . He often speaks of himself as a kind of impostor, someone who gives the impression of being far more knowledgeable in his field than he actually is. He is terrified of being exposed for his inadequacies. There is, however, something menacing about Mr. V. . . .Today as I wait for Mr. V. I am more tense than usual. I anticipate his criticism of my new office and I am apprehensive about this. Mr. V. attaches a great deal of importance to appearances and when displeased by surroundings that he regards as unattractive, he can be caustic. I realize, in fact, that I am rather self-conscious about the appearance of my new place and I am angry with myself for not having anticipated the problem and invested in some new furnishings . . ..Mr. V rings the bell. [I open the door]. He goes to the couch, unbuttons his jacket, and stretches out on it. . . [After] Mr. V has completed his silent survey of my office [he comments]: 'You are nothing if not consistent', he says. 'It's amazing. Your Sears decorator has done it again. She has duplicated the old place right down to the last shabby detail.' He pauses and then goes on. 'Wasn't it some philosopher who said that consistency is the hobgoblin of little minds?' A flash thought occurs to me, accompanied by a momentary feeling of triumph. Mr. V. has it wrong. The actual quote—I think it was from Emerson—is 'a foolish consistency is the hobgoblin of little minds'. It is on the tip of my tongue to say this but I know that in correcting my analysand I would merely be showing off and acting defensively. I refrain.*

One might consider Jacob’s restraint to be the proper and appropriate response to what could be considered Mr. V.'s baiting behavior. Rather than act out his countertransference irritation by retaliating, Jacob’s *“chose”* self-restraint, which could be explained as both an act of discretion—his wish to avoid embarrassing the analysand by calling attention to his error—as well as the maintenance of the proper analytic stance: contain your countertransference reaction, reflect on its meaning, and use the resulting insight to further the treatment by fashioning an intervention based on these newly-acquired insight. So far so good, until one considers what Jacob discloses about what he believes had likely driven his "choice," making it seem a whole lot less “chosen” than it first appeared: “My transference to Mr. V. has drawn much from my relationship to my father and other male authorities. Made anxious by the prospect of a clash with them, I avoided conflict. To ensure peace I let them be the winners . . . and sought to conceal my feelings of rivalry and competition. This, I think, is what has been happening with Mr. V. . . . I realize, however, that my aggressive feelings have begun to slip out around the edges in the form of the kind of thoughts I have just had” (pp. 8-9). Suddenly, what had appeared to be a well thought-out instance of self-restraint for the good of the treatment and the protection of the analysand’s narcissism begins to look more like action motivated chiefly by Jacob’s struggle with his own competitiveness, leading us to wonder whether a less conflicted analyst might be relatively more inclined to enact his retaliatory impulses[[3]](#footnote-3).

It seems likely that Mr. V. sensed--consciously or unconsciously--Jacobs's disinclination to strike back, which could well have given the patient license to speak up just as he had--no holds barred! Alternately, had Mr. V. been in treatment with an analyst who was apt to push back when taken to task, the development of the manifest transference might have looked somewhat different. Had this been the case, Mr. V.'s core aggression might have been expressed in a less direct fashion, for example—through passive-aggressive channels, just so long as—*and this is essential*—Mr. V. was reasonably comfortable with, and could abide by such *alternate* expressions of his aggression without feeling he’d been strong-armed into that position by the analyst. Such situations are unconsciously negotiated in the process of analysis on a regular basis. Alternately, if Mr. V. felt he was being forced to back down by the analyst’s overly aggressive response, he might have felt he was being relegated to the position of "the one done to" (Benjamin 2004), which could have led him to resist the role assignment. Another possibility has the analytic couple locking horns with neither party backing down, resulting either in the rupture of the therapeutic alliance or in a highly charged thrust in the therapeutic process that might prove productive to the extent the analytic couple struggles to work their way past the emerging power struggle. As can be seen, there are a number of different ways in which the situation could have played out *as a function* of the analyst's way of being.

Important implications of Jacobs' vignette

There are certain things worth noting about Jacob's analysis of this clinical moment. To begin with, Jacobs had more than one countertransference reaction. His most immediate (core) reaction was an impulse to retaliate, to strike back by shaming the patient for having misquoted Emerson. This we might consider *countertransference proper*. In response to this initial reaction, Jacobs had a second *"meta-reaction"*--a reaction to his reaction. Jacobs was not one to experience retaliatory aggression without becoming deeply unsettled by such feelings and it was this second countertransference reaction--his meta-reaction--that had been instrumental in determining whether his initial impulse to retaliate had a chance of becoming openly expressed. Just as patients have a “core" and a “manifest" transference, the same can be said of analysts--who have corresponding core and manifest countertransference reactions. In this particular case, Jacob's core countertransference reaction, which most likely served as commentary about what was going on in his patient's mind, had been eclipsed by his meta-countertransference, which played a determining role in what became manifest[[4]](#footnote-4).

Jacobs does not consider *the content* of his meta-reaction to have been determined by the patient's behavior. He does not see it as having resulted from being assigned a role to play by the patient (Sandler 1976a). Nor does he believe it to be a response to the patient's transference expectations. He also fails to see his reaction as a manifestation of projective identification. While Jacobs admits he was triggered by the patient's provocative critique, how Jacobs *ends up* responding, to Jacobs way of thinking, was *of Jacobs own making*--a function of his one-person psychology. Jacobs takes responsibility for *what it is in him that is his*, rather than imagining he'd been "made" by the patient to react in this particular fashion. Accordingly, he does not believe his meta-reaction serves as commentary about what was going on in his patient's mind. And while Jacobs's behavior undoubtedly ends up contributing to the intersubjective field--the two-person psychology--it did not directly originate from that field seeing that Jacobs considers his reaction as a manifestation of his *separable subjectivity*. Current trends that emphasize a two-person psychology, to the exclusion of the one-person perspective, contribute to our forgetting we each bring our own psychologies to the consulting room independent of the analytic third that’s constituted once the process gets underway. Diamond (2014) refers to these trends as a "rational turn," which some see as tantamount to a radical paradigmatic shift (Pine 2011, Fabozzi 2012).

What I am proposing by emphasizing the analyst’s separable subjectivity is a focus on how the analyst feels about what’s become stirred up in him (a *meta*-feeling)—whether he finds such psychic states, on an affective continuum: irresistible, highly pleasurable, a bit taxing though reasonably tolerable, emotionally inconsequential, disquieting, hard to live with, or completely unbearable. How the analyst ends up interacting with an analysand is partly determined by where the analyst's meta-reactions lie on this continuum—how personally tolerable or intolerable his stirred-up internal state is tending to be. In turn, the shape the analysand’s transference assumes (how it manifests) is partly a function of whether the analyst's internal responses to the patient’s emerging transference is *in concert with, or in opposition to—*is “conjunctive” or “disjunctive”[[5]](#footnote-5) relative to the patient’s way of being—what his behavior seems to be requiring of the analyst in terms of particular kinds of involvements and responses.

Another thing worth noting about Jacobs countertransference reactions is that they had been sufficiently conscious, making it that much easier for Jacobs to contain, reflect on, and learn from. This contradicts Renik's (1993) strongly argued position that "awareness of countertransference is *alway*s retrospective, preceded by countertransference enactment" which he declares to be "*invariably* the case" (p. 561). While such strongly-worded statements, made in no uncertain terms, may appeal to those who seek relief from the inevitable--and, for some, unbearable--uncertainties of psychoanalytic practice, the absoluteness of such statements should give us pause. Renik's unequivocal statements, like those made by others who feel likewise--to be discussed further along in the paper--are a sure sign the pendulum has swung too far in one direction and is in great need of being recalibrated.

**THE ANALYST'S WAY OF BEING**

There are two essential points that have been made thus far about the analyst's way of being: the range of ways in which various analysts differentially respond to a given patient's way of being is *a function of the analyst's particular way of being* and how a given analyst responds to a particular patient contributes to how the patient's transference takes shape. Analysts vary in their personal proclivity to "get into it" with patient by becoming embroiled in an enactment. Depending on the analyst's way of being, he may alternately feel more or less comfortable slipping into an enactment or, on the other end of the spectrum, may feel aghast at the prospect, dedicating himself to do what he can to avoid what feels to him like certain calamity. Whether such anxiety prohibits the reluctant analyst from becoming sufficiently engaged with the patient is a question to be taken up at the end of the paper. Analysts also vary with regard to how prone they are to feel as if they are "being made" by the patient to react in a given way. Some analysts describe feeling as if the patient is "pushing their button," drawing them in, stimulating their emotions, limiting their range of options, etc. Some feel they're being assigned a role that is personally repugnant--enough to "set them packing," metaphorically if not literally--a "disjunctive" experience that puts the patient’s needs and those of the analyst at cross purposes.

The analyst's *way of being* can also play a determining role in the sorts of *clinical interventions* he makes. Along these lines, Freud’s own *way of being* figured heavily in his thoughts about how one goes about conducting an analysis, admitting his recommendations were "the only one[s] suited to my individuality,” adding “a physician quite differently constituted might find himself driven to adopt a different attitude to his patients and to the task before him” (Freud 1912, p. 111). What a psychoanalyst sees as salient in the clinical material—be it a subtle shift in the analysand's associations, a slip of the tongue, the symbolic aspects of a dream, where his own reverie leads him, his countertransference reactions, the nature of the intersubjective field, etc—might seem to be a function of that analyst’s theoretical bent until one considers the possibility an analyst gravitates to one theory over another not strictly, or even chiefly, because of the strength of the convincing arguments set forth in support of that theory so much as the analyst’s personal psychology (Jacobs 1986, Faimberg 1992), a position some find unnerving to the extent they feel it undermines the scientific basis of psychoanalysis.

**THE VARYING DIMENSIONS OF TRANSFERENCE**

The essence of transference is commonly considered to be *perceptual* in nature: past experiences help determine how one presently sees, interprets and/or experiences the actions and attitudes of others. The analysand scans the data emanating from the analyst, highlighting and overemphasizing the salient behaviors *most consistent* with what he anticipates finding. Transference extends beyond a *readiness to perceive* and may involve turning to the analyst in the hope he will be able to satisfy, or contain, certain of the analysand’s wishes, needs, desires, or affect states. Accordingly, transference is not limited to perceiving the analyst as being like someone from one’s past (the “old object”); it can also involve looking to the analyst to fill the shoes of a once *wished-for* parent (the “new object”).

A two-person psychological perspective broadens our understanding of transference beyond the confines of the analysand's *perception* of the analyst or his *efforts to seek gratification* from the analyst. Here, I am thinking in terms of roles assigned by the patient to the analyst and the complementary roles assumed, in turn, by the patient[[6]](#footnote-6). For example, the analysand may assume the role originally played by the transference figure, resulting in his treating the analystmuch as he'd been treated by the original object as a child ("identification with the aggressor"). This is but one of the varied ways roles are assigned and assumed. This two-person perspective draws our attention to how the analysand unconsciously *works* *to induce* the analyst to adopt a particular role, combined with how the analyst behaves in response as the two co-construct the resulting transference-countertransference configuration. The one-person psychological perspective, by contrast, focuses on each party’s separable subjectivity--what it is they bring to the table in the way of personal, context-independent proclivities and resistances to react or resist in a particular fashion. Recognizing that neither the one- nor the two-person perspective can claim exclusivity, notes Benjamin (1995), requires we struggle with the tensions produced having to keep both perspectives in mind, even though doing so can only be achievable sequentially if not simultaneously (p. 6).

What's been laid out thus far is not new; it is generally understood and accepted, though some disagree with the extent to which the person of the analyst can affect the expression of the transference (Kernberg 1993, Etchegoyen 1991). What I wish to now add to the equation is the analyst's *unique affective response* to the experience of becoming stirred up in response to what is taking place in the consulting room—ranging from feeling that what he's feeling is desirable—on one end of the spectrum—to feelings it to be utterly intolerable, on the other end. Naturally, how the analyst feels about what he's being “required” to experience by virtue of his involvement in the treatment—if not specifically required *by the patient*--has much to do with his own way of being. Following this reasoning, the analyst may end up realizing (or frustrating) the analysand’s transference expectations by virtue of his willingness (or resistance) to behave in ways that roughly replicate those of an actual, or wished for, figure from the analysand's past. In this way, the analyst’s behavior helps validate (or negate) the analysand's construction of the analyst as the process moves from perception into "actualization" (Sandler 1976b, McLaughlin 1991, Chused 1991, Poland 1992). In comparable fashion, the analyst may also gratify or frustrate the patient's efforts to draw him into an enactment, get him to accept a role assignment, or induce him to receive and contain his projections.

**PROGRESSION IN OUR UNDERSTANDING OF COUNTERTRANSFERENCE**

The evolution in our thinking about countertransference can be thought to have taken place in three successive stages. The first stage occurred half way through the last century with the publication of papers by Heimann (1950), Tower (1956) and Racker (1957) that together helped re-define countertransference as an essential clinical tool rather than a bothersome impediment to the work. Heimann (1950) argued that “the emotions roused in [the analyst] are much nearer to the heart of the matter than his reasoning, or, to put it in other words, his unconscious perception of the analysand's unconscious is more acute and *in advance* of his conscious conception of the situation" (pp. 82, italics added). After stating as much, Heimann went a step further by declaring the analyst's counter-transference to be "*the patient's creation*, it is a part of the patient's personality" (p. 83, italics added), moving into theoretical territory many consider problematic to the extent such thinking fails to consider the analyst's separable subjectivity—the "hook" (Gabbard 1995; Westin & Gabbard 2001; Stanicke & Killingmo 2013) within the analyst upon which the analysand's projection could be "hung".

A third of a century before Boesky (1990) wrote about the necessity of the analyst's becoming drawn into enactments in order for the treatment to progress, Tower (1956) declared the analyst's countertransference reactions to be "of vital significance to the outcome of the treatment" (p. 227), functioning "somewhat in the manner of a catalytic agent in the treatment process" (p. 232). Tower refers to countertransference reactions as both inevitable and desirable, writing "their understanding by the analyst may be as important to the final working through of the transference neurosis as is the analyst's intellectual understanding of the transference neurosis itself, perhaps because they are, so to speak, the vehicle for the analyst's emotional understanding of the transference neurosis" (p. 232).

Racker's (1957) contribution to our understanding of countertransference chiefly involves his introduction of two contrasting terms—"complementary" and "concordant"—to differentiate two types of countertransference reactions. Complementary reactionsare defined as those involving the analyst’s being seen by the analysand as being like the original object, leading to the analyst’s feeling and/or reacting in kind *in accordance with this perception-interpretation,* potentially stimulating him to adopt the corresponding counter role that "plays against" the role assumed by the patient. By contrast, *concordant reactions* are characterized by the analyst “identifying” with the analysand's situation, resulting in an empathic response to the analysand’s experience.

We've now arrived at one of the chief goals of this paper--a proposed refinement in Racker's definition of complementarity based on the analyst's level of comfort or discomfort with what's become stirred up in him as he goes about treating the patient. Using role responsiveness (Sandler 1976a) as the model: to the extent the analyst's and the analysand's assigned and assumed roles more or less *comfortably complement* one another (are affectively acceptable to both parties), one would call the complementary relationship *"conjunctive.”* By contrast, *"disjunctive"* relationships are those in which the roles assigned prove personally repugnant to one or both parties (Faimberg 1992), unacceptable in that they feel alien to one's general way of being (Benjamin 2004). Under such conditions the situation may feel non-negotiable, thus jeopardizing the ongoing viability of the analysis. Mermelstein (2000) notes "complementarity becomes problematic when the perceptions and organizing schema of both participants are diametrically opposed, reciprocally threatening the other's functioning, and cannot be easily reconciled" (p. 726).

If the analyst doesn’t welcome what's become stirred up in him as he interacts with the patient, he may work to counter its effect. For example, if the analyst detests the role into which he feels he's being implicitly drawn, he may bristle and resist the role assignment, not realizing he's doing as much until after the fact. To the extent the analyst begins to experience, while interacting with an analysand, highly unpleasurable internal stirrings (affects, memories, thoughts), the resulting countertransference reaction is "disjunctive" and may result in the analyst's strongly rejecting the role he feels he's being assigned, traits or characteristics the patient attributes to him that he finds repugnant, and/or the projections he feels he's being asked to receive and contain. For example, feeling controlled by the pressures brought to bear for him to adopt a personally repugnant role assignment could result in the analyst’s conscious, or, more likely, unconscious efforts to turn the tables to show the analysand “who’s boss”—taking charge of the interaction and imposing an agenda of his own that dictates how he and the analysand are to be relating to one another, preempting the analysand who, the analyst feels, was trying to do likewise--a battle over whose to be "the doer" and whose to end up "the one done to" (Benjamin 2004).

The second stage in the evolution of our thinking about countertransference, which furthered our thinking about the analysand's impact on the analyst, occurred in the mid 1970s-80s. Sandler (1976a) noted, with certain analysands, how he'd sometimes *find himself* (that's the operative phrase) unwittingly acting in ways that were uncharacteristic of him for reasons that escaped him. Jacobs (1986) went a step further by exploring how particular factors in his own background led him to engage with the analysand in "an enactment." Of import is the fact that Jacobs does not believe his analysands were motivated by a wish *to cause* him to think or feel what it was Jacobs ended up thinking or feeling, placing him on the same page with Sandler (1976a), who did not see role responsiveness as a function of the analysand’s efforts to foist a role upon the analyst but, instead, saw it as “a function of the analyst's receptivity, not of the analysand's unconscious intention, and should not be regarded as projective identification, as something that the analysand wants to 'put into' the analyst" (Sandler 1993 p. 1105). Again, we see both these authors insisting on their separable subjectivities, rather than conceptualizing themselves as if psychologically yoked to the patient's efforts to "make them" feel certain things, do certain things, have certain memories, etc.

Since Jacobs introduced the term in the mid-1980s, the concept of enactments has increasingly been referenced and utilized to understand clinical material. As noted by Bohleber, Fonagy, et al (2013) in their sweeping overview of the subject, "the term 'enactment' is here to stay" (p. 509). This does not mean, however, that all agree about what the term means or what light it might shed on the patient's psyche. Bohleber, Fonagy, et al (2013) offer a serviceable definition of the phenomenon: "Enactment involves a collapse in the analytic dialogue in which the analyst is drawn into an interaction where he unwittingly acts, thereby actualizing unconscious wishes of both himself and the patient. This collapse implies disturbance of the symbolic function; something emerges that at the moment of enactment is not accessible by language. What follows this moment will determine whether the enactment will have therapeutic value, that is, whether the symbolic function will be restored and integrative work can or cannot happen." (p. 517). Enactment is thought to involve a loss of analytic capacity on the analyst's part--in reaction to instances when the patient's verbalizations are "meant *to do something or bring something about* rather than communicating something" (Busch 2009, p. 55)

A final stage in the evolution of our thinking about countertransference, evidenced in Aron's (1996) concept of "mutuality," pictures analyst and analysand reciprocally influencing one another in a circular, back-and-forth, chicken-or-the-egg fashion, making it nearly impossible to make out whose behavior set the wheels in motion in the first place. Many favor this model not only because it emphasizes mutual influence but also because it makes room for the possibility that roles might be assigned by the analysts to analysand just as they are assigned by the analysand to the analyst.

**CLINICAL ILLUSTRATIONS**

Let's begin by considering two clinical examples where the transference needs of the patient proved deeply unsettling for the analyst and, accordingly, were "disjunctive" relative to the patient's needs. In the first abstracted example, the patient's transference involves seeing the analyst as someone incapable of understanding what the analysand is going through (see Joseph 1985). In this particular case, what the patient was expecting and/or needing from the analyst is that he play the part, or "wear the attribution" (Lichtenberg, Lachmann, & Fosshage, 1992**,** 1996**)** of "the one who will never understand," playing against the patient's role of "the one who will never be understood." Feeling trapped within the assigned role of "the one who can’t understand"—at a loss as to how to extricate himself from having to live out that role—would likely prove unsettling for any analyst, though *more so* for analysts who pride themselves on their ability to help their analysands feel understood--underscoring the role the analyst's separable subjectivity plays in leading him to react to the patient in ways that may influence how the transference ends up manifesting. Interpreting to the patient his expectation/need to have an analyst who *does not and cannot understand* is a kind of understanding in and of itself and accordingly may be likewise disallowed by the analysand who wants nothing to do with the analyst's efforts to prove he does, in fact, understand--motivated, in part, by his need to feel it is so. Under such conditions, it might be in the best interest of the treatment to accept, at least for the time being, the role of "the one who can’t understand," which the analyst will only be able to do to the extent this role is on the *conjunctive end* of the conjunctive-disjunctive spectrum. Doing so, paradoxically, might be the sole way in which one might actually demonstrate understanding.

Other analysts have provided examples of how they'd come to experience aversive states in the process of treating particular kinds of patients. Steiner (2000) presents two cases in which the patients themselves "created states of discord [disjunctions] that left me confused and uncertain and sometimes led me to try to provide meaning that would make sense of the confusion and *reduce my anxiety*" (p. 246, italics added). Note the use of language--it was the patients who created Steiner's internal state--placing responsibility for what had gotten stirred up in him squarely on the patient's shoulders. Also note Steiner's admission that his enactment was in the service of making himself more comfortable--moving him closer to the conjunctive end of the conjunctive-disjunctive scale. McLaughlin (1991) describes a similar countertransference reaction in which his patient's behaviors "left me repeatedly in states of futility and bewilderment, doubting my capacities to see anything clearly about her or to articulate effectively. I took myself to task for my ineptitude and felt helpless and angry. . her behaviors effectively pressured me to experience these affects *as my own* with an intensity I found unusually painful[[7]](#footnote-7)" (p. 604 italics added). In both these clinical instances the ways in which these patients related to the analyst is conceptualized by these authors in terms of projective identification, where something is done to one by another, where the pressure from the patient creates in the analyst a narcissistic imbalance (Ellman 2010) sufficient to cause him to act in accordance with the pressures the patient is bringing to bear to promote action rather than containment by adopting a particular role, actualizing particular transference expectation (Sandler 1976b), or engaging in a particular type of enactment.

The second example of disjunctive intersubjectivity is that of Mr. R., a retired, married man about twenty years my senior who was referred to me after a lengthy treatment with another clinician had “petered out.” He presented with depression and intermittent suicidal impulses, complaining that “no one gives a shit about me, including myself.” Though he’d received considerable professional recognition in his field this did little to bolster his self-esteem. While he felt quite needy of praise from others, his neediness typically met with impatience from others who felt imposed upon by the patient’s incessant demands they provide him an audience for him to impress with his most recent, praise-worthy project.

The patient’s father sent mixed messages--he cherished his son yet denigrated him as incapable of achieving much in life, leaving the patient to feel he could not rely on himself and accordingly needed others “over” him to tell him what to do. By contrast, the patient presented his mother as a ghostly figure--someone who was in the background and was relatively inconsequential in his early development.

For several months the patient’s behavior stimulated something in me that led me to play the role of the mirroring parent who'd “ooh and ah” over his display of a recent invention or his considerable knowable about a wide variety of topics. Then, several months into the treatment, the patient began a session by noting that the fichus tree in my office was shedding leaves, using this observation as an opportunity to instruct me about how best to care for the plant. He told me that I should turn it so the unexposed side could get more light and he suggested a watering schedule that was best suited for the plant. I understood these to be metaphoric references to his feeling I'd been inattentive to him, but before that could be addressed something intervened that got us on an entirely different track.

As the patient went about educating me about indoor gardening I found myself growing irritated. I wasn't aware of the fact at first until I suddenly quipped after the patient completed his "lecture": "You know, I've had that plant for over twenty years!" The moment those words left my tongue I had a sinking feeling, aghast at what I'd just said. It was a simple statement, but its meaning was not been lost on the patient. The following session we had a chance to return to the event when the patient noted upon entering the room that I'd tended to the tree, which I had in fact neglected. Admitting to having heeded his advice was driven by my guilt and a wish to somehow "make up" for having responding to him in the fashion I had--another enactment.

I came to realize my feelings about having the patient educate me about plants could be expressed in this fashion: “Who do you think you are coming in here treating me as if I am some sort of naive imbecile who doesn’t know the first thing about plants. Let me tell you something, buddy. I have had this plant for twenty years. Did you hear that? *Twenty years*! Doesn’t that say *something* about my abilities as a gardener? Do you think you could keep a plant alive for twenty years? *Huh, pops?”* Naturally, none of this was ever said to the patient, though my irritation provided us an opportunity to analyze what had been going on in the room unbeknownst to either of us.

The patient had a father, not unlike my own, who could be discounting of his son’s abilities. This led to an interesting situation, for neither the patient nor I was anxious to play the part of the imbecilic child. At the point he chose to “educate” me, or, alternatively, show off how much he knew about yet another in a string of topics, I experienced the patient as treating me as his father had treated him and as my father had treated me. I was determined to have no part of this, and spoke up to “set the record straight.” If I was being assigned the role of imbecilic child to play against the patient’s role of all-knowing father, I wasn’t buying. Something had to give!

But was this, in fact, what the patient intended for me to feel? All I knew at this juncture was that I had ceased to play the role of father who marveled at his achievements and wealth of knowledge. The idea the patient had unconsciously intended to treat me as his father had treated him was a distinct possibility. But it seemed just as possible that his unconscious wish was for me to continue to play the role of admiring father rather than experiencing his "lesson" as I had--as an effort to make me feel like an imbecile just as his father had made him feel. Whichever the case, my own separable subjectivity had something to say about the matter, intruding in the way it had for reasons that were, at that moment, more driven by my own personal issues than it was by my continued availability to respond in kind to what it was the patient was trying to say or accomplish with me at that moment in time. While, on one level, the patient's intention may well have chiefly been aimed at my continuing to admire him for being knowledgeable, he ended up getting more than he'd bargained for. Had I not had the type of father I had, I might have been better positioned to continue to play the role of admirer that could serve as someone who could mirror back to the patient a view of himself as wonderfully capable and extraordinarily knowledgeable. But another aspect of my subjectivity emerged. As a result, I ceased to in conjunctive harmony with the patient. What I wanted was off this train!!!" In contrast with the case of Ted Jacob and Mr. V., in which the core countertransference impulse to retail seemed to serve as commentary about what was going on in the patient's psyche, in this particular instance my core countertransference reaction seems to be more of his own making.

Let's consider another of Jacob's (1986) clinical vignettes—this time one that illustrates conjunctive rather than disjunctive complementarity. Mr. K. is a patient Jacobs found *so* captivating that his mind never wandered once as it typically would from time to time with other analysands. Jacobs found this curious, ultimately leading him to realize the autobiographical basis of this "enactment." As it turns out, Mr. K.’s propensity to be "a captivating orator" ostensibly “transported" Jacobs back to a time he'd be sitting at the dinner table listening in awe as his father held forth on any number of topics as young Ted sat transfixed. “It was his show” writes Jacobs, “and if I spoke at all it was simply to ask for more details—the equivalent of my interventions years later with my analysand. . . [whose] transference wish [was] for me to play the role of appreciative audience.”

Jacob's revelation raises an interesting question that highlights the central thesis of the paper. While certain aspects of his experience with Mr. K. may have felt disjunctive to Jacobs, on balance the prevailing sense of his experience was chiefly conjunctive. We might wonder how Mr. K.’s co-constructed transference might have manifest had he been in treatment with a different sort of analyst, one—for example—who felt he was being asked to play a role he found personally offensive (an example of disjunctive complementarity). It seems easy to imagine such an analyst experiencing, for example, competitive strivings to prove that he, too, had much worth hearing, interrupting the patient's tendencies to "hold forth" in order to get a word in edgewise.

**DISCUSSION**

What has been proposed in this paper is a further subdivision of the complementary type of countertransference reaction into "conjunctive" and "disjunctive" subtypes based on the degree to which the analyst's internal states, in response to how the patient is behaving, is--along a continuum--tolerable or intolerable. Conjunctive reactions are those the analyst can more or less bear, and may even take pleasure in experiencing; disjunctive reactions, by contrast, lead to the analyst's feeling an urge to fight off such reactive feelings to the point he might even find such reactions totally abhorrent. Whether the analyst's countertransference reaction, on balance, leans more heavily in one direction or the other plays a determining role in his: 1) openness to accept the analysand's "role assignment," 2) comfort living with, rather than immediately challenging, the analysand's transference-based beliefs about who the patient believes the analyst to be ("wearing the attribution"), 3) personal predisposition and availability to engage with the patient in an enactment and 4) willingness and ability to receive and contain the patient's projections. Whether the analyst is comfortable, open and available to participate with the analysand in these varied ways--in our proposed terminology, whether his countertransference reactions are more conjunctive than disjunctive--can have tremendous clinical consequences.

A final point I wish to make before ending has to do with the question of whether the pendulum has swung too far in the direction of over-privileging countertransference enactments as the quintessential mutative therapeutic maneuver baring none. This brings us, full circle, to the vignette presented in the beginning of this paper, Jacob's treatment of Mr. V.--the patient who was acerbically critical of Jacob's new office. In a paper I'd submitted for publication to a leading psychoanalytic journal, I cited Jacob's case and wrote that I regarded Jacob's reticence to react when provoked a sign of good psychoanalytic technique.[[8]](#footnote-8) To my surprise, two of the three reviewers begged to differ—expressing the opinion that Jacobs had, in fact, robbed the analysand of a potentially mutative experience by failing to allow himself to become more reactively engaged with the analysand. This struck me as odd and led me to consider how far the pendulum has swung from one extreme to the other—from the condemnation of countertransference as a serious impediment to the treatment to a celebration of the countertransference enactment as *the* preeminent mutative event. The opinions of these reviewers, in conjunction with those expressed by various authors (Heimann 1950, Whitaker and Malone 1953, Boesky 1990, Renik 1993, 1996), illustrates how the overvaluing of enactments has gone so far as to lead some to fault analysts who are *characterologically disinclined* to succumb to the urge to act, as was the case with Jacobs in his treatment of Mr. V[[9]](#footnote-9), seeing such a "resistance" to enact as tantamount to a refusal to engage the patient. I consider this to be a most unfortunate development. The reviewers who’d insisted it would have been better had Jacobs "hauled off" and "let the analysand have it" in the name of enactment for the sake of the treatment, were *ignoring the simple fact that this is not who Jacobs is*--an aspect of his way of being, his separable subjectivity, as seen from a one-person psychological perspective, which fails to take into consideration fails to take into consideration the analyst’s irreducible subjectivity, which can neither be eliminated nor denied (Renik 1993, p. 562). Such matters are the sort that cause Diamond (2014) to counsel "caution in today's more exaggerated weighing of here-and-now transference interpretations, with its focus on *process* often replacing rather than supplementing the significance of unconscious content" (p. 544).

One's attitude about a given analyst's inclination or disinclination to become "embroiled" in an enactment varies depending on one's stance about such matter. Analysts vary to the extent they are susceptible to "regressions to less evolved perceptiveness in consequence of the stirring in him of old and only partially mastered conflicts" (McLaughlin 1991, p 600). Some seem more inclined to slip into enactments, others less so. Whether one judges those analysts who are more inclined to enact as reckless—as *insufficiently cautious*--or, alternately, as having sufficiently faith in their ability to regain their analytic footing whenever they momentarily lose their capacity to contain and reflect, makes a great deal of difference in one's attitude about such practices. The same can be said looking from the opposite direction—faulting analysts who are less inclined to enact as being overly intellectualizing and hence emotionally unavailable to their patients.

Evidence that the thinking of certain analyst may well have travelled into extreme territory is provided by what's revealed in the way in which these analyst's use language, speaking in no uncertain terms--using absolute statements that's a sure sign the pendulum has swung too far in one direction into highly questionable territory. Take, for example, Boesky's often-quoted remark that states the analysis "*will not proceed* to a successful conclusion" (p. 573 italics added) unless a countertransference enactment develops. Note how Boesky uses "will not" in place of alternate words such as "might not" or "will likely not," etc. Certainly such language is a red flag. The fact that Boesky's statement has been so frequently cited should give us pause. Four decades earlier Heimann (1950) had likewise spoken in absolute terms about how the analyst's countertransference is "the patient's creation" (p. 83). Renik is another who's comparable inclined to use of absolute words, seen in his paper about the analyst's "irreducible subjectivity" in which he employs the words "always" and "never" eleven different times--driving home his points in a most insistent and emphatic manner, which may be appealing to those wishing for a level of greater certainty in a psychoanalytic world that often leaves us struggling with doubt.

"The question of how to understand and use the meaning of the analyst's inner experience remains controversial," notes Diamond (2014 p. 541). One consideration is the fact that there is something romantic in the notion of intersubjectivity as it seems to be seen by some--which is very much at odds with Benjamin's (1995) perspective on the matter that underscores the analyst's separable subjectivity. The notion that we are connected to one another to such a remarkable degree that whatever happens in one person makes *direct reference* (is commentary on) what is going on in the other's mind may be overstating the case. For example, Ogden (1997) writes "as personal and private as our reveries feel to us, it is misleading to view them as 'our' personal creations, since reverie is at the same time an aspect of a jointly (but asymmetrically) created unconscious intersubjective construction that I have termed 'the intersubjective analytic third” (p. 569). Seeing one's psychic wanderings as inevitably tied to what is going on in the patient relieves one of the guilt of feeling one had been "asleep at the wheel" when one ought to have been carefully attending to material that *can be shown* to relevant to the patient, rather than tending to one's separable subjectivity. It is both appealing and reassuring to think that whatever becomes stirred-up in the analyst's psyche must serve as commentary about the patient's state of mind since such thinking helps lessen the sense of isolation and aloneness that is part and parcel of the human condition. But envisioning the analysts reveries, affect states, evoked memories, countertransference reactions as *invariably syncing* with what is emanating from the patient--and providing commentary about it—seems to me to be akin to the ideal, highly attuned mother-infant state of symbiotic union (Tower 1956). Some of the analyst's countertransference reactions are undeniably "about" the patient's current psychic condition, some are not. Leaving room for both possibilities is essential to the success of the psychoanalytic process.

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1. quoted in print 29 times to date (PEP), and frequently often heard during paper presentations at analytic meetings [↑](#footnote-ref-1)
2. a careful reading of Boesky's paper indicates this quote is taken out of context, seeing that Boesky doesn't mean to imply an enactment, in and of itself, could be considered mutative in the way some "interactionalists" claim it can be, but rather, that it's essential to recognize the analyst's inevitable, inadvertent contribution to the patient's resistance, which sooner or later must be faced if treatment is to progress toward a successful conclusion. [↑](#footnote-ref-2)
3. I am not implying that all who are comfortable with their aggression will necessarily act on those impulses, only that being more comfortable with one's aggression moves one *in that direction* if not over the line. [↑](#footnote-ref-3)
4. Not to imply Mr. V. would not have been able to sense a stifled impulse to retaliate--only to note that a directly expressed and a stifled reaction will contribute differently to helping mold the patient's manifest transference. [↑](#footnote-ref-4)
5. following a distinction drawn by Atwood et al (1987). [↑](#footnote-ref-5)
6. and vice versa (Ellman 2010, McLaughlin 1991)--seeing that role assignment does not issue strictly from the side of the patient. [↑](#footnote-ref-6)
7. While McLaughlin quotes Ogden (1979) as having noted that the analyst's responses are not "transplanted" but are his own, the quote just reference seems inconsistent with the authors referencing Ogden's broader view of the process of projective identification. [↑](#footnote-ref-7)
8. Granted I had at that moment overlooked his personal reasons for having acted as he had. [↑](#footnote-ref-8)
9. In fact, Jacob’s inactivity, under the circumstances, could equally be considered an enactment of another sort. [↑](#footnote-ref-9)