

(1998). *Progress in Self Psychology*, 14:203-218

## **Chapter 12 Expressive Relating: The Intentional Use of the Analyst's Subjectivity**

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“What incident do you remember as pivotal in your own personal analysis?” was the question I put to a small circle of friends and colleagues who were lingering over a last cup of coffee at a late night meeting.

One woman who had been orphaned at birth replied, “It was when, at a particularly difficult time in my life, my therapist said to me, To the best of my ability I want to be the mother for you that you never had.” Another, rather austere, self-contained woman said, “A turning point for me was when my analyst said with tears in her eyes, ‘I’ll cry for you until you can cry for yourself.’” Surprisingly, a third colleague said that her analyst told her in a moment of frustration, “I find it very difficult to work with you sometimes.... Just when I think we have a secure bond, our connection imperceptibly slips away.” My colleague went on to explain that this spontaneous expression of exasperation was a turning point for her because in that moment she recognized that her analyst was personally affected by her and was not just “being nice.”

Pivotal experiences in analysis are frequently occasioned by the heartfelt expression of subjective experience on the part of the analyst. They comprise, in some way, a fulfillment of the hope for a new beginning: a symbolic enactment that powerfully communicates to the analysand that the analyst is fully engaged in the relationship and impacted by it. The patients in this discussion had been able to elicit from their analysts expressions of a genuine desire to co-create the kind of relational experience that the patients needed in order to grow.

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I wondered if my colleagues' analysts knew that their personal expressions were experienced by their patients as a fulcrum for their analyses. Often, clinicians fail to attribute sufficient significance to their expressive participation with their patients. It is difficult to include this aspect of treatment in analytic writing and teaching because psychoanalysis is only recently, very slowly, emerging from the emotionless model of a mechanistic science that idealizes anonymity, neutrality, and an authoritative posture.

In the new relativistic paradigm, relational constructs such as optimal responsiveness, mutual influence, and intersubjectivity reflect a two-person psychology that allows for the possibility of the active expression of the analyst's subjectivity. The authentic expression of feelings and perceptions on the part of the analyst, arising out of the immediacy of the interaction and conveyed in a conscious and responsive way, is what I refer to as “expressive relating.”

Expressive relating entails an interactional engagement that includes disclosure characterized by an attitude of open responsiveness. It demands the willingness to take the emotional risk of stepping out from behind the mask of objectivity, as well as, at times, the courage to depart from a posture that would withhold from the patient the experience of the analyst experiencing him.

This chapter takes the position that the analyst's “personness” is a vital ingredient in self object experience. Expressive relating is proposed as an important dimension in the creation and maintenance of a selfobject bond.

## Expressive Relating and Selfobject Experience

One of Kohut's major contributions to psychoanalytic theory is the idea that it is an internal experience of an empathic other that makes self-cohesion and psychological development possible throughout the life cycle. He introduced the term *selfobject* to refer to another, experienced as part of one's self, whose attunement, greatness, dependability, and perhaps alikeness provides the nourishment necessary for self-cohesion and delineation. In the same way that food in the body, not food on the plate, provides nourishment, it is the internal use of the relationship with the other that constitutes a selfobject experience. This means that the analyst cannot provide a selfobject experience but can only facilitate a process through which this experience can take place. For example, an analyst may express interest in a patient, believing herself to be providing

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a selfobject function. However, if the patient experiences her as intrusive or insincere, the function will not have been served.

Selfobject theory has undergone much revision and expansion since Kohut's struggle to extricate his ideas from Freudian drive theory. Recent developments in self psychology have important implications for the exploration of expressive relating. Contributions toward refining self object theory within the last few years include the following new directions.

1. There is an increasing emphasis on the specificity of the selfobject. Bacal (1995) revises Kohut's formulations by noting that "it is usually the function of a *particular* other that is sought for selfobject experience" (p. 357). Orange (1995) draws on the contributions of attachment theorists who acknowledge that at the core of human functioning is a tendency to establish a powerful bond to a special other. She asserts that "the particular human being who provides selfobject experience matters profoundly" (p. 172).
2. The importance of the analyst's affective responsiveness and emotional availability is being elaborated. Orange (1996) suggests that the analyst's "expertise consists primarily in a capacity ... for reflective emotional availability" (p. 135). She suggests the concept of emotional availability as a replacement for the principles of neutrality and anonymity as guidelines for psychoanalytic practice. Emotional availability entails the analyst's communication of his awareness of the patient's emotional state and a readiness to respond emotionally. The emotional response of the analyst also acts as a belated healing by bearing witness to childhood abuse and trauma. Fosshage (1995) is making a vital place for the use of the analyst's subjective experience of the patient to facilitate selfobject experience. The direct use of the analyst's experience both illuminates the patient's subjective world and can also provide an experience of closeness and deep affirmation for the patient. Fosshage (1997) goes on to say that the analyst must be sufficiently emotionally expressive in order for the patient to feel that the analyst is meaningfully engaged with him and that he matters to the analyst.
3. The selfobject is being seen as existing on a continuum from merger to distinctness, not solely as an extension of the self. Bacal (1995) writes, "It is the function of the other that constitutes the hallmark of selfobject experience rather than contiguity with the sense of self" (p. 357).

4. The importance of mutuality in selfobject relating is being elaborated. Brothers (1995) addresses the importance to the patient of being trusted as a reliable selfobject provider for the therapist. Bacal and Thomson (1996) speak to the necessity of addressing the analyst's selfobject

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needs for an analysis to be successful. Fosshage (1995) points out that the analyst must be interactionally shaped by the patient in order for a selfobject experience to occur.

These revisions move in the direction of supporting the analyst in a more wholehearted engagement with her own particularity in a subject-to-subject exchange with her patients. The early Kohutian selfobject could be understood as a disembodied set of functions lent to the patient until transformed by optimal frustration into transmuting internalizations. A contemporary selfobject prototype can be seen as an emotionally available other with whom a particular bond has been forged, one who engages in the give and take of human intimacy.

Selfobject theory as elaborated by Kohut had one foot in the camp of a one-person psychology. A selfobject transference was viewed by Kohut as arising spontaneously from a narcissistic patient. The analyst's job was to refrain from interfering and allow this process to unfold, while interpreting the selfobject needs and longings to the patient. Intersubjectivity theory, which conceptualizes the patient and analyst together as an indissoluble psychological system to be explored and transformed, puts self psychology more firmly into a two-person theory (Stolorow, Brandchaft, and Atwood, 1987). The analyst's subjectivity, personality, organizing principles, and affective style make a significant contribution to the relationship, whether they are openly expressed or covertly communicated. The job of the analyst is therefore to accept responsibility for participating in and co-creating the selfobject matrix.

Expressive relating is one way for the analyst to use herself fully as an instrument for the creation of a selfobject experience—not that expressive relating will necessarily result in a selfobject experience. Rather, the analyst's self-expression is like the food on the plate. Whether it is appetizing or digestible will depend on the particular patient and the particular analyst in a particular moment.

### **Expressive Relating in a Historical Context**

New paradigms always have their predecessors—people who advanced ideas that were, at the time, considered radical, fringe, or simply wrong. Suttie was one of those thinkers whose brilliant work went unrecognized until very recently. Suttie's work, in sharp contrast to Freud's instinct theory, anticipates a fully relational approach that recognizes the importance of the person of the therapist in a healing relationship. His book

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*The Origins of Love and Hate*, first published in 1935, is predicated on his belief in the innate human need for companionship. He believes that it is through the analyst's love, or “feeling-interest responsiveness” (Suttie, 1988, p. 212), that the patient is cured.

Sandor Ferenczi, also radical in his time, was the first analyst to recognize the significance of the unique interaction between a particular analyst and patient. He highlighted the role of the

analyst as a real person and pointed out that the patient is aware of and responsive to the nuances of the analyst's behavior. Transference is co-created by the analyst and patient, according to Ferenczi, who was the first to use countertransference disclosure as a way of dealing with early traumatic experiences repeated in analysis (Dupont, **1988**, p. 214).

More recently, Bacal (**1985**) has made a major contribution to furthering our understanding of the relational essence of self psychology with his now well-known paper on “optimal responsiveness.” In this paper he challenges the Kohutian theory of optimal frustration, stating, “It has never been our intention as analysts to either traumatize or frustrate our patients, however optimally, but to understand them” (p. 207). He affirms the essential relational nature of self psychology, reminding us that, ultimately, interpretation and insight are not, in themselves, curative, but the means by which transformation takes place (p. 209). Although interpretation is the primary way in which we convey our optimal responsiveness, it is by no means the only way.

He concludes that creative selfobject transference is the result of a good deal of positive interaction with this new version (the analyst) of the old selfobject (p. 217). It is the patient's experience of the analyst as selfobject that is curative, and the responses of the analyst that are optimal are the ones that facilitate this experience (Bacal, **1990**, p. **364**). The therapeutic change in the patient that allows him to expect that others will respond to his selfobject needs is the result of a learning experience. “His subjective attitudes have changed as a result of significant experience in relation to his therapist as selfobject” (**1990**, p. **370**).

Expressive relating is a dimension of optimal responsiveness, which emphasizes the particularity of the analytic selfobject and the powerfulness of personal interaction in the flow of selfobject relating.

### **Expressive Relating is Grounded in the Empathic Stance**

According to Kohut, the empathic introspective mode of listening defines both theory and practice in a self-psychologically oriented treatment. He

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pointed out that what makes analysis unique is not the theory explaining the data but the method used to gather it (**Kohut, 1971**). For him, the capacity to think and feel oneself into the inner life of another person is the only valid means of investigation.

However, empathy is not only a tool for gathering psychological knowledge. Although he later equivocated on this point, Kohut (**1977**) asserted, in his now famous passage in *The Restoration of the Self*, that empathy is a psychological nutrient as important to psychological life as oxygen is to biological life (p. 253). He ventured into a two-person system by insisting that it is not the content of particular understandings in psychoanalysis that is curative but, rather, the experience of feeling understood by an empathically attuned other.

Expressive relating is shaped by Kohut's ideas in two ways. First, it is the patient who is the final arbiter of what is valid in the treatment. The therapist's task is not to “get the patient to see” his or her distortion of “reality.” Rather, the therapist seeks to enter the substrata of psychological life, where agreeing and disagreeing become irrelevant. Kohut (**1984**) said, “Many times when I believed that I was right and my patients were wrong, it turned out... that my rightness was superficial whereas their rightness was profound” (p. **94**).

Expressive relating is facilitative of the empathic mode of investigation. The analyst's direct use of his own experience helps to illuminate the patient's subjective world (**Fosshage, 1995**). When the analyst introduces her own thoughts and feelings into the dialogue, it is done in the spirit of invitation, as if she were saying: "Here is what rises in me as a result of our interaction. What does this evoke in you? How does it fit, or not fit, in your perceptual world?" The analyst judiciously makes her own inner life available in order to further the patient's unfolding experience.

Second, expressive relating functions within an ambience of empathic attentiveness, that is, an atmosphere in which the patient's affective experience is evoked and elaborated. Kohut (**1984**) spoke of the importance of the analyst's "freedom to respond with deeply reverberating understanding and resonant emotionality" (p. 82). This empathic resonance allows the analyst to track a patient's process. Through expressive relating, the analyst personally engages with the patient's process. While any particular expressions of the analyst's subjectivity may not "resonate" with understanding, his larger commitment to understand deeply becomes a container to hold these departures and returns to empathic listening. Expressive relating can be seen as an expansion of the repertoire of the responses that are included in an empathic mode of relating.

Expressive relating is an important ingredient in the creation of selfobject experience. However, it is critical that the therapist not only express

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herself in an authentic way, but that she also continually anchor her expressions in a careful understanding of the patient's experience of the moment. Empathic listening is the careful monitoring of an ongoing journey. It is as essential to psychotherapy as watching the road is to driving a car (Eugene Gendlin, personal communication). This kind of commitment to understanding the patient on as many levels as possible creates a growth-fostering atmosphere of nonjudgmental openness, curiosity, and acceptance.

At times, the analyst must be willing to disclose feelings or perceptions that might be upsetting for the patient to hear, but that, if left unsaid, would inhibit the spontaneous back-and-forth flow of the relationship. As one analysand put it, "Things are so dead around here when we can't say the unsayables." For example, an isolated, compliant, approval-seeking patient tentatively refers to her fear that her analyst is disappointed with her. The analyst responds after 20 minutes of halted conversation, "Yes, I think you were right. I was disappointed when you turned down the invitation to the family reunion." The patient says, "Now I feel all alone." The analyst then returns to the patient's experience and asks, "Did my moment of disappointment make you feel like I was leaving you?"

A new paradigm vision of the empathic stance is not a rigid adherence to reflecting the patient's view of things while avoiding disagreement. Rather, it is a valorization of and deep respect for the patient's inner world. It entails a commitment to nurturing the kind of trust that makes that inner world available and transformable. The analyst's willingness to disclose feelings and perceptions that are counter to that of the patient's can foster a sense of trust in the genuineness of the analyst's participation and demonstrate to the analysand his high regard for authenticity.

The success of the struggle that may result from this disclosure can depend on the empathic skills of the analyst. These skills include the ability to be empathic to oneself while seeking to

deeply understand the patient. Sucharov (1996) offers a “triadic model of psychoanalytic understanding” in which empathic listening “requires a shifting focus from the patient's subjectivity, to the therapist's subjectivity and to the constantly shifting intersubjective field in which these subjectivities take shape” (p. 6). It is also important for the analyst to be able to express herself in a personal voice rather than revert to an authoritarian position of superior access to ultimate truth.

An analytic discourse that makes use of expressive relating is mutually regulatory. Both people impact on one another, broadening and enriching their experiences of themselves in the moment. Growth occurs through the aliveness, authenticity, and intimate connectedness of this kind of

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interaction. It is a flow of risk-taking, understanding, and trust building, which brings to light more and more layers of sequestered self-experience.

In summary, expressive relating includes the following four features: the expression of the therapist's experience of the interaction, the willingness of the therapist to hold her subjective experience lightly, careful empathic listening for the impact and meanings of the therapist's expressions to the patient, and a commitment to furthering the patient's unfolding experience of the interaction.

### **Expressive Relating is Mutual and Asymmetrical**

Recent infant research and intersubjectivity theory have focused attention on mutuality in the analytic process. Stolorow and Atwood (1992) refer to a “continual flow of reciprocal mutual influence” (p. 18). Aron (1991) elaborates on the theme of reciprocity by observing that analysis is “mutual, but asymmetrical, with both patient and analyst functioning as subject and object, as co-participants, and with the analyst and patient working on the very edge of intimacy” (p. 43).

The primary relationship of mother and baby is a model of mutuality and asymmetry that has been helpful as a basis for exploring the complex workings of the analytic dyad. Analogies drawn from infant research have encouraged a shift from the “hands-off” style of analytic relating, characterized by silence and measured authoritative interpretations, to a more emotionally engaged, spontaneous, feelingful interactive style. The new analyst/mother seeks to be present and actively responsive to her patient, without burdening or distracting her from the primary task of growth and development. The emphasis of the exploration of countertransference disclosure is shifting from content (i.e., what does the analyst share?) to process, where the relevant question becomes “How does the analyst share herself while taking both mutuality and asymmetry into consideration?”

In this new model, self-disclosure is seen, not as the discrete revelation of information about the analyst previously hidden, but as a flow of interaction in which the analyst, as well as the patient, is open to sharing relevant aspects of self-experience as they emerge in the unfolding of a dyadic process. These disclosures are tentative, changing and ready to be influenced by the patient.

Hoffman (1992) asks the inevitable question, “If what the therapist does is so personally expressive, how is it any different from how anyone

might respond in an ordinary social situation?" He answers his question by saying that the difference resides in the therapeutic attitude toward the interaction and toward his own experience. He details that attitude as containing personal openness, analytic perspective on the process, curiosity about the significance of the interaction to the patient, and confidence that, with the patient's cooperation, the interpersonal event will become a useful part of elaborating the patient's relational patterns.

The asymmetry inherent in the analytic partnership does not necessarily postulate one mature, cohesive self (therapist) and another archaically organized self (patient). However, the analytic role does require that the analyst bring the more integrated aspects of her self-experience into the mutuality of the partnership. Sorting from a range of possible authentic responses, the analyst chooses that which can be most usefully presented to the patient. For example, an analyst, in his role as patient, might say to his therapist, "I feel utterly abandoned and alone right now." The same analyst might say to his patient, when similar feelings arise, "I have a kind of shut-out feeling just now." The two statements demonstrate an almost automatic role responsiveness. Both expressions are authentic, though drawn from different aspects of the well of self-experience. Each is particular to a desired outcome. The analyst, as patient, wants to experience the raw material of his previously unaccepted affect states. The analyst, as therapist, wants to make the kind of emotional connection that will enable her patient to deepen or broaden her experience of the moment and of their bond. Mutuality requires that the analyst cultivate an attitude of openness and personal sharing. The vulnerability of the patient in the asymmetry of the analytic endeavor necessitates that the analyst remain sensitive to the shifting needs of the particular patient within each interactional moment.

The question then arises: When would the personal expressions of the analyst be a hindrance, rather than a help, to the progress of treatment? Of course, there can be no "rules" of practice that would guide the analyst in deciding when to express an opinion or feeling and when to contain it. The combination of empathic attunement and trial and error, however, acts as a guide for the analyst in this regard. Just as interpretations are adapted to the patient's need at any particular moment or period of therapy, so the personal expressivity of the analyst is also adapted to the patient's needs. Much of the time, a response to the requirements of the moment are as automatic as the mother's moment-by-moment decisions regarding how she will most effectively express herself to her infant.

The question then becomes, not with which patients should we use expressive relating, but what kind or manner of expression will deepen,

broaden or lighten the moment. The patients or periods of treatment, which Slochower (1996, p. 323) speaks of as "holding," may require the articulation of aspects of the analyst's subjectivity that tend to be confirming, encouraging, and conjunctive. Those patients that she views as needing "mutuality" will, at times, call for more challenging, separate, and disjunctive expressions on the part of the analyst.

My contention here is that, often, responses given in a "personal voice" are more impactful and useable for the patient. This may be true even for some patients in a narrow mirror

transference. Consider the difference between saying: “Can you say more about that?” and saying, “I am really interested in hearing more about that.” Consider the difference between: “You must feel really proud of this” and “I am excited to hear about this.”

A patient who had recently cut down from two sessions a week to one session a week said he felt disconnected and needed the analyst to somehow address this change. The analyst said, “I’m imagining that the loss of contact might be painful for you.” The patient felt confused and dissatisfied. The therapist then said, “I miss you on Thursdays when I don’t see you.” The patient was deeply touched and could feel his own sense of loss for the first time.

### **Clinical Illustration**

Ann came to me because she desperately wanted to move forward in her life but was unable to take even the smallest step in that direction. She had become more and more isolated over the past several years and was seeing no one but her doctors and her therapist. She said she had been physically ill since puberty, with a mysterious kind of chronic fatigue syndrome. The situation was worsening since she lived off a small family inheritance, which was now running out. Her recent years had been spent researching her illness and trying valiantly to make herself well by experimenting with medication and diet.

Ann was the only child of a severely depressed and rejecting mother and an insecure, distant father. She tried not to need anything from her parents and grew up silent, numb, and isolated.

Ann and I are an easy fit in that she needs to be sought and found, and I feel confident in my willingness and ability to seek and encourage her. We are a difficult fit in that she experiences her problems as having a physical base, and I tend to minimize physical concerns and focus on the psychological.

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The crisis in our treatment about which I will present began when Ann was feeling more attractive and confident and took an important step to go out on a date with a neighbor. This turned out to be a terribly disappointing experience. After her date, Ann was lifeless and discouraged. She spoke in the next few sessions about how her illness was “devastating and debilitating” and that she was horrified to consider the possibility that she might never be able to make herself well. I listened attentively but without much response. (I thought she was probably feeling sick because of her disappointing date and some insufficiency in how we were handling this disappointment.) After a silence she said that, when her money ran out, she wouldn’t even have the energy to pack up her apartment. She would have to put her cat in his case and sit on a park bench as a homeless person. I became alarmed at this possibility. Although she had said that she felt anxious about her money running out, her way of dealing with it had been to rely on an unflappable faith that she would find a cure for her physical illness and immediately be able to earn a living. I told her that we both really wanted her to get better. But in the event that she didn’t get better—have more physical vitality—I felt we had to have a back-up plan. She said there was no back-up plan. If she didn’t recover from her illness, she was convinced there would be no way her life could continue.

I felt worried about what would become of her. I felt remiss about not helping her face the imminent challenge of being without energy or money. I feared I had colluded with her denial of the seriousness of the situation. I was aware of a jumble of feelings, including frustration and helplessness.

Ann began the next session by telling me how hopeless she had felt in the session before. She said her sickness was debilitating and that I didn't seem to understand or believe that she couldn't possibly work. She said, "Maybe if I sit on a park bench, a kind policeman will find me and take me home with him."

I said, "You seem to feel like you are more likely to get an empathic response from a stranger than from me." She fell into silence.

The next session:

*Ann: You don't understand how sick I am. If you did, you would react to words like devastating and debilitating.*

*Lynn: I really missed it, didn't I? (I could see more clearly how the selfobject bond had become disrupted by my lack of responsiveness the week before.)*

*Ann: Why don't you show that you have some feelings about this? That would help me to really feel the impact of this devastation. (She*

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*seemed to me now like a frantic child beating on my chest.)*

*Lynn: You need me to have a feeling response instead of getting practical.*

*Ann Yes.*

*Lynn: The policeman in the park might be more moved by your situation than I seemed to be.*

*Ann: Why didn't you have an emotional response to the awful things I was telling you?*

*Lynn: (I appreciated the risk of Ann's direct appeal to me, and I wanted to participate fully with her.) I think I got anxious about the real situation.*

*Ann: My family has money. Right now, it seems like there is no "real" danger of their letting me be homeless. (Perhaps she was responding to my anxiety by reassuring me, or she had gotten the real response she needed.)*

Next session:

*Ann: I don't know what is happening to our relationship—you don't respond when I've told you that is the most important thing. You must be mad at me—when you are quiet I always assume that you are hating me or that you have something to say which will be intolerable for me, like that you think that my sickness is psychosomatic or that you hate me. Since you can't say those things to me you are quiet. (I felt some combination of eureka and gulp.)*

*Lynn: Maybe we can make some room for me to say things that I fear would be difficult for you. I do feel on thin ice in making any connections between your illness and what is happening between us.*

*Ann: Well, now I am finally able to tell you my reactions to what you say. When you are silent, I feel you as hating me and contemptuous of me as my mother was in her silence. (Starts to cry.) All those terrible feelings my mother had for me were communicated by her silence. (She looks up and smiles provocatively.) I wish you would experiment with telling me, for a week, what you are thinking and feeling in every pause between us. (My heart leapt at seeing her come alive.)*

*Lynn: That would certainly be interesting. It's so much better to know my every thought and feeling rather than imagining the worst.*

*Ann: Yes, any feeling is better than not knowing. It makes me so anxious. (She buries her head and sobs.)*

*Lynn: (After a few moments) I'm sorry that my silence made you so anxious. And this anxiety is a feeling that I hate you?*

*Ann: Even if you did hate me, it would be better to hear it. It could be helpful to see how that could be worked out. I could apologize to you for whatever it was that made you hate me. I never got a chance to do that with my mother. (I thought about this for a moment, trying to reconstruct what I had felt.)*

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*Lynn: I could have bits of hate mixed in with lots of other feelings. When you said you would sit on a park bench with your cat, it was so vivid for me I felt alarmed. I think I felt a lot of mixed feelings. Like a mother watching her child playing in traffic, I felt something like—"Oh my God. I need to stop this." There was worry and love and anger and recrimination and lots of other things mixed in.*

*Ann: I'm sorry. It seems like some part of me knew I wasn't going to do that.*

*Lynn: What was that about for you?*

*Ann: I think maybe it was like threatening suicide to make you worry.*

*Lynn: Oh I get it. You felt you had to go that far to get a passionate response from me. You know, this reminds me of when you were four and threw yourself into the irrigation ditch accidentally on purpose. You so wanted a passionate response from your mother who hardly noticed and would never recognize that you were threatening to kill yourself. (Ann had related this story to me several times as a way of conveying to me how desperate her childhood had been.)*

*Ann: The only feelings my mother ever showed toward me were jealousy, contempt, and self-pity.*

*Lynn: When you threatened to kill yourself with me by painting the park bench picture of disaster, I became extremely rational and probably seemed detached because I felt anxious.*

*Ann: I don't believe you have caring feelings for me unless I see them. It's so hard to take in that you care. I've never experienced real caring before.*

## **Discussion**

One of the major themes of this complex and intricate treatment is my process of learning from Ann to relate as a subject with whom she can have a new relational experience. Ann's history and expressed need cries out for an emotionally available other—a new relatedness. Because of her deeply entrenched sense of being an outsider, unwanted and forbidden to speak, she needs a clear invitation from me to join the give and take of human intimacy. I learned to draw from the well of the "I" my own subjectivity—for the purpose of developing a new "us"—one in which Ann's particularity can be appreciated as it unfolds and develops.

Because from Ann's perspective her problems are primarily physical in nature, the effectiveness of interpretation is quite limited, and I must rely heavily on the tool of moment-to-moment interaction. Ann has led the way in this, and I have followed, sometimes reluctantly and sometimes eagerly. Ann has gained confidence, through our many cycles of rupture and repair, to pursue the interaction she needs instead of withdrawing.

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Ann's childhood and adulthood up until now have been characterized by silence, isolation, and despair. She is trying, in fits and starts, to give human relationship another chance.

The crisis that I related came when Ann experienced me as unresponsive to her after her disheartening date. Our interpretations of the situation were quite different, and I wasn't able to transcend my subjectivity enough to feel myself into hers. She escalated her outcries to me by threatening to sit on a park bench until a policeman would take her away. I tried interpreting the empathic failure and her anger at me. She continued "beating on my chest" and finally confronted me directly: "Why didn't you have an emotional response to the awful things I was telling you?" I was touched by the risk she was taking in her directness and answered her directly that I had gotten anxious about her situation.

The exchange that followed was a spiral of risk, understanding, and trust for both of us. It ended with her realization that she was trying to make me "worry" and with my understanding that she was feeling desperate to get a response, as perhaps she had when she was 4 years old and threw herself into a ditch. Ann spoke of this session as an experience of "caring," by which she meant we were both willing to struggle with our feelings in relation to each other.

Caring is the name Ann gave for what Bacal (1990) refers to as a corrective selfobject experience. "The establishment and repeated re-establishment of the selfobject relationship following disruptions associated with inevitable frustrations, strengthens the self and promotes a sense of entitlement and confident expectation of being reliably listened to and understood and that one's essential psychological needs will be met" (pp. 360-361).

## **Conclusion**

In recent years psychoanalysis has been undergoing a profound paradigm shift. What was once viewed as essentially a one-person system is increasingly being seen as a two-person system. Principles of therapeutic practice previously taken for granted, such as anonymity, abstinence, and the primacy of verbal interpretation, are being reevaluated and expanded or replaced by such two-person concepts as optimal responsiveness, mutual regulation, and intersubjectivity theory. There is a growing interest in exploring dimensions of therapeutic action. It is no longer seen as possible or desirable for the analyst to sit on the sidelines, studying the dance of the patient, calling out observations. Psychoanalysis is a partner dance in

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which the conscious and unconscious organizing beliefs, the hopes, fears, and personality structures of patient and analyst commingle, determining the direction and flow of unfolding relatedness.

I introduced the designation "expressive relating" to refer to the therapist's conscious use of her own subjectivity to facilitate this very particular kind of therapeutic interaction. Although it

is understood that both patient and analyst contribute to selfobject relating and it is in fact impossible to untangle the input made by each, this chapter has focused on the contributions of the analyst—not simply her cognitive contributions, but her personhood—her unique way of being in relation. The implicit and explicit “I” statements that the analyst makes available to the patient—her thoughts, feelings, and reactions—are among the necessary ingredients in the workings of a selfobject bond.

## References

- Aron, L. (1991), The patient's experience of the analyst's subjectivity. *Psychoanal. Dial.*, 1:29-51. [→]
- Bacal, H. (1985), Optimal responsiveness and the therapeutic process. *Progr. Self Psychol.*, Vol. 1, ed. A. Goldberg. New York: Guilford, pp. 202-206. [→]
- Bacal, H. (1990), The elements of a corrective selfobject experience. *Psychoanal. Inq.*, 3:347-372. [→]
- Bacal, H. (1995), The essence of Kohut's work and the progress of self psychology. *Psychoanal. Dial.*, 5:353-366. [→]
- Bacal, H. & Thomson, P. (1996), The psychoanalyst's selfobject needs and the effect of their frustration on the treatment: A new view of countertransference. *Basic Ideas Reconsidered: Progr. Self Psychol.*, Vol. 12. Hillsdale, NJ: The Analytic Press, pp. 17-35. [→]
- Brothers, D. (1995), *Falling Backwards: An Exploration of Trust and Self and Experience*. New York: Norton.
- Dupont, J., ed. (1988), *The Clinical Diaries of Sandor Ferenczi*. Cambridge, MA: Harvard University Press.
- Fosshage, J. L. (1995), Countertransference as the analyst's experience of the analysand: Influence of listening perspectives. *Psychoanal. Psychol.*, 12:375-391. [→]
- Fosshage, J. L. (1997), Listening/experiencing perspectives and the quest for a facilitating responsiveness. In: *Conversations in Self Psychology: Progr. Self Psychol.*, Vol. 13, ed. A. Goldberg. Hillsdale, NJ: The Analytic Press, pp. 33-55. [→]
- Hoffman, I. (1992), *Expressive Participation and Psychoanalytic Discipline*. New York: WAW Institute.

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- Kohut, H. (1971), *The Analysis of the Self*. New York: International Universities Press. [→]
- Kohut, H. (1977), *The Restoration of the Self*. New York: International Universities Press.
- Kohut, H. (1984), *How Does Analysis Cure?* ed. A. Goldberg & P. Stepansky. Chicago: University of Chicago Press. [→]
- Orange, D. M. (1995), *Emotional Understanding: Studies in Psychoanalytic Epistemology*. New York: Guilford.
- Slochower, J. (1996), Holding and the fate of the analyst's subjectivity. *Psychoanal. Dial.*, 6:323-354. [→]
- Stern, D. (1985), *The Interpersonal World of the Infant*. New York: Basic Books. [→]
- Stolorow, R. D. & Atwood, G. E. (1992), *Contexts of Being: The Intersubjective Foundations of Psychological Life*. Hillsdale, NJ: The Analytic Press.
- Stolorow, R. D., Brandchaft, B. & Atwood, G. (1987), *Psychoanalytic Treatment: An Intersubjective Approach*. Hillsdale, NJ: The Analytic Press.

- Sucharov, M. S. (1996), Listening to the empathic dance: A rediscovery of the therapist's subjectivity. Presented at the 19th Annual Conference on the Psychology of the Self. Washington, DC.
- Suttie, I. (1988), The Origins of Love and Hate. London: Free Association Books.