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THE ANALYST'S APPROACH AND THE PATIENT'S PSYCHIC GROWTH

BY WARREN S. POLAND

Psychoanalysis, which shares many functions with other therapies, is built upon its unique concern for the unconscious forces active behind a patient's symptoms and difficulties. What defines psychoanalysis is the analyst's approach as a disciplined engagement in the service of exploring those forces and their roots, an approach that is the product of curiosity working in the service of the other. As a result of the analyst's actualizing this approach, the patient comes to benefit not only from whatever specific declarative interpretations and insights have been explicitly opened, but also, importantly, from observing and taking in the unspoken underlying psychoanalytic mental processes. In this light, the patient's significant capacities for empathy, a subject often neglected, are also discussed.[1]

Keywords: Analytic approach, curiosity, naive patient fallacy, patient's empathy, service of the other.

> The basic relationship of the patient to the analyst springs from what his [the patient's] unconscious perceives of the unconscious of the doctor.
>
> —Nacht (1962, p. 207)

[1] My comments draw deeply on the vast ocean of thought generated by analysts across generations. While I will cite a few, it would be impossible to acknowledge all who have contributed to what I say. I take responsibility for my own views, but I emphatically do not suggest that my views are merely of my own creation.

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INTRODUCTION

While it shares many therapeutic aspects with other clinical approaches in the broad range of psychotherapies, and does so beneficially, psychoanalysis has central qualities that define it, that set it apart as unique. Its core concern with seeking increased self-knowledge, self-mastery, and freedom for the patient by exposing and exploring those unconscious forces that lie hidden behind manifest functioning leads analysis to use a particular approach of emotionally engaged but disciplined inquiry by the analyst. It is a process that commands the analyst's mainly silent self-analysis in the service of the patient's analytic work, a process the patient senses. As a result, psychoanalysis is defined by *how* an analyst explores, not by *what* the analyst then finds. And the patient learns that *how*.

CLINICAL ILLUSTRATION

A clinical moment:

Ms. R was a bright but severely guarded woman, one who had been raised in a family of great social privilege but who as an adult lived as if alienated from the world. For the first several years of our work together, she stayed emotionally distant as she tried to do what she believed was expected—that is, satisfy me by speaking of her current life and of her childhood, but do so in a way that hid any genuine feeling and guarded against personal engagement. She spoke to satisfy the other, not to express herself. Whenever I addressed what was actually developing between us, my invitation for her to speak openly of her experiences and feelings seemed only minimally accepted.

Yet slowly, a tiny step at a time, Ms. R began to open. She could not complain, but we gradually learned how severely harsh her childhood had been: how she not only suffered physical abuse from her mother, but how much more harrowing had been her experience of what Shengold (1989) termed *soul murder*. She was told what she felt and told what she thought. Any sign of her having a thought of her own was not only squelched but taken as forbidden rebellion. At age six she could debone a fish flawlessly, but she did not know how to play. Her childhood seemed an endless effort to survive by avoiding notice while living in the underground.

At times I commented to Ms. R about aspects of her style. For instance, when I realized how intensely observant she was despite her seeming detachment, how she seemed never to miss a trick, I mentioned a piece of film that *she* brought to *my* mind. It was the image of one little girl sitting among others in an early film by Margaret Mahler of mothers and children in a waiting room. Every time that child began to crawl, to move to explore as all the other children did, her mother picked her up and placed her back in her original spot, always forcing the child to stay still. After a while, the child stopped even trying to crawl. The film's narrator commented on the intense curiosity the child subsequently manifested. The little girl stayed still but never missed a thing, always taking in everything with her eyes.

I wondered about the usefulness of my telling the patient something so intellectual, but what I said did not seem academic to Ms. R. For her, I was helping make sense of a piece of her life, and doing so in a way that opened the possibility of connecting her style to developmental forces and experiences, even from early preverbal days.

Our work continued at the patient's cautious, glacial pace, only gradually building tentative trust. Then, other early experiences opened in a much less delicate way, indeed in a way that seemed to be exposed by a sadistic force coming from me.

One day during an otherwise ordinary session, there was a sudden loud explosion just outside my office window. Startled, Ms. R burst out, "What was that?" Calmly and in a soft voice, I answered, "What was what?"

If we were both surprised by the noise and if I was surprised to hear what I said as not what I would expect myself to say, I was then further surprised by my patient's response. What I think I had had in mind when I made my odd remark was a sense of commonality between us, the feeling that we had come so far that she and I could share being frightened, yet we two could face that threat together, even with humor. Of course, I too had been startled, but then I thought I could be reassuringly playful, my words implying "You and I can together play in the face of such shock." But that was not how Ms. R heard what I said, so I then followed *her* line of thought rather than my own.

I was surprised she had taken my joke, cruel as it might seem, as if it were a statement about reality. Naturally, I was also concerned about my

own sadism. Yet Ms. R's instant concern was as if to re-right herself after being disoriented. She wanted urgently to get clear whether in fact there had been a noise, whether in fact she had heard what she did or whether she had imagined it—this despite the fact that, without doubt, there had been a shocking noise.

What then emerged was a universe of memories from which, we learned, Ms. R's developing sense of reality had been undermined by a mother who decided for her when she was hot and when she was cold, when she was alert and when she was sleepy, when she was hungry and when she was full. It was as if she had been raised always to disown her own perceptions but to accept reality as it was defined by the other.

Looking back at it, the interchange seems to have arisen out of a confluence of the undercurrent of sadism with which the patient was raised, the characteristic guilt feelings and more deeply buried sadism of the patient herself, and the reservoir of my own personal sadism called to life in our relationship. My recognition of this, together with my unspoken acknowledgment of the meanness of my remark, led us to explore how this rapid transaction captured experiences from the earliest periods in Ms. R's life. These were times in which what Ms. R as a girl felt was never defined by how she experienced her bodily sensations, but by her conscious acceptance as true of whatever her mother had proclaimed those sensations to be. One association led to another as memories tumbled out.

In what had been years leading up to this incident, my attitude had always been one of curiosity about the implications of whatever appeared. That approach was also present here: I was of course keenly curious about my personal sources for speaking in a teasing way, as if uncaring cruelty were a fitting way to express shared vulnerability to helplessness. The specifics of what I learned of myself were not, I believe, something to burden the patient with. Nonetheless, that I shifted a bit in my stance to myself and our clinical engagement is something I believe the patient could and did infer. Indeed, I think such incidents were actually important elements that made possible the patient's growing trust in my *trying* to be honest and thus trust in our work together.

"In the service of the other" implies that priority is given to the other's need, not to one's own. It was tempting to explain to Ms. R what I

had had in mind with my comment, but it was clinically more appropriate to follow where *she* had turned in *her* understanding. If the patient moves on, I first try to follow where the patient has gone. Resistance cannot be defined as the patient's moving away from what the analyst expects to come next, from what the analyst has in mind.

This incident can illustrate some of what I wish to discuss. In the course of our earlier work, I had offered declarative interpretations of the connection between the patient's experiences and urges, my comments about the child constrained by her mother in Mahler's film an instance. Equally important, on the whole (and "on the whole" is as good as one can get), I had also tried to maintain an outlook of analytic curiosity. That included respectful openness to her—not dismissing her urges and fantasies and whatever they evoked and elicited in me as pathological, but rather valuing them as expressive and informative, using my own emotional reactions as also informative. Then, having taken what I heard and experienced as data for consideration (which does *not* mean taking my own emotional reactions as if they could be translated directly as informative about the patient), I remained curious about possible meanings.

While the content of the words I subsequently spoke resulted from that process, I believe the patient could and did observe and infer both the curiosity and work of self-taming that went into what I said. The long experience, slowly developed over our shared time together (which by now she had come to trust, at least in part), made her know I was working emotionally primarily in her service, and this allowed her to move on without having to first explore aspects of my sadism beyond whatever was transferentially cogent to her. It seemed that at least for that moment, we had done that enough so that she could maintain her own efforts at inquiry.

ORIGINS OF THE PSYCHOANALYTIC WAY OF THINKING

My premise is that what is specifically psychoanalytic in clinical work arises from the force of the analyst's curiosity tamed in the desire to utilize that curiosity primarily in the service of the patient. The analytic

point of view, the result of that combination, includes not only declarative interpretations but also the essential background interpretive attitude, with both necessary to have a truly mutative benefit for the patient.

To see where we are, let us consider how we got here. Psychoanalysis, the revolutionary route to self-knowledge, grew out of the insights of a lonely genius struggling toward insight in "splendid isolation" (Masson 1985, p. 412). Even as Freud strove toward self-analysis, at the same time, he approached patients with the very mind-set that would prove successful with himself: an insatiable curiosity that kept him listening over and over and over to what each had to say, convinced that seemingly meaningless symptoms and associations had to mean something.

Freud's genius provided the awesome power that let him grasp the importance and meaning of what he was observing, but genius alone was not enough. It was Freud's indefatigable *curiosity*, his always searching for what might be hidden behind what was manifest, that was the force driving his unrelenting explorations, that pushed him to succeed. As Freud wrote to Fliess, "I am actually not at all a man of science . . . . I am by temperament nothing but a conquistador . . . with all the curiosity, daring, and tenacity characteristic of a man of this sort" (Masson 1985, pp. 397-398). His push to mastery was driven by daringly tenacious curiosity.

It was that curiosity that preceded and made possible his many breakthroughs, whether regarding dreams, infantile sexuality, or any aspect of the power of the unconscious. Nothing was dismissed as meaningless. Everything that might arise in the mind of the person under consideration, whether himself or his patient, was valued as worthy of search.

At the same time, in his clinical work as in his self-analysis, Freud's respect for each patient's meaningfulness was manifest in his persistent search for forces at work hidden behind their mysterious difficulties. Curiosity was shaped by respect.

There is an inevitable tension built in between those two forces: curiosity to satisfy oneself and respectful regard for the needs of the other. With the luxury of retrospection, we now see that problems followed from Freud's failure, at first, to recognize the differences between self-analysis and clinical analysis. He was slow to realize the effect of his own presence and influence on patients, slower still to appreciate their in-

fluence on him. He was slow to acknowledge the role of transference, slower still to appreciate the power of countertransference. Yet ever open to new learning, bit by bit Freud's growing appreciation of those forces led him to spell out in his papers on technique the import of two person engagement, and thus the importance of neutrality, abstinence, and anonymity—not as goals, but as principles in the service of exploration.

The need to respect and accommodate to the patient's individuality in refining analytic technique had not been as immediately evident as had been the driving force of curiosity. As we now know, the tensions between one-person and two-person psychologies, between what is intrapsychic and what is interpersonal, do not yield to easy resolution. Nonetheless, it was from the marriage of *curiosity* with *respect for the other* that clinical psychoanalysis was born.

Let us consider how far we have moved from those early beginnings. More than a century has passed since Freud first excitedly wrote Fliess of his personal discovery, the oedipal nature of his own fantasies, and in that dozen decades the world has vastly changed. With it, psychoanalysis has expanded explosively, growing from the insights of a lonely genius to the turbulence of so vast and diverse a field of learning that we now name it *pluralism*.

Growth has brought its own problems. With pluralism, parochialism has ensued. That is not surprising, for the variety of analytic points of view is great—beyond the containing capacity of any individual mind. Focus of attention on any single point of view necessarily implies a turning of attention away from the multiple contrasting and even conflicting views. The result is that concepts that have contributed to the development of new schools of thought at times, unfortunately, have also brought with them loyalties that constrict allegiances to limited points of view.

At our worst or our most anxious, we become defensively dogmatic and quarrelsome. Our disputes often then attach themselves to the most outward manifestations of the structure of our analytic work, as if the mechanics of the analytic instrument are more crucial than are the underlying aims for which those mechanics exist. Frequency of sessions, use of the couch, use of a telephone or of other new media of communication, handling of the analyst's self-exposure, relative neutrality or absti-

nence—all these and endless more become areas of dispute in which underlying principles are too easily obscured by battles over rules.

I do not suggest that matters of structure and of an analyst's style are without profound implications for the analytic process. While the analytic process is undoubtedly affected by its frame, it is not the mechanical machinery of physical space and time that determine whether analyzing is going on. Those aspects matter, but the analytic work is essentially determined by the nature of the relationship of the clinical partners in their emotional psychic space, by the aims the collaborative inquiry struggles to accomplish (Poland 1992).

It is necessary to transcend partisanship. We have been enriched by detailed clinical reports of so many analysts from so many analytic schools that one observation commands recognition: successful analytic work has been reported, and reported in detail, by members of all major schools of analytic thought. These many schools have enlarged psychoanalysis—but most valuably when their contributions have been added to our common treasure. Knowledge is cumulative.

Thus, it appears valid to accept successes reported by analysts adhering to the full range of modern analytic schools. That being so, what is likely is that powerful underlying forces essential to analytic inquiry matter more than do superficial differences. What are those forces that unfold in common in all successful analyses? Can it be that some matters can be dealt with privately by a patient so long as certain essential core issues are sufficiently dealt with by the analytic couple? And, if that is so, what are these issues?

We should not be surprised that our path has led us full circle back to our basic concept, the meaningfulness of hidden forces, now applied to ourselves, analysts at work. Our theme arises from recognition that debates of technique too often have been focused on manifest aspects, not the underlying meanings behind them. Technique is the analytic approach actualized, inexorably so since unconscious forces contribute to the shaping of manifest behavior of the analyst at work.

Appreciative of Schafer's (1983) early commanding study of the analytic attitude, a broad and deep survey of multiple aspects of analytic technique, I too have thought in terms of attitude. However, reflecting on the broad range of forces underlying that term of complex inner

compromise, I came to conclude that for me the word *approach* works better. It is not that critical distinctions exist between the two words, but rather that there is a cluster of connotations each bears that accounts for my choice. Intended or not, to my ear, *attitude* has too static, too fixed a quality; it carries undertones of posture and stance. *Approach,* in contrast, feels as if it bears more of a sense of activity, of movement. It suggests attitude alive at work, sounding more close to a verb than merely a noun. It is to emphasize the *active* psychological engagement of the clinical partners, unconscious or conscious, nonverbal or verbal, that leads to my preference for the word *approach.*

The forces at hand in an analytic approach include the analyst's multiple and varied underlying motivations for practicing analysis, together with their taming—the analyst's professionalism informed by education, experience, and practice. This implies that what matters most from the analyst's side in what develops in an analysis are not simply the mechanics of manifest technique, but more likely their implications, the unspoken and also unconscious meanings that evidence the analyst's analytic approach—the mind-set, outlooks, and feelings, all of which are ways of thinking and engaging the world that the patient can and does read, even when the analyst's own mind may not be conscious of them.

THE PATIENT AND THE ANALYST'S MIND

Before proceeding further to define the analytic approach, it is first fitting to step back and address possible doubt, the question of how much difference what is in the back of the analyst's mind actually makes to the patient if left unspoken. Are not the analyst's manifest actions, what is said and done, really all that count? Is not the nature of disorder such that psychic conflict leaves the patient unable to read the analyst's mind with significant accuracy?

I think we have to answer both *yes* and *no.* Yes, it is so that psychic disorders lead the patient to find and see what he expects to see. On the other hand, no—that does not mean that this is *all* the patient can take in.

Our literature has paid so much attention to the analyst's empathy that it has tended to overlook the patient's similar reading of what lies

behind what the analyst says. One noteworthy exception appears in Hoffman's (1983) outstanding survey of attitudes about the blank screen. In the course of his incisive and extensive study primarily addressing the so-called blank screen and countertransference, he also refers to

> . . . what might be termed *the naive patient fallacy*, the notion that the patient, insofar as he is rational, takes the analyst's behavior at face value even while his own is continually scrutinized for most subtle indications of unspoken or unconscious meanings. [p. 395, italics in original]

Our relative lack of focus on the patient's perceptive skills may be little more than a reflection of how often we analysts underestimate patients' psychic strengths. In support of the patient's ability to read us, I offer two points. One may be merely anecdotal; the other, however, results from substantial study throughout our history.

First, the anecdotal. Let us consider candidly our own coffee table conversations when they touch on our personal past analytic experiences. How often we hear about quirks, foibles, and inhibitions of our prior analysts. What might once have been complaints are softened by time to a tone of sympathetic acceptance, yet we hear that one analyst could not tolerate *this* subject; another, *that*. One could not hear *this* kind of viewpoint straight on; another, *that*.

At times one hears statements that go something like "He just could not hear me if I talked about such-and-such, but we were able to get around to it another way." Or "We never really discussed such-and-such, but somehow I was able to work it through on my own."

These commonplace remarks are not to be dismissed solely as remnants of unresolved transference. Instead, it is likely that in the wish to get help, the patient adjusts to the analyst's idiosyncrasies. Indeed, how else could patients manage to succeed analytically in a world of analysts with so widely ranging and even seemingly contradictory theoretical approaches and styles? We ourselves as patients give evidence of the ways a patient is attentive to and bends to the idiosyncrasies of any specific analyst.

That brings us to the second indication of the patient's concern for the analyst's way of thinking, one more than merely anecdotal. Even as

we cherish putting things into words, our experience consistently teaches us the power of unconscious communication.

One of the most valuable lessons learned in analytic experience is that a child identifies with the unconscious conflicts of the parents. It is not what the parents explicitly battle over that has deepest impact, but it is precisely what the parents cannot and do not talk about that registers most deeply and often influences the child most. No one survives infancy successfully without learning the skill of reading between the lines as well as possible.

That is so for the vulnerable patient as it is for the vulnerable child. Wanting to understand the patient, the analyst is empathic. Is it plausible that the patient would be any *less* empathic than the analyst, considering that it is the patient's very life that is at stake in the analysis?

That the patient predominantly expresses transferential forces does not mean that other parts of the patient are not also silently at work. With the vastness of our attention to the analyst's empathy, how slight seems the attention given the patient's reading between the analyst's lines.

Just as the child must learn to navigate the language and styles and emotional fashions of the parents, so must a patient manage to navigate the inevitable preferences and constrictions of the analyst. In learning to know us, the patient manages to get done what work can be done within *our* limitations. Indeed, it is only by staying respectful of the patient's reading of the analyst's unspoken messages that an analyst can render useful the crucial task of *listening to listening* (Faimberg 1996).

THE ANALYTIC APPROACH

Let us return to the analytic approach, that product of curiosity united with and turned to the service of the analyst's respect for the introspective efforts of the patient.

The analyst's mind-set not only helps shape the atmosphere of the analytic situation, but itself becomes an essential part of the medium of the analytic work. Clinically, that the patient takes in observations of how the analyst handles conflicts that have been evoked by the patient's forces brought to life has by now become broadly accepted. As Racker

(1957) succinctly put it, "Every possible psychological constellation in the patient also exists in the analyst, and the constellation that corresponds to the patient's is brought into play in the analyst" (p. 321).

Thus, not only does the patient benefit from the content of what the analyst says focused on the specific issue of the moment, the patient also has the benefit of observing, and observing repeatedly, the analyst's way of handling conflicts, the analyst's preferred ways of delaying impulsive discharge and instead turning inner conflict into data for consideration. *The analyst's approach informs the patient how the analyst analyzes.*

The issue is complex because, while central, insight is not the only goal of an analyst at work. Indeed, there are broad clinical goals that analysts and non-analytic therapists alike share—goals such as working toward the relief of pain, toward increased patient comfort and symptom relief. Furthermore, there are important clinical functions in analysis in addition to those of psychic investigation and exploration. Thus, to be clear on what psychoanalysis can uniquely offer, we must define what marks a process as distinctively *psychoanalytic.*

From painful experience, we have learned to be both cautious and reluctant before saying that something is *not analytic.* Too often, that has been a statement too easily used as a way of defending one analytic point of view by arrogantly dismissing another. Respecting the caveat against such self-serving arrogance, we are nonetheless left with the realization that, if we cannot say that something is *not* analytic, then we are unable to say that something else *is* analytic, and *analysis* is then left meaning nothing because it is used to cover everything.

Schneider (2012) has valuably clarified that *non-analytic* and *anti-analytic* are separate categories—that non-analytic absolutely need *not* mean anti-analytic—and even that inclusions of non-analytic functions are not only valuable, but indeed are essential elements in a psychoanalytic approach. Now we face having to try to sort out what defines that which is uniquely psychoanalytic from that which is not analytic, doing so while cautiously protecting the place of the many non-analytic functions that may be simultaneously valuable and even necessary to psychoanalysis, but that do not demarcate it.

What underlies an approach as specifically psychoanalytic rather than simply broadly therapeutic is the central concern for the power and

import of unconscious forces at work. What is uniquely psychoanalytic in practice is the disciplined effort to expose, explore, and understand those forces, including, in the process, the pressures that have led to keeping those forces hidden. All this takes as its clinical goal the patient's resulting introspective capacity for self-mastery and consequent broadening of freedom of choice.

That disciplined use of the analyst's self in the clinical engagement in the service of—indeed, as mentioned above, as part of the medium for—the patient's emotionally engaged introspective exploration marks clinical analysis. The word *disciplined* necessarily includes the analyst's own private, active self-analysis as part of that clinical work—whether that self-analysis is processed consciously or unconsciously, and whether that self-analysis is made explicit or, wisely and more commonly, kept silent and implicit.

Present in all this is the struggle toward insight, toward emotional self-knowledge. We should not be surprised that insight results in an increased capacity for self-mastery, because the passion to explore grows directly out of a curiosity that is basic to human growth. It is part of one's instinct to mastery. For the analyst at work, the drive to understand and to know comes to clinical life in the service of another urge: the desire to cure, to help, to aid the other (motivations essential but not unique to psychoanalysis). I will add just a few words about each: *curiosity* and *therapeutic intent.*

The drive to know—essential to the analyst's curiosity—has, since the time of Freud, been widely studied, perhaps emphasized most by Bion. Putting that curiosity into the service of the patient, which is the analyst's psychoanalytic therapeutic intent, at times creates a conflict. This is likely what provoked Freud (1912) to offer the model of the surgeon for dealing with the need to elicit pain in the patient in the short term in the service of long-term benefit. The conflict is evident in Glover's (1927) identifying the analyst's fear of his own aggression as the source of "over-solicitousness about the patient's reactions" (p. 512).

The tension between the analyst's curiosity and wish to advance inquiry, on the one hand, and the analyst's staying sensitive to the patient, on the other hand, demands creativity on the analyst's part. This is a large part of what makes clinical work an art. Yet whatever the conflict,

the value of clinical analysis derives from channeling the analyst's personal desire to know into the service of respect for the other in the other's own right. Indeed, as in my opening illustration, it is the patient's sensing and benefiting from all that goes on that allows true emotional progress to result.

Still, even when investigation and comfort seem balanced, other derivative tensions appear, tensions that at times have led to dismissal of the importance and value of interpretation. Interpretation, putting into words significant links between transference dynamics and genetic roots, at times seems in conflict with other, non-interpretive functions.

> In helping to structure a psychoanalytic situation, the analyst provides a holding environment, an empathic ambiance, and a capacity to contain the anxieties and conflicts taken in from a patient's emotional projections. The analyst respects, listens, hears, regards, and witnesses. The analyst stands as guardian of the analytic work and protector of the patient's interests while the patient sets aside some normal waking executive mental functions. The analyst, with the assistance of private self-analysis, acts to be available to the patient as a new object for both continued and new mental development. [Poland 2002, p. 811]

All of these matter. Nonetheless, the list, while not comprehensive, goes far beyond the charge of interpretation extending conscious understanding. Often these differing pressures seem at odds.

Difficulty in integrating these differences, reinforced by reaction to authoritarian and rigidly narrow views of analysis, has led at times to an overreaction, one that devalued and dismissed interpretation. In addition, appreciation of the place of nonverbal communication has ironically been itself misused to repudiate the importance of interpretation. If insight can result without the analyst having spoken an explicit interpretation, then interpretation must not be essential for psychic change and growth.

It was for those reasons that when I first addressed this subject, I wrote of an *interpretive* rather than an *analytic* attitude:

> Decreasing attention to *explicit* interpretations has brought with it a devaluing of an *approach* that is interpretive in nature—the

> unspoken but nonetheless communicated basic attitude that privileges search for unknown and as yet undiscovered meanings. This *interpretive attitude* not only searches for ever new levels of meanings but also, crucially and profoundly, values that search. [Poland 2002, p. 812, italics in original]

A specific, manifest declarative interpretation is not only of worth, but is often essential to free up psychic forces fixed in a symptom or other frozen function. It is hard to conceive of successful psychoanalytic work in which explicit communication of declarative interpretations and implicit nonverbal communication of an interpretive analytic attitude have not both been active. While a declarative interpretation contributes significantly to a patient's introspective progress and resulting insight, it is the analyst's ever-present interpretive approach transmitted through the parallel and shared introspective experiences that is crucial to increasing the patient's self-analytic skills. The analytic approach is based on the conviction that unknown meanings lie behind manifest meanings, and that conviction is communicated as it is actualized in the analyst's engaged self-inquiry, silent though it be.

The centrality given to declarative interpretations early in analytic history is a natural consequence of our field's birth in a self-analysis. The effect was as if self-analytic insight could be transposed to the office, with the patient's analytic understanding remaining that of an uncomplicated one-person psychology. Understandable excitement over early discoveries in depth psychology, as already noted, obscured or delayed recognition of the importance of the clinical engagement. The results were narratives of content that developed without appreciation of the interactive process alive behind the growth of those narratives. And as an added result, declarative interpretations seemed the sole heart of the cure.

Only with increasing appreciation of how the transference was actualized in the clinical engagement could the interpretive stance of the analyst come into focus. Recognition of the unconscious communication of that analytic interpretive point of view is vital to the patient's not only internalizing specific insights, but also becoming much more able to generalize self-knowledge, to take personal benefit from internalizing the skill of self-analysis.

By the patient's *generalizing self-knowledge,* I refer to what seems implicit in a patient's making use of an analyst despite the analyst's at times narrowness of approach. Once internalized, insight can spread. A common example is seen in the frequency with which a patient's fear of flying is tamed without explicit analytic focus on that specific symptom. Once conflicts over helplessness are exposed and explored, the fear of flying often significantly fades. It then seems reasonable to think that some central conflicts have been mastered sufficiently for the patient to be able to extend working through on his own, whether or not it is done consciously.

Indeed, Reid and Finesinger (1952) observed such an increase of self-knowledge outside conscious attention as the effect of *a spreading factor* quality by which insight extends itself. This intrapsychic aspect of a *spreading factor* is itself evident in the good analytic situation. A successful analytic situation is one in which the patient, able to intuit and infer the self-inquiry of the analyst's mind at work, can then extend personal analytic mastery to areas not brought explicitly into the clinical conversation. Much of this processing occurs outside the patient's own conscious attention.

In the illustration of my work with Ms. R, declarative interpretations (both dynamic and genetic) had been essential to the building up of sufficient trust for her to develop increasingly her own self-analytic facility. It was her internalization of an interpretive curiosity that made possible her introspective usage of my unusual intervention in the incident described. She was thus able to turn an interchange into data profitable for introspection, indeed doing so more swiftly than had I. In psychologically important ways, the analyst is always behind the patient, always following, leading only in the manner of demonstrating how to explore, how to look.

THE APPROACH TO THE APPROACH

Before concluding, let us consider just a moment how that *how-to-look* model of analytic work gets first established. It is a method set from the start.

Someone with a difficulty and someone offering professional help come together, moving toward each other and bearing the conventional roles of patient and doctor or therapist. Analysis, however, is premised on setting aside what is conventional for what is undeniably nonconventional, aiming for exploration of what is private behind what seems public.

In entering this fresh relationship, *each* partner approaches the other as a stranger, an outsider to the other's personal universe, with *each* vulnerable by virtue of being alien to the other's inner world of meanings and expectation. This is so for the analyst as well as the patient, despite the availability for the analyst of the fall-back sense of safety of having a professional identity—too often the fantasy of the analyst's being the one of the two who knows better how to live life, a fantasy patient and analyst may even share. Just as the patient utilizes neurosis to contain vulnerability, so can the analyst use professional position, and even more often misuse analytic theory, to decrease the feeling of vulnerability that comes from being ignorant of the other's, the patient's, emotional universe.

For the work to proceed, what is essential is that, instead of imagined safety by virtue of being the one who owns the room, the analyst accepts personal ignorance, tolerating associated helplessness in dedication to working in the service of the patient. With such commitment in place, that is, with the analyst's faith in the analytic process sufficient to let the analyst tolerate not knowing, and with the patient's willingness to take enough risk so as possibly to receive help, the two can join to create their new, singular, and profitable partnership.

Valid analytic exploratory work demands true inquiry by both partners. Only that can ultimately lead to unexpected learning, to discoveries and surprises, rather than to the *quod erat demonstrandum* satisfaction of finding preordained proofs.

IN CLOSING

Psychoanalysis is only one of many therapeutic approaches designed to relieve a patient's pain, to help a patient live a less symptomatic and less constricted life, but it is a unique one. Its singularity comes from

its central appreciation for the vital significance of unconscious forces at work, with its structure shaped to facilitate the patient's use of the clinical engagement as the living medium for experiential inquiry into those forces.

The analyst's contributions to the shared task arise from a broad range of motivations, with curiosity, a crucial part of the mind's instinct to mastery, fueling the ongoing search for hidden meanings and unconscious roots. Balancing curiosity with respectfully purposeful concern for the patient is one of those areas where it is fitting to speak of the "art" of clinical work.

It is in navigating the area at the edge of darkness between the differing psychic realities of the analytic pair—and doing so for the primary purpose of the *patient's* analysis—that analytic exploration can lead to genuine insight. Yet it is not only from the manifest interchange between the analytic clinical partners that the patient becomes able to transcend symptoms and constrictions. Remarkably and momentously, beyond what is manifest in the clinical work, the patient's capacity for psychic growth is liberated and facilitated by the patient's learning how the analyst's mind works while it is also silently working psychoanalytically.

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