THE (AND THIS) ANALYST’S INTENTIONS

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In my practice of analysis, I intend to construct, co-create, and enter into a therapeutic dyadic system, and evaluate the progress. I will describe the intentions I have formed and subscribe to after 50 years of analytic practice using “I” when what I refer to is personal, and “the analyst” when what I refer to is more general.

CONSTRUCTING

As compared to what each analysand and I co-create in a particular dyad, by construct I mean intended contributions to the analytic process that I personally bring to my analytic therapy with any of my analysands. These general facilitating provisions involve my construction of the setting, my understanding and intimacy with myself, and the theory I employ to understand my analysand, myself, and the dyad we will co-create.

The Setting

Each analyst makes choices of the physical and aesthetic arrangements of office, furnishings, times for practice, times away for meetings and vacations, and range of fees that work for him or her and hopefully will allow optimal coordination with present and future analysands. The goal behind the pragmatics is to construct “arrangements that establish a frame of friendliness, consistency, reliability, and an ambience of safety” (Lichtenberg, Lachmann, & Fosshage, 1996, p. 88; see also Lichtenberg, 2005).

Self-Awareness

Analysts bring to every clinical situation as a minimum a depth of self-knowledge about personal motives and values, pat-
terns of responsiveness, and a capacity for introspection derived from their personal analysis. In addition, each clinical experience provides analysts with the opportunity both to continuously expand the range of their self-awareness and to acquire knowledge of blind spots that inevitably emerge in transference–countertransference co-creations. Stated differently, I believe analysts are essentially committed to lifelong continuous self-analysis.

**Constructing a Theory of Clinical Utility**

Each analyst brings to each clinical challenge a theory of how the mind works, how to perform the task of analysis, and what brings about positive change. Whether consciously intended or not, each analyst constructs a personal theory from which he or she derives guidance and comfort. The personal theory may closely resemble one of the formally articulated theories espoused by one of the diverse analytic schools, or be more of a hybrid sampling. The theory that an analyst employs to begin clinical work operates as a hypothesis that, if confirmed by its effectiveness, will be sustaining for that analyst. However, given the wide diversity of clinical challenges, adherents of all analytic theories have either modified their initial formulations or abandoned them in favor of another. In constructing a personal theory, each analyst balances loyalty to a founder and/or training analyst, inclinations to seek “certainty” from group affiliation or from individual experimentation, and an inclination to be conservative or innovative. Pressure to modify or reconsider has come from evaluations of clinical effectiveness and/or research, especially developmental research such as studies of affect regulation, attachment, and mentalization. Whether adhering to an existing theory or seeking or making modifications, analysts construct a theory to enable them to have a reasonable degree of confidence in their ability to recognize, explore, and alter problematic patterns.

**CO-CREATING**

To ascribe co-creating a dyadic system to an analyst’s intention may seem strange either in the past or present. In the past, the technical recommendations for an analyst to remain neutral, ab-
stinent, and anonymous were intended to restrict the analyst’s side of the interchanges to objective interpretation, at least as an ideal. The analyst’s intention was to have what emerged during the analysis be as much as possible a creation of the patient’s psychic processes, influenced as little as possible by the analyst’s conscious and unconscious, verbal and gestural, communications. For analysts who currently hold to this technical recommendation and the theory of prevention of countertransference contamination that buttresses it, “co-creating” is what analysts intend not to do.

Analysts like me who emphasize co-creating the analytic experience argue that to refer to an analyst’s intention to co-create what transpires is irrelevant. Analyst and analysand can’t not co-create the analytic experience; it is inherent in the process. The analyst’s intention is to recognize his or her explicit contribution to the co-creation and be sensitive to his or her implicit contribution, especially when problems arise. Core support for dyadic co-creation arises from infant research. Baby and mother rapidly develop a system of coordinated communication based on anticipation of cues (Beebe & Lachmann, 2002; Sander, 2008). Further small indications are the frequent observation of analysts and patients taking similar hand and postural stances, and the immediacy of affective impact (Schore, 1994). During analysis, along with their explicit communications, analyst and analysand co-create an out-of-awareness implicit level of communication that contributes to a sense of intimacy that hearkens back to early dyadic attachment experiences.

An analyst’s explicit contribution to co-created communication arises from the specialized sophisticated quality of analytic listening. A specialized mode of analytic listening has reflected the analyst’s intention since Freud’s discovery of the revelations made possible by free association. The counterpart for the analyst to the analysand’s free association is to adopt a form of hovering attention, characterized long ago by Theodore Reik as “listening with the third ear” (1951) to be open to the unexpected. While hovering describes an ideal listening attentiveness, in a clinical hour analysts can only hover for so long before their attention focuses on a specific theme, pattern, and/or emotion. The goal for some analysts is to listening without preconception,
plan, or anticipation, setting an ideal I regard as impossible to achieve. However, when guided listening is regarded as inevitable and/or desirable, the specific guide for analysts to strive for has changed many times. One view has been for analysts to strive for objectivity as an observer, limiting their subjectivity, reaction, and values as much as possible. Another view has been for analysts to use their theory, say of psychosexual development, to more sensitively recognize and interpret emerging associations of orality, anality, or oedipal configurations. Alternatively, an analyst’s theory may privilege manifestations of defense, aggression, or an enactment for prime consideration. Still another focus may privilege transference, countertransference, and/or projective identifications.

The listening stance that I have come to follow has been described as the empathic mode of perception (Lichtenberg, 1981), or empathic listening (Schwaber, 1981). Using this listening stance, I attempt to sense into the state of mind of the analysand. From the analysand’s narrative and nonverbal communication, I attempt to apprehend and, in a loose sort of way, comprehend the analysand’s themes, affects, ways of regarding his world, goals, motives, and values, and his way of regarding me. I try to stay at the edge of what he tells me intentionally, what he tells me inadvertently, and what I can sense he doesn’t want me, or him, or both of us, to know. This is the edge where shame, humiliation, embarrassment, guilt, and fear lurk and often take over. However, if I intend to maintain a persistent focal point from within the state of mind of an analysand, I cannot do so as a consequence of how the mind works. Furthermore, I would not want to restrict my focus only to the patient’s perspective and eliminate other valuable sources of information. Thus, while I privilege the empathic mode of perception, I let my mind wander over a broad terrain, including how other people in the patient’s current and past narrative have seen and reacted to him, and how I am regarding and reacting to him more “personally,” less as a “professional.” Other wanderings include shifts in concentration with the intrusion of a personal preoccupation seemingly divorced from the patient, but sometimes a useful source of clues to understanding. Still other wanderings take me into an awareness of drowsiness, or a loosely formulated “cloudy”
state of reverie, which for me is sometimes creatively productive and sometimes simply avoidant.

A product of listening that I cherish is when I am able to identify what I call the theme of the hour. Picking up themes involves intentional play with metaphors arising from the explicit and implicit narrative and gestural communication, and shifts in the associative flow. Picking up themes also involves a mind shift from listening to a patient to listening to an awareness of one of the many motivational themes that I carry “in the back of my mind” from all my learned and constructed theories of significant developmental and adult goals, conflicts, and desires. While knowing what to look for makes it easier to find, unless the search has the freshness of creative play and discovery, it becomes ritual and deadening (Hoffman, 1998).

Through empathic perception and wandering attentional focus, I intend, hopefully, to encourage analysands to join me in a co-created spirit of inquiry. I say “hopefully” because I recognize that I will often fail in my attempt. While I may want to explore, my analysand may want an immediate provision or relief. Furthermore, even a joint attempt at inquiry will often be overturned by the inevitable co-creation of states of anger, disappointment, contempt, fear, discouragement, envy, shame, pessimism, and dissociation. I intend that the creation of affective and dissociative states that restrict or limit reflection originate mainly from my patient’s problematic organizing proclivities rather than mine. Asymmetry of the origin of an affective or dissociative state does not mean one-sidedness. Turning inward to sense my contribution and participation opens opportunities for sensing more deeply into the interplay of each’s conscious or unconscious subjectivity. Consequently, failures in maintaining moments of exploration provide many of the richest opportunities for exploration of significant patterns of dysregulation. Particularly rich moments of mutual recognition emerge from the sorting out of the mutual contributions to disrupted explorations.

Alternatively, when a joint spirit of inquiry has originated co-creatively, golden opportunities for analytic exploration evolve. I have described these opportunities as moments during which analyst and analysand share an observational platform from which to recognize, examine, and discuss a memory, dream, and
event, and especially a shared experience. During these moments of joint reflective inquiry, an issue being explored can be related effectively to the context from which it originated. Additionally, one or another perspective in the present or derived from the past in the present can be both widened and interlinked through metaphor.

ENTER INTO

I intend to be a “participant observer.” How much participant and how much observer will vary from moment to moment and during different phases of an analysis. If analysis is thought of as creating a theater of the mind comparable to a play or a dream, an analyst can position himself as the audience (observer), identified with the patient in the scene (empathic participant), identified with someone else in the scene (mentalizing participant), or entering the scene (participant actor). Historically, the analyst’s “role” was defined in theory if not in practice by the restrictive criteria of neutral, objective observer and interpreter, any other activity being regarded as a parameter (Eissler, 1953). Today most analysts recognize that an enactive component is inherent in the analytic process and that both talking and being silent are actions that convey meanings beyond the content of specific exchanges. At times, I experience the immediate analytic situation as providing me with an opportunity to enter actively into lively exchanges. At other times, I experience the situation as inviting me to be a composed, silent listener allowing the analyst’s verbal and nonverbal communications to flow freely with the minimum of intrusion from me. At these times, I restrict my “comments” to nods, ums, and ahs of encouragement, or simple statements of the “I understand” or “expand a bit” variety. This role of the interested analyst absorbed in the other with temporary surrender of the self has great merit as a means of gaining awareness of the other, and great danger of being resorted to as a defensive hiding place for an analyst troubled by unwelcome countertransference reactions.

Sandler (1976), in his depiction of role responsiveness, offers a way to conceptualize the enactive pull on analysts that in
some theories is regarded as a countertransference danger, in others as a countertransference opportunity (Racker, 1968), and in others as a manifestation of projective identification. Rather than resisting the patient’s discomfiting seduction, provocation, demand, or appeal, I try to allow myself to slide into the role I sense myself being cast in, whether best friend, narcissist, brilliant, stupid, tyrant, mother, father, brother, sister, lover, boyfriend, girlfriend, victim, victimizer, rescuer, or disappoiniter. I may find it easy to fit myself into the role into which I am cast, or I may find it necessary to consciously use my imagination. I may become aware that I have taken on a role in an enactment only after having been alerted by a change in my affect, vocal tone, form of expression, and/or posture.

On the basis of clinical experience, I describe three approaches that guide my entry onto the stage of an ongoing analysis: working with models scenes, the wearing of attributions, and disciplined spontaneous engagements. I regard these approaches as guidelines for enlivening improvisation and creative use of an analyst’s self.

Models Scenes

A major goal of my listening is to discern connections and meanings of patterns communicated to me verbally and nonverbally, gesturally and imagistically. I listen loosely, that is, without intending to draw any immediate conclusion about the patient’s communication. Listening loosely, I often have a sense of explicitly or implicitly recognizing a pattern and then making metaphoric linkages that connect present context, stresses, and conflicts and the influence of the past in the present. Alternatively, when listening loosely, I often experience puzzlement, confusion, and uncertainty about a pattern being communicated, and especially about my role in the pattern. Even when I can grasp the verbal flow reasonably well, I may be drawn into and puzzled by the enactive dimension of the overall communication. Listening further on during the session or during a subsequent session within the analytic workweek may reduce my puzzlement. Not infrequently as I do the ordinary session-by-session processing, I will carry in the back of my mind a query about a pattern that
has eluded my understanding, especially one that involves me enactively. Then at an unpredictable moment in the future, a happening, movie plot, story, dream image, or interaction, usually brought by the patient but sometimes the result of my self-analysis or reverie, will provide a metaphoric link that unravels the mystery. The originator of the insight may be me or the analysand or sometimes both more or less simultaneously. The recognition may build over time or occur in a sudden “aha” experience, but working with the model scene occurs after the initial insight. Working with a model scene involves analyst and analysand both modifying, correcting, and expanding the original scene. Additionally, the modified model scene can be used as a metaphor for larger meanings and relations to other significant patterns at different stages of the analysis and the past. Analyst and analysand subsequently treat their co-creation as “property” having a joint ownership that each controls and can use for further exploration. The experience of having a jointly “owned” model scene, like memories shared by family members, creates a sense of intimacy and connection (Lichtenberg, 2005).

Wearing an Attribution

Through his paradigmatic recognition of transference during analytic treatment, Freud discovered a universal proclivity of humans to attribute more or less accurate traits, characteristics, attitudes, feelings, and intentions to other humans as well as to animals and at times inanimate objects. The analytic method is designed to encourage analysands to experience and reveal the attributions they “project” onto the analyst, while hopefully lessening the comparable inclinations of the analyst through personal analysis and introspection.

As with working with a model scene, wearing an attribution begins with an analyst’s recognition of its existence and nature. The attribution may be explicit: “You were annoyed with me yesterday” or “Are you bored, or drowsy?” or “You never answer my questions.” In addition, an analyst may assume that an attribution is implied in a communication such as a patient’s generalities about “people like his father who understand intellectually but miss people’s feelings.” The familiar assumption of an attri-
bution by analogy to an analysand’s emotional story about past or present people in his life presents a difficult decision. Is the analysand’s narrative about his overly intellectual cold father a displaced reference to how he is experiencing the analyst, and, if so, is the match uncomfortably close? Or is he experiencing the analyst as a sympathetic empathic listener to his painful experience? In the first case, the attribution is that the analyst comes through to him as intellectual and insensitive and he needs to be guarded. In the second, the experience governing the analysand’s sense of the ambience is that the analyst is empathically attuned to his distress and he feels safe.

Once an attribution is recognized and agreed on, I attempt to cast myself in the particular role of annoyed, bored, drowsy, unresponsive to questions, insensitive to feelings, and/or critical. I may easily identify the origin of the attribution in my emotion, facial expression, phrasing, and tone. If so, I will straightforwardly acknowledge the identified state and attempt to open a discussion of its embeddedness in the flow of our co-created experience. I may not be able to identify the contribution assigned to me as having taken place in our interaction, and I will ask the analysand to describe what she observed or experienced about and from me. From her description, I may be able to observe myself as she sees me and gain a view of my contribution to our interaction that I had not been aware I was communicating. Or I may be unable to perceive myself as viewed by the analysand and will then employ my imagination to conceive of the “me” in the attribution. I will try to engage the analysand in a discussion of her and me as I am perceived by her and conceived by me in the attribution, but I will switch linguistically from referencing myself in a substantive (I was . . .) to a conjectural or as if (I came across to you as . . .) mode. Regardless of whether I converse in a substantive or conjectural mode, I intend to have the analysand look at our intersubjective realm as a playful creation of virtual reality. In a shared creation of virtual reality, metaphoric links easily enable facilitating disclosures by the analyst (Renik, 1998) and explanatory revelations of the analysand’s past in the present to come to the fore. The entry of my explicit subjectivity into the analytic process combines traditional transference–countertransference interpretations and
mutual recognition of subjectivities (Benjamin, 1998). An analyst’s openness to wear and jointly explore an attribution both provides a model for an analysand and inclines the analyst to make subtle adjustments that enhance the analytic work (Lichtenberg, 2005).

Disciplined Spontaneous Engagements

At particular dramatic moments, analysts make affectively loaded utterances they did not intend consciously but that represent a latent intention. These communications seem to just pop out of the analyst’s mouth. These unexpected outbursts often occur during a heated dialogue and take the form of an immediate engagement. While analysts generally try not to be drawn into immediate engaging, I believe an analysis in which an unexpected, unplanned, spontaneous contribution of the analyst never occurred would be likely to be an empty, “technique driven” procedure. I have studied a number of spontaneous communications of my own and those of colleagues and supervisees and concluded that the communications are disciplined in that they do not break the frame of the analytic agreement and trust. They are affectively strong, less reflective, and more immediately engaging than most other communications of the analyst. In the instances I have explored, they originate when the analyst’s humanity demands that he or she can no longer be silent, restrained, and expectant. I believe spontaneous engagements are a by-product of the impossible task of analysts to simultaneously track both those communications that are explicit and those that are enactive. Despite the analyst’s ideal intention to monitor both levels, the subtle pressure of the enactive communication, especially when unrecognized, pulls analysts into roles that only become apparent after the spontaneous engagement has occurred. Rather than the failure of analytic technique or a pathogenic countertransference intrusion, I believe disciplined spontaneous engagements indicate that an analyst has allowed himself or herself the flexibility of imagination to enter roles, and the playful freedom to improvise in ways that contribute moments of unplanned affective intersubjective meeting of minds. The conscious or unconscious recognition by analysand
and/or analyst that a transgression of the usual mores of analytic discourse has occurred adds to the power and excitement of the moment (Lichtenberg, 2005).

DYADIC SYSTEMS

Analysts intend to benefit patients through an exploration conducted within a therapeutic relationship. Once established, the relationship of analyst and analysand (1) enables the process of exploration (working alliance), (2) makes a major contribution to the therapeutic process in itself (implicit relational knowing), and (3) becomes in itself a central focus for exploration (transference interpretation). In this traditional schema of interacting separate selves, primary emphasis is placed on the intention to increase the effectiveness of the patient’s self-regulation, with less importance given to the mutual regulation implicitly taking place. Rather than emphasizing the interacting of separate selves, a dyadic systems perspective brings into sharper focus the significance of analyst–analysand mutual regulation, and in particular an affective domain that emerges between them.

The dyadic systems perspective draws on observations of the field of mutual regulation and affective state that emerges between caregiver and infant, and that later emerges with varied intensity in many temporary or persisting dyads throughout life. Winnicott’s (1953) concept of transitional phenomena most closely approximates what I am describing. In the space between the child and the blanket, the child creates an emergent ambience of safety, tenderness, and a presymbolic presence of a caring other. In the space between analyst and analysand the same presymbolic potential to create an affective ambience is maintained, but the relationships are more complex and usually have gained symbolic representation. The complexity of interplay within the analyst–analysand dyad arises from constant adjustments in conversational space, relational space, and cognitive space (Lichtenberg, 2005).

Conversational space refers to how analyst and analysand deal with their verbal and gestural communication. When speaking, does each respond to cues from the other to continue, to pause, to give the other a turn, or does one tend to dominate,
to interrupt, to refuse to speak when desired to do so by the other? Is the speech meant to inform or obfuscate, to arouse and hold the interest of the other, or to repel and deaden? Is the verbal message organized to maximize the time available, or to fill the time with “noise”? Are they addressing each other in converging or diverging tones, rhythms, gestures, and formal or colloquial forms of speech?

Relational space refers to the degree to which patient and analyst open themselves to the fullest possible awareness of the humanity (subjectivity) of the other and the needs of the other for a secure attachment in the midst of a re-creation of whatever insecure attachments have to be experienced and resolved. If the needs of one, usually the patient, totally dominate relational space, the opportunity of the other to enter and share the exploratory stage is reduced, impairing the receptivity of each for the other. When a power shift in relational sharing leads to a disruption, can a balanced mutuality be restored with a gain in recognition of each’s subjectivity?

Cognitive space refers to how open analyst and patient are to recognize, identify, and reflect on the domains of explicit and implicit inner and external experiences as they unfold moment to moment in the analysis. Disturbances in cognitive space occur when either the emotional intensity (affect state) or dissociation of one or both participants obliterates the capacity for reflection and awareness of any context or perspective other than the current disruptive state. Optimal cognitive space supported by an emergent ambience of safety opens the way for metaphoric exchanges similar to those I have referred to as working with a model scene or sharing an observational platform.

EVALUATING PROGRESS

An evaluation of progress requires an understanding of how change occurs, and which changes constitute therapeutic gain. I will discuss two theories of change, one that derives from systems theory and construes progress more abstractly, and a second that derives from clinical theory and construes progress in more experience-near terms.

A dynamic, nonlinear systems theory of change: Beginning
with the initial contact, analyst and analysand organize and stabilize their particular dyadic system and the affective ambience that emerges between them. Each session introduces a new perturbation ranging in intensity; too little lessens the likelihood of progress, too much introduces the threat of chaos, the middle range being the most productive over time. As the analysis proceeds, each domain of affective ambience, conversational space, relational space, and cognitive space stabilizes, destabilizes, and restabilizes. The small increments of change that form with each restabilization are unpredictable in direction—more or less consolidating, more or less promoting resilience, more or less expanding mutual awareness, and decreasing or increasing the influence of the problematic past on the present. The rate of change of destabilization and restabilization tends to be slow in the manner commonly regarded as “working through” or associatively working over (Loewald, 1980). At some generally unpredictable moment, a tipping point is reached in this process, and a more pronounced shift in trajectory occurs. The “aha” experience of understanding a model scene, the introduction of a new area of inquiry, the shift from dissociation to affective involvement, and the recognition of a need to increase the frequency of sessions are examples of positive shifts in trajectory. Tipping points can bring the dyad too close to chaos and lead to impulsive provocations, rejections, and ill-advised decisions and symptomatic acts.

Nonlinear systems theory does not tell analysts anything they did not already know clinically. It provides a way to look at the process through different lenses. The analyst, while listening, conceptualizing, hesitating, proposing, explaining, sympathizing, objecting, losing concentration, regaining concentration, groping blindly or seeing exciting connections, is of necessity too immediately involved in the present moment (Stern, 2004) to track the continuous shifts of stabilizing, destabilizing, and restabilizing. Knowing that these shifts in the stability of the organization of the dyad are continuously happening provides a bird’s-eye view of the process and helps to account for the “more” that occurs than meets the involved observer’s “eye.”

Using a different metaphor, the dynamic systems portrayal of continuous small shifts in stability along with greater shifts in
trajectory is like looking at a painting’s underpinning in an x-ray. The artist’s shifting back and forth, omitting leads she began, emphasizing others, and making some dramatic omissions and inclusions can be recognized as a creative struggle that would not be recognizable in the finished product. I believe analyst and analysand are often struggling to maintain their confidence during long periods in which each finds it difficult to identify progress. For analysts, to have the two views I have postulated—a bird’s-eye view and an x-ray view—can be sustaining, especially during periods when the immediate results of the analyst’s explicit understanding and interventions are disappointing. To know that an implicit progressive dynamic process is probably occurring despite lack of immediate confirmation can provide much-needed encouragement to persist in the effort.

Clinical theory takes a more direct approach to evaluating progress, an approach more compatible with an analyst’s conscious intention. The primary principle is to see “what comes next” or, stated more formally, “we follow the sequence of an analyst’s interventions and analysand’s responses to them to evaluate their effect” (Lichtenberg, 2005, p. 156). For example, tracking the micro processes of a sequence in a session can facilitate recognition of movement from an unpromising stalemate to an increasingly lively exchange following receptive listening or responsive commenting. Other positive indicators are an improved dialogue, a shift in the ambience, and a further series of informative associations and revelations.

Progress can be evaluated on a broader scale by following the sequence beginning in a particular session, say at the beginning of an analytic week, and observing subsequent development of a theme in later sessions. Resilience or the capacity to self-right after the recognition and removal of an obstacle or restoration from a disruption provides a specific measure of momentary progress. A more persisting measure of progress lies in a jointly expanding awareness of self with self (introspective reflective awareness) and self with other (intersubjective awareness or mentalization). In instances in which the “other” is the analyst, analysands gain insight into who they are to the analyst and the analyst to them while analysts increase their awareness
of the same. But “joint” means something more. “Joint” refers to a process whereby the expansion of analyst’s and analysand’s knowledge of the subjectivity of the other emerges from their interplay during their clinical exchanges while the modalities of their successful interplay become a source of implicit relational knowledge.

Analytic theorists have attempted to account for the changing “peopling” of our minds using concepts such as the restructuring of internalized symbolic representations, the revising of internal working models, and the reorganizing of schemas of self with other. I prefer to describe a biphasic process. One factor is how successful I am in holding each of my analysands in my mind. The other factor is how successful I am in establishing my presence in the analysis sufficient for the analysand to sense the sustaining power of being held by me. Progress both in my holding an analysand in my mind and in an analysand’s sense of being held can be recognized in the developing positive experience of mutual safety and trust, and in the negative experience of fear of abandonment at times of loss of direct contact due to breaks in the continuity of treatment sessions. Holding an analysand in mind is a complex incremental development affecting each aspect of time. The analyst in any session reacts to the analysand in the present while adding depth of knowledge of him in the past, and creating an image of him in the future. A subtle, hard-to-evaluate indicator of progress lies in the creative image of the analysand-in-the-future based on the potential for development that reveals itself in the session-to-session interplay. This session-by-session development of a sense of the analysand’s potential parallels that of a parent, mentor, or sponsor forming a sense of the adult a child or adolescent can become. The changing image of child-in-the-future and analysand-in-the-future in the parent’s and analyst’s mind provides often unrecognized guidance to facilitating interactions. Fuller recognition by analyst and analysand of each other’s subjectivity involves not only what each is currently experiencing, but also some sense of what possible development each is moving toward.

A criterion frequently used to indicate progress in the management of conversational space is that the discourse becomes
more collaborative. That answer is tricky because what might be
evaluated as a collaborative effect of the ongoing analytic work
is context determined. Becoming more succinct is a positive in-
dicator for a patient who has been chattering away in a preoccu-
pied, discursive manner. Becoming less succinct is a positive in-
dicator for a patient who has been avoidant, withholding, overly
crude concrete, or obsessinal. Becoming freer emotionally is gener-
ally a positive indicator for many patients who are reluctant to
express anger, shame, fear, sadness, or joy, sensual arousal, af-
fection, or longing. Becoming less free emotionally, that is, more
regulated, is a positive indicator for patients easily prone to af-
flect states of rage, panic, paralyzing shame, guilt, depression or
euphoria, passion, or rapture. Only then can these patients func-
tion well in conceptual space with a return of cognitive capacity
to be reflective and open to metaphorical linkage.

A problem in evaluating the response to an intervention lies
in the camouflaging of nonacceptance in the form of compli-
ance—the "yes" being spoken and the "but" kept hidden. As ana-
lysts and analysands increase their knowledge of the other, com-
pliance can be better distinguished from an authentic "yes," the
"but" can be stated overtly, and the objection can be a valuable
contribution.

Finally, what would indicate to analysts that they are increas-
ingly able to evaluate progress and track the consequences of
their interventions? A main means to evaluate progress being
made from tracking responses to an intervention lies in the ther-
apist’s increasing skill in predicting the impact of an intervention
before it is made. The progress I am referring to is largely out of
awareness, intuitive, and implicit. It is comparable to a mother
observing her baby’s responses and learning how and when she
will elicit a smile or what rhythm of offering a spoonful of food
will be responded to with a well-timed open mouth. Analysis
progresses both when analysts are able to intuitively sense the
likely positive impact of an intervention and when they can be
free on occasion to risk an intervention outside the known safety
zone. Each analyst–analysand dyad is unique, as is the humor,
novelty, improvisation, play with metaphor, and joint spirit of
inquiry that gives analysis its animation and positive results.
REFERENCES


