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## The Myths of Free Association and the Potentials of the Analytic Relationship

Irwin Z. Hoffman

The author challenges the traditional and still prevalent view of ‘free association’, arguing that it entails three forms of denial (also formulated in terms of corresponding myths): 1) denial of the patient's free agency; 2) denial of the patient's and the analyst's interpersonal influence; and 3) denial of the patient's share of responsibility for coconstructing the analytic relationship. That responsibility includes some degree of consideration of the analyst's needs. Sometimes, the patient's good judgment to that end may be reflected in what is automatically and mistakenly reduced to a form of ‘resistance’. Attention to the patient's responsibility must be balanced against the effort to provide a uniquely safe environment for the patient's revealing of shame and anxiety-ridden feelings and attitudes. But the therapeutic action of psychoanalysis, ideally, includes the cultivation, through lived experience, of the dialectical interplay of self-expression, on the one hand, and caring relational engagement, on the other. Recognition of the patient's free agency does not preclude exploration of constraining structures laid down in the past. On the contrary, it deepens such exploration. At the same time, it opens the door to the possibility of explicit recognition, via challenge, criticism, or affirmation, of the patient's contributions to the analytic work.

I am going to present some critical thoughts on ‘free association’ and ‘evenly hovering attention’ from a relational-constructivist point of view (**Mitchell and Aron, 1999**). The orientation that is generating my critique entails a combination of ideas that many relationally oriented theorists probably share, and ideas or points of emphasis that are more my own as developed under the rubric of what I have called ‘dialectical constructivism’ (**Hoffman, 1998b**). I will not be attempting here systematically to tease apart the common relational and the more idiosyncratic dialectical-constructivist perspectives, although some of the distinctive features of the latter may become apparent.

Free association is still one of the sacred cows of the psychoanalytic tradition; it is a term one tampers with at peril of his or her psychoanalytic identity. Can you claim to be a psychoanalyst if you do not ‘believe in’ free association? Kris declares, ‘For me, the central point in psychoanalysis is the commitment to the free association method’ (**1996**, p. 7). Similarly, with respect to the defining importance of the concept, Bollas, in what he feels is a position closely following that of Freud, states, ‘Psychoanalysis can be said to be taking place if two functions are linked—the analysand's free associations and the psychoanalyst's evenly suspended attentiveness. I think of these functions as the *Freudian pair*’ (**2001**, p. **93**, original italics).

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And yet, perhaps more than any other core psychoanalytic concept, to the extent that one moves from a one-person to a two-person perspective on the patient's experience, or even to a paradigm that aims to integrate those two, or from a positivist to a critical constructivist epistemological position, free association is a notion that must be redefined, and its operational, pragmatic application as a method must be rethought.

I want to call attention to a set of three fundamental features and implications of free association that—from a relational-constructivist perspective—constitute a series of myths that I believe entail various kinds of denial. I want to identify these myths and these forms of denial, and to suggest some alternative ways of thinking about the process. Along the way, either implicitly or explicitly, I will be addressing the complementary notion of evenly hovering attention. The three forms of denial (and myth) are:

- 1) the denial of the patient's agency (i.e. the myth that the patient is not a free agent);
- 2) the denial of the patient's and the analyst's interpersonal influence (i.e. the myth that the patient and the analyst are largely unaffected by each other's interpersonal attitudes and actions); and
- 3) the denial of the patient's share of responsibility for co-constructing the analytic relationship (i.e. the myth that the patient does not share responsibility with the analyst for the quality of the analytic relationship).

Because the last incorporates each of the others and because I believe it entails the most controversial argument, more of this essay, proportionately, will be devoted to it than to the other forms of denial and myth.

### 1. The Denial of the Patient's Agency

In the interest, allegedly, of providing a more direct route to the patient's unconscious process, free association is said to entail a suspension of conscious choice and therefore of the patient's judgment. As Kris says, 'the word "free" connotes the absence of conscious direction' (1996, p. 9). Instead of *deciding* what to speak of, the patient is encouraged to say whatever 'comes to his or her mind'. The assumption is that what 'comes to mind' is *not* 'chosen' so much as it surfaces as an unbidden thought, one that ideally the patient passively witnesses and reports, like the passenger on the train looking out the window and reporting what he or she sees in Freud's (1913, p. 135) well-known analogy.

The trouble with this account is that it denies the extent to which the patient as an agent might be implicated in whatever he or she 'finds' has 'come to mind'. After all, rather than simply 'happening', like the weather, or even, perhaps, a dream, the patient's thoughts might emerge as a function of the patient's actively *thinking* them. Thinking can be a voluntary 'action' no less than moving one's arm or one's leg. At a minimum, there is a subtle interplay in the patient's experience between active agency in thinking and passive receptivity to emerging 'associations'. In addition, the account assumes that the movement of thought is linear, that only one idea is

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present in the patient's mind at any given moment. But what if that isn't true? What if, subjectively at least, the patient feels he or she has several things coming to mind *simultaneously*, several things that he or she *could* speak of, so that *only by choosing* will it be possible to speak at all? If that's the case, some judgment will be necessary in order to make that choice. If the injunction against active choosing is strong enough, patients will—in effect—be encouraged to *deny* the sense in which they have felt themselves to be participating as agents in the process. Consequently, the criteria by which they make decisions regarding what to talk about and how to talk about it are less likely to be recognized much less explored.

If the patient's agency is denied in free association, moreover, there is another important consequence. The split between the roles of patient and analyst is then exaggerated and the atmosphere becomes even more tilted in the direction of the analyst's dominance than it might have been otherwise. The patient is called upon to suspend conscious intellectual judgment, whereas the analyst is set up to be the voice of wisdom in the situation from moment to moment. I believe that is the case even if the analyst's wisdom is said to emerge from his or her *unconscious* attunement to the patient's unconscious experience (allegedly, the great achievement of the 'Freudian pair'), since the analyst still *ends up* with a claim to conscious knowledge of the truth about the patient's inner life. I think a different atmosphere emerges—one that is *more* egalitarian even though still decidedly asymmetrical—if the patient is regarded *more* as one who is exercising judgment and purposeful imagination in the process of communicating, whereas the analyst is regarded *more* as one whose interpretive contributions also have associative and unconsciously self-expressive meaning.<sup>1</sup>

I realize that promotion of the patient's collaboration in reflecting on the meaning of his or her associations and on points of possible resistance has the potential to foster some sense of the patient's agency in the process. Such a working alliance is highlighted in the approach of the ego-psychologists (e.g. **Gray, 1994; Busch, 1999**). In my view, however, that aspect of the patient's participation is not enough to offset the more than optimal dominance that falls to the analyst as a result of denial of the patient's agency and judgment in the act of free association itself.

It is important to recognize that conscious agency and unconscious processes in both analyst and patient are not dichotomous. As is well expressed in an illuminating dialogue between Altman (**2002a, 2002b**) and **Stern (2002)**, reflective agency and unformulated experience can work synergistically, with each informing and enriching the other in verbal and nonverbal actions. Altman writes, 'that although we get swept along by unconscious experience, we also seek a sense of agency in relation to these experiences. We are responsible for what develops within the analytic process

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<sup>1</sup> I have recently discussed two contemporary psychoanalytic case reports, one by Peter Fonagy and one by Joseph Newirth, in which the analyst, in my view, fails to offer the patient recognition as a responsible, collaborating agent and as a co-contributor to the process. Instead, the analyst, in both instances, systematically keeps the analyst in her place as the source of allegedly revealing associations that are the objects of the analyst's exclusive interpretive judgment and that provide the basis for his exercise of power, for his unrelenting dominance in the analytic situation (see **Fonagy et al., 2004; Hoffman, 2005**).

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even as we are carried away by it' (**2002a, p. 511**). Altman is referring here primarily to analysts, but the same surely applies just as well to patients.

The notion of 'unconscious choice' is problematic. As I've suggested elsewhere (Hoffman, **1998b**, pp. xvii-xviii), neither the language of voluntary action nor the language of mechanistic causality seems suitable to describe this aspect of human agency. Both languages must be considered *metaphoric* when applied to this realm and each omits the dimension that the other captures. Moreover, there is no escaping the element of mystery that accompanies any notion of free will to the extent that it connotes what Rank calls a 'primary

cause' (1945, pp. 44-5; see also Hoffman, 2000, pp. 828-9). Altman (2002a, 2002b) and Stern (2002) in the above-mentioned dialogue confront the aspect of that mystery as it relates to the interplay of verbal and nonverbal experience. What we choose to say and do has as its wellspring something inside us that is beyond what we can fully know. Stern tells us that

The background of a thought, the web of unexpressed and unarticulated meanings that support any explicit reflection, cannot possibly be brought into the verbal realm, because it is the very nonverbal nature of the background that makes an explicitly articulated verbal foreground possible.

(2002, p. 522)

Just as the context of verbal understanding always includes nonverbal, unformulated experience, so too the context of conscious choice always includes a sea of involuntary feelings and predilections. Let us not forget, however, that a linear, strict determinism is not any more 'satisfying' intellectually since it merely begs the question of origins. I choose to locate the 'inexplicable' in the phenomenon of human freedom since its existence seems compelling pragmatically, morally, and phenomenologically, and since much of our thinking, for all intents and purposes, clearly takes it for granted.

There is precedent for recognition of the patient's agency in the literature, although it is relatively rare and, overall, has not received the emphasis it deserves, nor have its logical implications been fully appreciated. Rank stands out as one whose thinking was very much organized around the place of the will in human experience. Mitchell (1988) wrestles with the tension between traditional Freudian determinism and the free will that is often implicit in the way the process and the goals of psychoanalysis are formulated. He reviews the work of Farber, Schafer, and Shapiro, all of whom deal with the issue more explicitly than most theorists. Mitchell emphasizes the importance of integrating the roles of given internal and external realities with the role of the individual's free will:

Both Nietzsche and Rank suggested that the processes underlying the patterns which make up a human life are more usefully compared to the creation of a work of art, and the artistic metaphor allows for a more balanced and complex vision. (p. 255)

The self is not produced by motives and causes; there is also the creative will of the individual. Clinical work which does not take this into account becomes an intellectual exercise in explanation and rationalization, rather than providing increased responsibility for one's past and present choices, choices made with clarity and deliberation as well as choices clouded by self-deception and distraction. (p. 257)

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As we will see, with respect to free association, despite his emphasis on the general importance of free will, Mitchell allied himself in certain respects with the traditional view of the role of the patient as a contributor to the analytic process, seeing his or her responsibility as significantly reduced as compared to that of the analyst.

## **2. The Denial of the Patient's and the Analyst's Interpersonal Influence**

Traditionally, free association was said to arise from within the patient with little or no real influence coming from the analyst. The couch itself, and the absence of eye contact,

allegedly increased the extent to which what came to the patient's mind was uninfluenced by the actuality of the analyst's participation.

Presumably, however, this view of the method was laid to rest a long time ago. More than half a century has passed since **Macalpine (1950)** called the analytic community to task for failing to acknowledge that the relatively silent analyst was not simply creating a space for spontaneously emerging associations that would offer a 'pure culture', as it were, of the patient's unconscious process. Instead, she said analysts had to acknowledge, to themselves and each other if not to their patients, that they were systematically depriving their patients of an object relationship, a deprivation that was designed to induce regression and, with it, affective states associated specifically with object-related frustration and loss, a powerful 'suggestion' indeed.

Macalpine spoke only of the basic structure of the ritualized setting, as it was then organized, not of the analyst's more *personal contributions*. It remained for Racker, also in the 1950s, to identify that aspect of the analyst's reactions to, and influence on, the course of the patient's associations. Racker wrote, 'We have increasingly realized that the patient *acts out through associating*' and 'We are ... giving more attention towards the roles the patient desires the analyst to accept and play, according to the imagos he represents for the patient' (**1968**, p. **56**).

There are few if any theorists who do not acknowledge this aspect of free association, what Kris calls its 'action meaning' as opposed to its 'lexical meaning' (**1996**, pp. 72-4). However, for some it is a secondary possibility, one that emerges relatively rarely, whereas for others it is a predominant feature of the process and a very important, if not the most important, feature, in terms of providing a basis for therapeutic action. The difference between the two perspectives can be seen in the weight that each gives to the flow of the patient's associations as distinct from the flow of the interaction in generating opportunities for new levels of awareness and integration. When the emphasis is on free association itself, as in the work of those with an ego-psychological perspective such as **Gray (1994)** and **Busch (1999)**, aspects of the patient's self that have been shut out in one way or another are seen as finding their way into the flow of the patient's thoughts, into the sequence of ideas that can emerge when the patient feels safe enough so that what has been alien and forbidden can be allowed into consciousness, even if in disguised form, and can be communicated, and accepted. Conversely, when the emphasis is on the interaction, multiple aspects of self are seen as distributed between the analyst and the patient. The experience of each is seen as embodying aspects of the whole of the patient's mental life. Various 'parts' of the patient's psyche are projected so that they may be more fully

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represented in the analyst's countertransference experience than in the experience of the patient. These 'parts', embodied in what Racker calls 'complementary identifications', can include aspects of the patient's self and of his or her internal object world that are 'bad' in the sense that they are 'condemned by the patient's superego, or are at odds with something in the analyst's or the culture's value system, as well as aspects that are 'good' in that they might reflect virtues corresponding, more or less, with qualities of the patient's ego-ideal. Indeed, even the patient's capacities for reflection, judgment, and insight might be projected so that it behooves the analyst to think twice before blithely accepting and unreflectively enacting the part of the voice of wisdom (Racker, **1968**, pp. **27-8**). Of course, analysts' recognition of, and reflection on, this enactment is made that much *less likely* when the splitting off of the

analytic function and its allocation to the analyst in the process is virtually institution-alized. But, in the early version of the relational paradigm that Racker advocated in the 1950s, it is primarily through interpretation of transference-countertransference enactments that the analyst can foster the patient's reintegration of those projected parts of his or her person.<sup>2</sup> The emphasis on such interaction radically transforms the meaning of 'free association' and its place in the analytic work in tandem with transforming the meaning of 'evenly hovering attention'. Racker wrote,

Free association, from this point of view, involves a *pathological process*, and must *not* be considered as a curative process. The latter consists in the reintegration of ... parts of the ego through ... interpretation. ... [T]he awareness of the fact that such communication of material on the part of the patient involves giving away a part of his personality, constitutes, I believe, one of the grounds on which many of the analysts of today interpret with much greater frequency, thus returning to the patient that which he has placed in the analyst, and which in reality pertains to him. (p. **37**, my italics)

I would regard this particular statement as something of an overcorrection on Racker's part since it does not allow for *times* when what predominates are the patient's interest in communicating and being understood and the analyst's interest in understanding, in other words, something like the unobjectionable positive transference complemented by an unobjectionable positive countertransference. A more balanced view would allow for that being the most salient feature of the interaction *at times*, while also recognizing the frequency with which the kind of projective process Racker describes becomes prominent.

Notice that it was *that* long ago, about 50 years ago, that Macalpine's and Racker's radical contributions emerged in the psychoanalytic literature. These ideas did not *begin* with contemporary relational theory, although they have certainly been picked up and further developed by the relational movement. An important advance beyond Racker has been to embrace more fully the inevitability and desirability of a flow of enactment that may *precede* explicit reflection and interpretation and that holds within it complex alloys of repetition and new experience, including, sometimes,

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<sup>2</sup> Racker's point of view developed within a Kleinian framework and undoubtedly contributed to the evolution of related concepts in that tradition such as projective identification and splitting. His ideas, however, have also been highly influential in the development of the relational paradigm (**Hoffman, 1998b**, see especially, chapter 4).

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their highly paradoxical interplay (**Ehrenberg, 1992; Ghent, 1992; Mitchell, 1993; Renik, 1993; Davies, 1996, 1999; Stern, 1997; Benjamin, 1998; Hoffman, 1998b; Pizer, 1998; Bromberg, 2001**). The constructivist view encourages a much friendlier attitude toward phases of *not knowing* multiple aspects of the meaning of *one's own* participation, alternating with, even mingled with, phases of collaborative exploration of various possibilities that are embedded in the interplay of the transference and the countertransference. A second advance, emerging primarily from the relational movement and building upon Racker's notion of complementary identification, has been the recognition of 'normal' variants of dissociation and multiplicity as they affect the interaction (e.g. **Davies, 1996; Bromberg, 2001; Mitchell, 1993; Stern, 1997**). This theoretical development has added much complexity

and sophistication to our understanding of the role of enactments in the process. I think, however, that, even before we get to such contemporary developments, it is worth noting that the resistance to relatively *early* challenges to the original concept of free association has been and continues to be formidable, and that their implications have been absorbed only slowly and inconsistently.

In this respect, I differ from **Henry Smith (2004)**, whose recent critique of free association and evenly hovering attention is related to my own, in so far as he argues that much of the difference between relational theorists and neoclassical theorists is exaggerated at least, if not downright mythical. Smith has asked rhetorically, ‘in this era is there anyone who would consider any psychological phenomenon apart from the context in which it appears?’ (**2001**, p. **497**) In fact, I believe the reports of the death of that way of thinking are greatly exaggerated.

Indeed, investment in free association as an avenue into the patient's unconscious, uncontaminated by ‘objectively’ assessed external influence, persists in remarkably pure forms. That is not to say that perspectives on free association cannot be found—even in nonrelational literature—that are more integrative of relational principles. **Smith (2001)**, in fact, brings some compelling examples of such thinking to our attention, crediting such authors as Arlow, Isakower, Gardener and Jacobs. But the suggestion, on the other hand, that there are contemporary theorists who view free association in a *noncontextual* light is hardly a matter of setting up a straw man! Kris, whose point of view Smith himself (**2004**) actually challenges quite vigorously, wrote the following in a 1996 updated edition of his text on the subject:

[S]ooner or later in most analyses the patient experiences the relationship as ‘unfair’, in the sense that the patient must reveal all but expect no return in kind and must love unrequited. Clarification and interpretation of such transference reactions will be most readily assimilated by the patient—with corresponding progress in freedom of association—if *the patient can recognize the reality of the analyst's intentions and obligations*. That is, the analyst responds only when he has something useful to say. He must not yield to the temptations of responding to love and hate *in any way* except to promote free association. (p. 26, my italics)

It is noteworthy I think that this view of free association reflects nothing of Macalpine's or Racker's viewpoints. Indeed, Kris cites neither Macalpine nor Racker even for the purpose of differing with them. Kris sees the patient's experience of deprivation as *misattuned* to ‘the *reality* of the analyst's intentions and obligations’

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whereas Macalpine would see it as reacting to the analyst's *actual intention* to deprive the patient of an object relationship. Kris considers it possible for the analyst to maintain a prescribed attentive, objective analytic attitude, regardless of what the patient may bring in the way of influence, whereas Racker would expect responses to ‘love and hate’ to be very prevalent and to create motives for action that are hardly limited to determination ‘to promote free association’.

Adherence to a view of free association as relatively uncontaminated by the influence of the analyst is not restricted to those who come out of a neoclassical or ego-psychological tradition. Consider the following formulation by Bollas, whom some have

identified with an intersubjective viewpoint (see **Gerhardt and Sweetnam, 2001**). Praising free association, he states, in a small book with that title published in 2002: '[T]he analyst is left with Freudian faith: a belief that *if one gets rid of oneself (and all of one's theories)* and surrenders to one's own emotional experiences, then eventually the patient's unconscious thought will reveal itself' (p. 37, my italics).

In the same remarkably one-person vein, fully in keeping with what **Stolorow and Atwood (1992)** refer to as 'the myth of the isolated mind', Bollas asserts,

It is not long before the analysand begins to appreciate associative thought. After all, the material used by the analyst will have come, in this respect *entirely* from the patient. The source of truth, such as it is, will have derived from the analysand's process of thought.

(**2002**, p. 54, my italics)

For Bollas, the analyst's nonintrusive presence provides a very special kind of nurturant environment that 'vigorously supports the analysand's freedom of mind and internal object relating' (**2001**, p. **95**).

This claim, however, is precisely the one with which Macalpine took issue in 1950, arguing that the standard Freudian stance did *not* merely create the conditions for spontaneous self-expression through free association, but amounted instead to a form of deprivation with powerful influence on the patient's experience. More to the point from a relational-constructivist point of view, the mistake to which both Kris's and Bollas's views lend themselves is an overly confident sense on the part of analysts that they can *know* their intentions as well as what they are accomplishing. What is denied here is, first, the fundamental and irreducible *ambiguity* of the analyst's behavior, as well as the fundamental ambiguity of the patient's communications and the consequent amenability of both to innumerable plausible interpretations (of which Macalpine's is one); and, second, the likely skewing of the analyst's understanding of him- or herself and of the patient, to a degree that *the analyst cannot readily ascertain*, in accord with cultural and subcultural influences, characterological tendencies, and the pressures of the countertransference.

### **3. The Denial of the Patient's Share of Responsibility for Co-constructing the Analytic Relationship**

#### **A subtle shift in the allocation of responsibility**

The concept of 'free association' encourages the patient to speak of whatever occurs to him or her without censorship. The aim is to reduce inhibitions of all kinds, including

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any that might derive from concern about the impact on the analyst of what is said. As I understand it, this is a major thrust of Gray's and Busch's interpretation of defense as it interferes with the free emergence of the patient's repudiated wishes and attitudes. I would submit, however, that this whole perspective is grounded in a view of the analyst as primarily a technical instrumentality rather than a person. The assumption is that analysts can effectively remove themselves from the field, that, as Bollas puts it, they can 'get rid of [themselves]'; they can cultivate a position of such detachment that not only will it be the case that their theoretical convictions will have little significant effect on their understanding, but also the patients' provocations—not to mention their more subtle ongoing contributions—

as long as they are restricted to 'words', will have little serious influence on the analyst's experience.

The more we think of the analyst to be involved as a person in a relationship, the more there is reason to modify our perspective on the patient's responsibility. I want to pause here to emphasize that giving more weight to the analyst's personal involvement does not negate the power of the analytic situation to mitigate or attenuate that involvement and therefore to reduce the analyst's narcissistic vulnerability beyond what would be possible in an ordinary social situation. We have to work hard not to caricature each other's positions. At the same time, we would do well not to overcorrect polarization by *understating* differences. Even a consistent difference in *emphasis* sustained over hundreds perhaps thousands of hours spanning many years, amounts to a huge difference in terms of the kinds of experiences that are promoted and the likely basis for therapeutic action. In fact, I would argue that a paradigm difference, associated, for example, with a difference in the underlying epistemology governing practice, amounts to neither more nor less than a systematic difference in emphasis.

Within the relational movement, in which there is greater emphasis on the analyst's personhood, the analytic work takes on the character of a struggle to build a quality of relationship that is promoting of change. That project includes, but is not limited to, promoting insight into the sources and expressions of the compulsion to repeat old patterns.

Even in a more traditional paradigm, it is not, of course, merely 'insight' that is the source of change and working through, but rather the analysis of the transference, which, in turn, as Loewald put it, entails 'chiseling away the transference distortions' (1960, p. 225). According to Loewald, what brings the new object relationship into play is largely the analyst's interpretation of the patient's distorted perceptions. In the relational paradigm, however, the analyst has to struggle more to extricate him- or herself and the patient from various forms of transference-countertransference enactment in which the analyst is a co-contributor. According to the relational analyst, it is necessary for the analyst to reflect on his or her own participation; recognize possible contributions to enactments; include reference to such contributions in the interpretive work, especially in the analysis of the transference; take an interest in the patient's conscious and unconscious plausible interpretations of those contributions; and struggle with the patient to co-construct new ways of being and relating that compete with, and ultimately supersede, the patient's compulsion to repeat old patterns of expression of needs and wishes and defenses against them.

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For the relational analyst, in addition to appreciating the role of enactments as they bear upon the patient's associations, it is fully understood that the associations themselves have meaning in the context of the analyst's participation. Nevertheless, I believe that the relational movement, for the most part, has not explicitly challenged the fundamental rule as such. It remains the case that the patient's role is to try to say whatever comes to mind, preferably without 'censorship', without the exercise of judgment, and ideally without worrying about the analyst's human vulnerability. Free association is complemented to a greater degree by a kind of free unfolding of the interaction, including transference-countertransference enactments, as forms of expression that become the objects of critical reflection and that provide avenues, eventually, for therapeutic action. But here too, no special emphasis is placed on the *patient's* responsibility for the kind of interaction that he or she promotes. Mitchell, in one of his last publications, wrote,

We ask of the analyst that he loves and hates *irresponsibly*, allowing feelings to emerge without conscious screening and concern for their implications and utility. We ask of the analyst that he loves and hates *responsibly*, allowing feelings to emerge, but *never* without also taking into account their implications for the analytic process, of which *he is the guardian*.

(2000, p. 132, my italics)

I believe this formulation of the unquestionably necessary asymmetry is too dichotomous. It is a logical implication of an increased emphasis on the analyst's personal participation in the process that we consider a subtle shift in our view of the patient's role and in our understanding of his or her responsibility. Along with recognition of the patient's agency in choosing what to speak of and how to speak of it, why *wouldn't* the patient be called upon to exercise *some* greater degree of judgment in considering the impact of his or her words and other aspects of his or her behavior on the analyst? The implicit principles governing the patient's conscious and unconscious choices as he or she contributes to the co-construction of the analytic relationship, the way that judgment is exercised, are regularly the objects of critical reflection and exploration. One hopes to establish a climate that encourages a mix of (1) habitual/ characterological, (2) regressive/underlying, and (3) imaginative/new constructions of the interaction, on the one hand, and critical reflection on the constructive process itself, on the other. Insight is embedded in a multifaceted relationship, the *whole* of which offers a complex kind of corrective experience (Hoffman, in press).

It has been increasingly understood that *the analyst* has greater responsibility than was previously believed to contribute to that quality of relationship in ways that go beyond empathic listening and interpretation. Even Loewald, in what Cooper identifies as his more radical departure from analytic tradition—after conveying a wide range of types of caring activity entailed in good *parenting*, including many modes of engagement that are psychological and physical, verbal and nonverbal—returns to the analytic situation and asserts, 'In analysis, if it is to be a process leading to structural changes, interactions of a comparable nature have to take place' (Loewald, 1960, pp. 229-30, quoted in Cooper, 1988, p. 25).

So we have come a long way in appreciating the complexity and potentials of the role of *the analyst* in making some kind of corrective experience possible, but

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we have not yet taken the additional step of allocating some greater responsibility to *the patient* for contributing to that quality of relationship. And of course the more we think of the patient literally as like the child, and the younger the imagined child is—the closer to infancy he or she gets—the less likely we are to consider the patient to be one who shares responsibility for the shape and course of the analytic relationship. The decisive factor in the background is the idea of the 'Freudian pair', the coupling of a patient who, in 'free associating', is not really a responsible agent with an analyst who, in participating with 'evenly hovering attention', is not really a person.

Although underdeveloped, there is precedent in the literature for attending to the responsibility of the patient for the quality of the analytic relationship. There is a current of literature, specifically, that recognizes the patient's therapeutic effects on the analyst. Aron's (1996, pp. 129-138) review of this 'subversive line of thought' (p. 131)—bearing on an aspect of the broader issue that concerns me of the patient's responsible agency as it affects the

process—points to the contributions of Ferenczi, Groddeck, Jung, Winnicott, and Tower. Within the interpersonal tradition, Aron refers to Thompson, Tauber, Fromm, Singer, Searles, Levenson, and Wolstein; and, within self-psychology, to Bacal and Stolorow. Commenting on the place and the gist of this perspective, Aron writes,

The line of thinking that I have traced has never received mainstream acceptance by the psychoanalytic community. It has always met with a response that acknowledges that mutuality between analyst and analysand may happen sometimes, and may be powerful when it does happen, but it should not occur too often if the analyst is well-enough analyzed to begin with. After all, the obvious argument goes, the analysis is supposed to be for the patient's benefit, rather than for the analyst's. How unethical and unprofessional it is to put the analyst's needs ahead of the patient's.

The tradition that runs from Groddeck and Ferenczi, through Fromm, Searles, Winnicott, Levenson, and Wolstein turns this argument on its head. Their legacy paradoxically suggests that the patient may well need to put the therapist's needs first at least in some respects. Unless patients can feel that they have reached their analysts, moved them, changed them, discomfited them, angered them, hurt them, healed them, known them in some profound way, they themselves may not be able to benefit from their analyses.

(1996, pp. 135-6)

Since Aron's review, other contributions to this dimension of the process have accumulated. **Slavin and Kriegman (1998)**, for example, in keeping with Aron's suggestion, propose that the analyst may have to change in order for the patient to benefit. Davies offers an especially eloquent statement of the patient's potential to affect the analyst and of the mutual holding that is sometimes necessary:

As fellow psychoanalytic travelers on this highly personal and perilous journey, patient and analyst together come to realize with some trepidation and dread that we are oftentimes dependent on each other for safe passage through these transformational straits. We must therefore negotiate in ever more effective and reliable ways how we will confront conflict and survive dangerous encounters. With each successful negotiation, the patient becomes less afraid of all that is new. However, the analyst grows safer too, and becomes able to rely upon the developing analytic skills of the patient. Here I believe the analyst becomes a more hearty explorer, willing to take greater risks, to confront more intense dangers in order to enrich and enliven the quality of the overall journey. She comes to understand via a finely

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tuned unconscious communication that the patient has been able to provide certain critical holding functions for her, and she thus becomes capable of undertaking forays into the deeper recesses of her own unknown and irrational places.

(1999, p. 204)

In challenging traditional views of free association, I am suggesting that we recognize the patient's ongoing agency in the analytic situation, which includes, but is not restricted to, the patient functioning 'as therapist to his analyst' (**Searles, 1975**). I would go further than is

usually ventured, even in the tradition of 'subversive' thinking that Aron reviews and that has continued to develop, especially in the relational literature, in considering the value sometimes of explicit recognition by the analyst of the patient's contribution to the process, recognition that might entail either appreciation or constructive criticism. And yet, in focusing on the patient's responsibility, I am still encouraging a significant shift in *emphasis*, not a wholesale dismantling of the wisdom of traditional views of the process. It is tempting, I think, to back away from the challenge of such subtle modifications and from the complexity of the issues that they reflect and to reduce what is being proposed to an extreme position that would destroy the baby with the bathwater of longstanding principles governing psychoanalytic practice.

Again, we begin with an increase in recognition of and support for the analyst's personal participation in the process. That increase does not even come close tounding the fundamental asymmetry of the analytic situation in terms of the degrees to which the analyst and the patient are continually exposing their inner lives and their personal concerns and problems. The analyst remains in a more protected position, one that, along with other factors, enhances his or her ability to activate an aspect of self [what **Schafer (1983)** refers to as the analytic 'second self' (p. 291)] that is more *consistently* capable than the analyst's ordinary social self of subordinating self-interest to attention to the experience of another person. If the analyst's narcissistic vulnerability is less in play than it might be under ordinary social circumstances, the freedom the patient has to express him-or herself becomes greater than it might be outside the analytic situation. Moreover, there is no question that it is in keeping with the purposes of psychoanalysis to hope that even the more destructive aspects of the transference will be played out within the context of the analytic relationship. Recognizing the patient's share of responsibility for the co-construction of the quality of that relationship is not intended to block that crucial aspect of the process. Nevertheless, in proportion to the sense of increase in the analyst's personal involvement, the freedom of the patient to say whatever comes to mind without *any* regard for the analyst's feelings must also be qualified. Although it is problematic to suggest any call for restraint relative to the aim of creating a safe environment for the emergence of otherwise 'unacceptable' attitudes and feelings, it must nevertheless be acknowledged that there are limits to what the analyst should be required to tolerate without objecting, limits that undoubtedly will vary depending on the analyst, or even depending on the analyst's state of mind at a particular time. Moreover, even with respect to moderate forms of transference expression, we do, after all, want to encourage critical thinking that can, in the long run, contribute to changes in the patient's ways of being and relating. The aim of the arrangement is not merely to

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mitigate the full impact of the patient's wishes and attitudes, through, in part, the asymmetry of personal exposure and vulnerability, but also to create an optimal kind of availability for a trial kind of relationship that has potential generalizability to other relationships. That optimal availability provides the patient with attenuated and yet crucial opportunities for new levels of healthy integration of multiple polarities: of self-expression and responsiveness to others; of self-interest and generosity; of being cared for and being caring; ultimately, of being loved and being loving.

In this paper, I have been linking the exercise of the patient's agency primarily with the exercise of restraint, because that is so often the target of interpretation of 'resistance'. That connection is misleading, however, in that communications that are bolder, that are openly

expressive of less 'acceptable' thoughts, and that line up more closely with what might be construed as merely 'saying what comes to mind' also reflect the patient's agency. They are choices the patient is making that may have the potential to push the process forward and that may reflect considerable creativity, wisdom, and courage. Although overtly challenging, even such communications may entail considerable restraint in that they stop short of degrees of provocation that would preclude their being put to good analytic use. Restraint and expressiveness are not mutually exclusive, of course; rather, they coexist in varying figure-ground relationships in every communication (cf. Mitchell, 2000, pp. 125- 46). In keeping with Ghent's (1992) discussion of paradox, often patients push the envelope in a way that brings both participants into a space where something needs to be negotiated and understood that is on the edge of destructive enactment, on the one hand, and of the exploration of untapped healthy potentials in the relationship, on the other. Some kind of unconscious wisdom, moreover, may sometimes be at work in the patient to bring him or her into that space with the analyst where, ultimately, something may have a better chance of being worked out (Altman, 2002b).

### Clinical illustrations

To illustrate, I will draw on three cases described in previously published work, as well as several additional vignettes. The patient I call Diane, in chapter 8 of *Ritual and spontaneity in the psychoanalytic process*, begins a session, in the waiting room, with 'I'm here for one reason and one reason only, and that is to get some Valium® [diazepam]. If you can't help me get some, I might as well leave right now' (Hoffman, 1998b, p. 209). Ken in chapter 9, at the end of his first appointment in my private office (we had been meeting at the university) that is on a high floor that can trigger the patient's phobia of heights and vertigo, says, 'I'm not falling apart, but could you please walk with me to the elevator?' Manny, introduced in chapter 10 of the book, and discussed further in a later essay (Hoffman, 2000), who was 86 years old at the time of the events reported, shows up at the door of my house on the day that I arrive home from the hospital following triple-bypass surgery. He wants to deliver a check to pay for not-yet billed sessions in the weeks immediately preceding the surgery (pp. 825-6).

Another patient, after a series of sessions in which the climate is warm and collaborative, is suddenly extremely hostile. No matter what I say, he says, contemptuously,

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'If you say so' or 'I guess you know' or 'Whatever you say, Hoffman' or 'Sure, that must be it, sir! You're the boss'. This has happened a few times previously over a period of years, but it is hardly his typical way of relating. A young woman stares at me at the end of a session insisting that I should be attuned enough to her to know what her nonverbal communication means. She is adamant about it and quite angry for the last ten minutes of the session. A half-hour later, she calls to apologize and to say that on reflection she decided that what she was demanding was unreasonable and she offers some ideas about why she got so stubborn about it. A patient of a supervisee is regularly depreciating of the therapist, systematically ignoring all the effort the therapist has made to help her and all the unmistakable ways she actually has helped her. One day at the end of a session, the patient says as she's leaving, 'You know you really are an extraordinarily good friend. You deserve a lot better than how I treat you.'

What I want to say about all of these examples is that these patients are free agents, as much as any of us are free agents whether we are in the patient role or not, and they are

responsible, for better or for worse, for their actions. The things they are doing are not merely flowing mechanically out of what comes into their minds as a result of their intrapsychic dynamics, bypassing their judgment and their capacity for choice. Patients are not *merely* displaying their ‘conditions’ or their ‘dynamics’, leaving them out there for their analysts to operate on and to ‘treat’. Rather, in the context of the influence of internal and external factors, they are choosing to act in ways that shape their relationships with their analysts in particular directions. The co-construction of those relationships is integral to the prospects for therapeutic action, and we, the analysts, are not the only people in the consulting room with the ‘expertise’ and responsibility relevant to those prospects.

The contrast with most medical services might help clarify my point. Let us say a patient needs surgery. Now, even if the patient is a surgeon him- or herself, none of his or her expertise is relevant to the actual procedure as it is carried out while the patient is under anesthetic. It is the operating surgeon who does the work. But the know-how in relationship building that patients bring with them when they *begin* therapy or analysis is continually relevant to what is accomplished in *this* kind of process. Loewald makes the point regarding allocation of responsibility in psychoanalytic work as it bears on collaboration in the ‘study’, right from the start, of the patient’s mind, a view that foreshadows our contemporary, much broader and complex sense of what ‘collaboration’ can mean:

The mental processes and structures we study in our patients are essentially the same as our own and of the same order of reality (psychic reality), as well as of the same order as the processes and structures by means of which we study them. Our traditional standard of objectivity implies that making something an object of investigation means to subject it to procedures, ultimately mental ones, which are in principle extraneous and superordinated to the processes inherent in the object. ... [P]sychoanalytic investigation ... is based on the premise that analysand and analyst are both participants and that the analysand, too, is capable of a measure of objectivity toward himself as well as toward the analyst. The analysand must, at least to some extent, have developed an ‘observing ego’ in order to get the analytic investigation off the ground.

(1970, p. 279)

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Too often, I think, we are so attentive to what the *patient* does to create difficulties and to what *we* do to overcome them, we miss the possible creative wisdom of our patients’ contributions, both, for example, in constructing various types of enactment and in helping to extricate themselves and their analysts from them. Diane, with her demand for diazepam, took herself and me deep into that space in which we seemed to be deadlocked in a hopeless power struggle, but then it was *she* who began whispering after I got on the phone and was waiting to speak to her internist, ‘This is crazy! I could do this myself’ and it was I, for better or for worse, who went through with the call (Hoffman, 1998b, p. 211). What followed was an extremely fruitful exploration of the meaning of the whole episode, including reflections on whom each of us might have represented from the patient’s past. Could not Diane be viewed as the primary architect of this entire, highly evocative, illuminating, and relationship-promoting scenario? Similarly, in requesting that I walk with him to the elevator, Ken may seem to be inviting an enactment of an illicit violation of boundaries repeating that destructive

aspect of his relationships with his parents. But at the same time he seems to be seeking something new. As I wrote regarding our 'extra-analytic' walk:

at the very moment that I transgress I am aware, implicitly, that the patient and I are also trying to construct a *non-catastrophic* transgression, a *non-incestuous, non-suicidal, non-homicidal* violation of the rules. We are trying to differentiate this illicit act, stepping out the door together, from stepping out of the 21st floor window, from being drawn into an incestuous abyss with the mother, from killing the mother, from killing the father, from being killed by the father, from the mother killing herself [as she actually did]. In these scenarios the patient may be either in the parent's or in the child's role, casting the analyst into the complementary position. (p. 234)

So there is creative wisdom in the patient's initiative, carrying potentials for corrective experience and for subsequent analytic reflection of the kind that emerges in the ensuing hour (pp. 235-8). As a third example, Manny's visit to my house becomes the occasion, subsequently, for a critical remark from me on the phone, which is followed by a very emotional exchange of emails, including his calling me a phony and my protesting the severity of his 'charges' (Hoffman, 2000, pp. 826-32). Upon the resumption of sessions, which in itself reflected a choice on Manny's part that ought not to be taken for granted, the whole sequence becomes the basis for extraordinarily rich analytic work, in which, among many other things, Manny considers his identification with his invasive mother, even as he and I also recognize how different he is from her and how much my critical response might have missed the generous and loving intent of his action (pp. 833-5). Again, so much is accomplished here that is inspired and shaped by Manny's contributions, both in the sense of expansion of analytic understanding and in the sense of growth within the analytic relationship.

The clinical implication of what I am saying is that it legitimizes a whole range of responses that must be excluded if everything the patient says or does is seen as 'determined' (in keeping with denial of the patient's agency) and if the analyst is not present enough as a real person (in keeping with denial of the analyst's and the patient's interpersonal influence) to challenge the patient to be responsive to him or her at that personal level. In the paradigm I am encouraging, it is within the realm of possibility, in the case of the patient who suddenly turns hostile, that, after the tenth

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sarcastic 'Whatever you say, doctor', and after a series of attempts to interpret and understand, the analyst might say, 'You know you're being awfully rude. I want to understand what this is about, but I don't think I deserve to be treated this way, so I wish you'd find another way to express what you are feeling. In fact, I wish you would tell me *more* about what you are feeling more directly.' When a patient who has been depreciating then expresses remorse (like the woman who apologized after a session or the woman who acknowledged that the analyst had been a good friend), it becomes reasonable for the analyst to say something like: 'You know I appreciate that. Your attacks have been kind of hard to take. It's generous of you to apologize. I do want to know how I disappoint you and don't want you to stop telling me about those feelings, but it does mean a lot to me to hear that you also appreciate the value of our relationship and what I've tried to offer'.

Bear in mind that, in the traditional paradigm (and I think that encompasses the traditional *relational* paradigm), it is rarely if ever reasonable for a patient to apologize for

such things, much less have the analyst express appreciation, since the analyst is always above 'needing' it. The apology *automatically* becomes another 'neurotic' expression of the patient's excessive worry about how the analyst feels. The reality, of course, could be the whole range of combinations of 'called-for' concern and excessive, 'neurotic' worry. My point is that it is a two-person negotiation in which each party might at various moments be *legitimately* criticized or appreciated by the other, or be self-critical or, in some measure, proud because of ways in which he or she has seemed to affect the immediate interaction and the relationship as a whole. This perspective, moreover, does not interfere in the least with exploring the meaning of the patient's experience and behavior as it reflects the influence of the past and of various internal psychological structures. On the contrary, it deepens that exploration. It does, however, discourage total *reduction* of meaning to those historically based, imprisoning factors to the point, once again, of excluding the patient's agency and responsibility and associated potential for some blame and credit for the present course of the analytic relationship.

### Conclusion

Let me say that I believe that in general we may not have that far to go in terms of what we expect of our patients. I think there is a gap here between what we *actually* expect and what we *acknowledge* we expect. In other words, in general, perhaps we take for granted the patient's ongoing intuitive sense of some of the ingredients that the relationship requires. In closing, I want to return here to my critique of the standard emphasis on denial of the possibility of responsible, relationship-cultivating 'restraint', seeing it almost always as irrational 'resistance' that requires interpretation. I am not saying that the patient, because of factors in the transference, may not often err on the side of more inhibition and constriction than is necessary. I think that is probably very common. But it is much too one-sided to say that that is the only kind of excess to consider. I think that often we are silently grateful to patients for giving us the opportunity to interpret their 'inhibitions' instead of immediately confronting us with *every* thought that occurs to them that they might be tempted to express (cf.

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Hoffman, 1998b, p. 147). If a patient is graphically elaborate and explicit about an erotic fantasy in a manner that seems clearly designed to be sexually stimulating, the analyst might question, interpret, and confront in a manner that conveys at least an implicit suggestion that the patient try to find a way to convey those thoughts that is more reflective and more in keeping with analytic purposes. Sometimes, both participants are called upon to exercise the 'art of understatement', a point I discussed (Hoffman, 1998a) in connection with a poetic illustration of that kind of artful dialogue in a case presented by Davies (1998) involving the management of erotic transference and countertransference. No one would think twice about telling a patient who was starting to undress to keep his or her clothes on. The idea that words are a completely different category of 'action', protected by the sacrosanct rule of 'free association', denies the enormous power that words have in the construction of human experience. Instead of attending so selectively to the possibility of 'resistance' whenever we notice our patients exercising restraint in what they decide to tell us, we could consider giving them credit sometimes for their artfulness in imaginatively and sensitively contributing to an optimal analytic relationship. Then we might find more opportunities to affirm our patients as responsible, social human beings rather than being so

focused on their allegedly neurotic censorship and inhibitions, which are rendered seemingly unnecessary by our own illusions of saint-like interpersonal transcendence and tolerance.

### **Translations of Summary**

#### **Die Mythen der freien Assoziation und die Potentiale der analytischen Beziehung.**

Die Autor stellt das herkömmliche und noch immer vorherrschende Verständnis der "freien Assoziation" in Frage und behauptet, dass es drei Formen der Verleugnung enthalte (die zugleich als entsprechende Mythen beschrieben werden). Es verleugnet (1) die freie Urheberschaft des Patienten, (2) die interpersonale Einflussnahme zwischen Patient und Analytiker und (3) den Anteil des Patienten an der Verantwortung für die Ko-Konstruktion der analytischen Beziehung. Diese Verantwortung umfasst einen gewissen Grad an Rücksichtnahme auf die Bedürfnisse des Analytikers. Dass der Patient diese korrekt wahrnimmt, spiegelt sich mitunter in etwas wider, das automatisch und irrtümlich auf eine Form des "Widerstandes" reduziert wird. Die Aufmerksamkeit für die Verantwortung des Patienten muss in einem ausgewogenen Verhältnis zu dem Bemühen stehen, diesem eine einzigartig sichere Umwelt zur Verfügung zu stellen, in der er seine scham- und angstgefüllten Gefühle und Einstellungen offenbaren kann. Doch die therapeutische Wirkung der Psychoanalyse umfasst idealerweise auch die durch gelebte Erfahrung erfolgende Kultivierung der dialektischen Wechselwirkung von Selbstäußerung einerseits und anteilnehmendem relationalen Engagement andererseits. Die Anerkennung der freien Urheberschaft des Patienten schließt die Erforschung der ihn einschränkenden, in seiner Vergangenheit gebildeten Strukturen nicht aus, im Gegenteil: Sie vertieft diese Exploration. Gleichzeitig öffnet sie der Möglichkeit die Tür, über Infragestellung, Kritik oder Bestätigung die Beiträge explizit anzuerkennen, die der Patient zur analytischen Arbeit leistet.

**El mito de la asociación libre y el potencial de la relación analítica.** El autor pone en discusión el punto de vista tradicional y todavía predominante sobre la 'asociación libre' considerando que esta conlleva tres formas de negación: 1) del libre albedrío del paciente; 2) de la influencia interpersonal del paciente y del analista; y 3) de la parte de responsabilidad del paciente en la co-construcción de la relación analítica. Esta responsabilidad incluye un cierto nivel de consideración de las necesidades del psicoanalista. Algunas veces el buen criterio del paciente a este respecto puede reflejarse en algo que es automáticamente reducido de manera equivocada a una forma de "resistencia". Poner el énfasis en la responsabilidad del paciente debe, naturalmente, tener como contrapartida el esfuerzo de aportar al paciente una atmósfera especialmente segura que le permita transmitir sentimientos y actitudes libres de vergüenza y ansiedad. Pero la acción terapéutica del psicoanálisis implica, idealmente, favorecer, mediante la experiencia vivida, la interacción dialéctica entre la autoexpresión, por un lado, y el cuidado del compromiso relacional, por el otro. El reconocimiento del libre albedrío del paciente no implica la exploración de figuras coercitivas

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pertencientes al pasado. Por el contrario esta exploración resulta mucho más profunda. Al mismo tiempo se abre la posibilidad de un reconocimiento explícito, a través del desafío, las críticas o las afirmaciones, de las contribuciones del paciente al trabajo analítico.

**Le mythe de l'association libre et le potentiel de la relation analytique.** L'auteur interroge la conception traditionnelle, et encore prévalente, de l'«association libre», en considérant qu'elle entraîne trois types de déni: 1) déni de la liberté d'agir (libre-arbitre) du patient, 2) déni de l'influence interpersonnelle du patient et de l'analyste, 3) déni de la part de

responsabilité du patient dans la co-construction de la relation analytique. Cette responsabilité inclut un degré de prise en compte des besoins de l'analyste. Quelques fois, la pertinence du jugement du patient à l'égard de cette finalité peut se refléter dans ce qui est automatiquement réduit, de façon erronée, en une forme de « résistance ». L'attention portée à la responsabilité du patient peut être contrebalancée par l'effort pour fournir un environnement singulièrement sécurisé, capable d'accueillir la révélation, de sa part, de ses sentiments et attitudes de honte et d'angoisse. Mais l'action thérapeutique de la psychanalyse comporte, idéalement, l'entretien, à travers l'expérience vécue, de l'interaction dialectique entre l'expression de soi, d'un côté, et le soin de l'engagement relationnel, de l'autre. La reconnaissance de la liberté d'agir du patient n'exclue pas l'exploration de structures contraignantes dictées par le passé. Au contraire, elle approfondit une telle exploration. En même temps, elle ouvre la voie à la possibilité de reconnaissance explicite des contributions du patient au travail analytique, à travers ses interpellations, ses critiques, ou ses affirmations.

**Il mito delle libere associazioni e le potenzialità del rapporto analitico.** L'autore mette in questione il punto di vista tradizionale e tuttora predominante sulle libere associazioni, sostenendo che comporta tre forme di diniego: 1) del libero arbitrio del paziente; 2) dell'influenza reciproca nel rapporto fra paziente e analista; 3) della parte di responsabilità del paziente nel costruire il rapporto analitico. Tale responsabilità comprende un certo livello di considerazione per i bisogni dell'analista. Talvolta la comprensione del paziente di tali bisogni si può riflettere in ciò che viene automaticamente e erroneamente ridotto a una forma di 'resistenza'. L'enfasi sulla responsabilità del paziente deve naturalmente essere controbilanciata dal tentativo di fornire al paziente un ambiente particolarmente sicuro che gli permetta di rivelare sentimenti e assetti interni densi di angoscia e di vergogna. Tuttavia per una vera azione terapeutica della psicoanalisi, è necessario coltivare, direttamente nell'esperienza analitica, un rapporto dialettico fra l'espressione di sé e un relazionarsi maturo e responsabile. Il riconoscimento del libero arbitrio del paziente non preclude l'esplorazione di strutture coercitive appartenenti al passato. Anzi, questa esplorazione ne risulta approfondita. Al tempo stesso, si apre la possibilità di un riconoscimento, attraverso sfide, critiche o affermazioni, dei contributi del paziente al lavoro analitico.

## References

- Altman N (2002a). Where is the action in the 'talking cure'? *Contemp. Psychoanal.* 38: 499-513. [\[→\]](#)
- Altman N (2002b). Reply to Stern. *Contemp. Psychoanal.* 38: 527-9. [\[→\]](#)
- Aron L (1996). *A meeting of minds: Mutuality in psychoanalysis*. Hillsdale, NJ: Analytic Press. 292 p. [\[→\]](#)
- Benjamin J (1998). *Shadow of the other: Intersubjectivity and gender in psychoanalysis*. New Haven, CT: Yale UP. 128 p.
- Bollas C (2001). Freudian intersubjectivity: Commentary on paper by Julie Gerhardt and Annie Sweetnam. *Psychoanal. Dial.* 11: 93-106. [\[→\]](#)
- Bollas C (2002). *Free association*. Cambridge, UK: Icon. 80 p.
- Bromberg PM (2001). *Standing in the spaces: Clinical process, trauma, and dissociation*. Hillsdale, NJ: Analytic Press. 376 p. [\[→\]](#)
- Busch F (1999). *Rethinking clinical technique*. Northvale, NJ: Aronson. 218 p.
- Cooper A (1988). Our changing views of the therapeutic action of psychoanalysis: Comparing Strachey and Loewald. *Psychoanal. Q.* 57: 15-27. [\[→\]](#)
- Davies JM (1996). Linking the 'pre-analytic' with the postclassical: Integration, dissociation, and the multiplicity of unconscious process. *Contemp. Psychoanal.* 32: 553-76. [\[→\]](#)

Davies JM (1998). Between the disclosure and foreclosure of erotic transference-countertransference: Can psychoanalysis find a place for adult sexuality? *Psychoanal. Dial.* 8: 747-66. [↗](#)

Davies JM (1999). Getting cold feet, defining 'safe-enough' borders: Dissociation, multiplicity, and integration in the analyst's experience. *Psychoanal. Q.* 68: 184-208. [↗](#)

- 60 -

Ehrenberg DB (1992). *The intimate edge. Extending the reach of psychoanalytic interaction.* New York, NY: Norton. 210 p. [↗](#)

Fonagy P, Denis P, Hoffman IZ (2004). Miss A [with commentaries]. *Int. J. Psycho-Anal.* 85: 807-22. [↗](#)

Freud S (1913). On beginning the treatment. *SE* 12, p. 121-44. [↗](#)

Gerhardt J, Sweetnam A (2001). The intersubjective turn in psychoanalysis: A comparison of contemporary theorists—Part 2: Christopher Bollas. *Psychoanal. Dial.* 11: 43-92. [↗](#)

Ghent E (1992). Paradox and process. *Psychoanal. Dial.* 2: 135-59. [↗](#)

Gray P (1994). *The ego and analysis of defense.* Northvale, NJ: Aronson. 254 p.

Hoffman IZ (1998a). Poetic transformations of erotic experience. Commentary on paper by Jody Messler Davies. *Psychoanal. Dial.* 8: 791-804. [↗](#)

Hoffman IZ (1998b). *Ritual and spontaneity in the psychoanalytic process: A dialectical-constructivist view.* Hillsdale, NJ: Analytic Press. 310 p. [↗](#)

Hoffman IZ (2000). At death's door: Therapists and patients as agents. *Psychoanal. Dial.* 10: 823-46. [↗](#)

Hoffman IZ (2005). Standard psychoanalytic dominance and creation of interludes of equalization of power in the psychoanalytic situation: A discussion of case presentation by Joseph Newirth. *Psychoanal. Inq.* 25: 328-41. [↗](#)

Hoffman IZ (in press). Forging difference out of similarity: The multiplicity of corrective experience. *Psychoanal. Q.* [↗](#)

Kris AO (1996). *Free association: Method and process.* Hillsdale, NJ: The Analytic Press. 144 p. [↗](#)

Loewald H (1960). On the therapeutic action of psychoanalysis. In: *Papers on psychoanalysis*, p. 221-56. New Haven, CT: Yale UP, 1980. 434 p. [↗](#)

Loewald H (1970). Psychoanalytic theory and the psychoanalytic process. In: *Papers on psychoanalysis*, p. 277-301. New Haven, CT: Yale UP, 1980. 434 p. [↗](#)

Macalpine I (1950). The development of the transference. *Psychoanal. Q.* 19: 501-39. [↗](#)

Mitchell SA (1988). *Relational concepts in psychoanalysis. An integration.* Cambridge, MA: Harvard UP. 340 p.

Mitchell SA (1993). *Hope and dread in psychoanalysis.* New York, NY: Basic Books. 285 p.

Mitchell SA (2000). *Relationality: From attachment to intersubjectivity.* Hillsdale, NJ: Analytic Press. 173 p. [↗](#)

Mitchell SA, Aron L, editors (1999). *Relational psychoanalysis: The emergence of a tradition.* Hillsdale, NJ: Analytic Press. 496 p.

Pizer S (1998). *Building bridges: The negotiation of paradox in psychoanalysis.* Hillsdale, NJ: Analytic Press. 248 p. [↗](#)

Racker H (1968). *Transference and countertransference.* New York, NY: International UP. 203 p. [↗](#)

Rank O (1945). *Will therapy and truth and reality*, Taft J, translator. New York, NY: Knopf. 305 p.

- Renik O (1993). Analytic interaction: Conceptualizing technique in light of the analyst's irreducible subjectivity. *Psychoanal. Q.* 62: 553-71. [↗](#)
- Schafer R (1983). *The analytic attitude*. New York, NY: Basic Books. 316 p. [↗](#)
- Searles HF (1975). The patient as therapist to his analyst. In: Giovacchini PL, editor. *Tactics and techniques in psychoanalytic therapy, Vol. II: Countertransferences*, p. 95-151. New York, NY: Aronson.
- Slavin MO, Kriegman D (1998). Why the analyst needs to change: Toward a theory of conflict, negotiation, and mutual influence in the therapeutic process. *Psychoanal. Dial.* 8: 247-84. [↗](#)
- Smith HF (2001). Obstacles to integration: Another look at why we talk past each other. *Psychoanal. Psychol.* 18: 485-514. [↗](#)
- Smith HF (2004). The analyst's fantasy of the ideal patient. *Psychoanal. Q.* 73: 627-58. [↗](#)
- Stern DB (1997). *Unformulated experience: From dissociation to imagination in psychoanalysis*. Hillsdale, NJ: Analytic Press. 293 p. [↗](#)
- Stern DB (2002). Language and the nonverbal as a unity: Discussion of 'Where is the action in the "talking cure"?' *Contemp. Psychoanal.* 38: 515-26. [↗](#)
- Stolorow R, Atwood G (1992). *Contexts of being: The intersubjective foundations of psychological life*. Hillsdale, NJ: Analytic Press. 160 p.

- 61 -

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