Chapter 7

Understanding and Relational Engagement in the Analytic Process

We contend that all show involves tell, and all tell involves show. Words and actions, remembering and repeating, association and enactment, interpretation and non-interpretive interventions are all transformations of each other. They all contain and rely upon one another, and should be thought of dialectically rather than dichotomously. (Lewis Aron, 2013)

The relational model, in the broad, historical sense that Greenberg and Mitchell (1983) had in mind when they first introduced the term, has brought with it an increasing appreciation, and theoretical embrace, of the relational factors involved in the psychoanalytic process. Every major “relational model” theorist has introduced new ways of thinking about these relational factors, which grow out of the theorist’s total paradigm that includes the nature of mind, development, psychopathology, the analytic process, and therapeutic action. Most of these theorists have been careful not to say or imply that relational engagement means abandoning the emphasis Freud placed on understanding as a central objective and curative mechanism of psychoanalytic treatment.¹ Winnicott (1969/1971), for example, in the introduction to his paper on “The Use of an Object,” famously wrote:

…it is only in recent years that I have become able to wait and wait for the natural evolution of the transference arising out of the patient’s growing trust in the psychoanalytic technique and setting, and to avoid breaking up this natural process by making interpretations. It will be noticed that I am talking about the making of interpretations and not about interpretations as such. It appals me to think how much deep change I have prevented or delayed in patients in a certain
classification category by my personal need to interpret. If only we can wait, the patient arrives at understanding creatively and with immense joy, and I now enjoy this joy more that I used to enjoy the sense of having been clever. (1971, p. 86; italics and misspelling of “appalls” in the original!)

In other words, the central importance of understanding and interpretation is not being eschewed; it is being re-situated within a larger relational context defined, in Winnicott’s case, by such factors as the creation of a holding environment, non-impingement, the winning of trust, an implicit expectation regarding the patient’s self-analytic motivations and capacities, the analyst’s own sense of joy and aliveness in the process, and, in general, the establishment of relational conditions conducive to the emergence of understanding and self-understanding as an aspect of analytic growth.

As in so many areas of analytic discourse, Winnicott’s thinking here opened a “potential space” in both clinical theory and analytic practice—a potential space that made possible the (r)evolution that became relational psychoanalysis. In his deceptively personal, homespun prose, Winnicott introduced an expansion of the nature and role of psychoanalytic understanding to include understanding of the relational conditions—i.e., the kinds of relational engagement, environment, and atmosphere—thought necessary for the emergence of understanding, and ultimately, for the patient’s psychological growth.

This shift frees the analyst’s efforts to understand from the classical straightjacket within which verbal interpretation was the sole, or at least privileged, vehicle for expressing that understanding. Rather, a new space has opened up wherein the analyst’s understanding
may tell her that what could be most helpful for a given patient at a given point in
treatment is some non-verbal relational response that better meets the patient’s need of
the moment, or better serves the creation of an analytic process that is optimally
facilitative of the patient’s overall growth process. In short, in this new analytic potential
space, theoretically-informed relational engagement is thought to reflect, not forsake,
understanding (both general and case-specific) and is thought to be an essential factor
contributing to a patient’s experience of “feeling understood.”

Yet, with the progression of relational theory from its mid-century pioneers
(Balint, Fairbairn, Winnicott, Sullivan, Bion, Kohut, Loewald, Racker, Searles) to the
profusion of relational, intersubjective, constructivist, and hermeneutic perspectives that
have emerged during the past three decades, the theorized relationship between
understanding and relational engagement has become increasingly complex and murky.
In the present chapter I sort through some of this complexity as background for
articulating my own current integration of these two co-occurring, interpenetrating
dimensions of analytic interaction. The essence of my position is stated in Principle 3 of
the meta-theory of needed relationships (see Introduction):

Progressive fittedness involves progressive understanding, progressive shaping of
the ways we learn to listen, process, and speak with each patient, and progressive
fittedness in the forms and qualities of relational engagement that emerge in each
treatment. Understanding (“truth”) and relational engagement are viewed as
inseparable and as operating synergistically. In Sander’s (2008) language,
achieving progressive fittedness in the service of either a child’s or patient’s psychological growth requires both specificity of recognition and specificity of connection.

As the opening quote from Aron (2013) indicates, I am not alone in thinking about the analytic process in this way. Undoubtedly, many relational analysts and therapists now adopt some version of this holistic view of analytic engagement. But it is far from universally accepted. Different theorists, and schools of analytic thought, still privilege one side of the dialectic over the other. Thus it is useful to look at the evolution of relational thinking about these issues in order better to understand the diversity and murkiness that still prevails.

Because of the length of this chapter, necessitated by the scope of the topic and its centrality as an issue in much contemporary relational analytic theorizing, I will briefly outline the sequence of sub-topics (sections) here and summarize the major points of the chapter in its concluding section.

(1) I begin by examining some of the major relational formulations regarding the relationship between understanding and relational engagement in therapeutic action and transformation. Major theorists covered include Kohut, Mitchell, Weiss and Sampson, Stolorow, contemporary Bionian authors, Ehrenberg, Hoffman, Aron, and Harris.

(2) I examine in depth the recent trend in analytic theory, influenced by mother-infant research, neuroscience and cognitive psychology, privileging the role of “implicit” (un-symbolized, non-verbal) relational processes over “explicit,” interpretive
communications in therapeutic action (D.N. Stern et al, 1998). Using a clinical vignette, I argue that the issues here are more complex than this literature has recognized, and that a more holistic view is called for. Among authors extrapolating from mother-infant research to adult treatment, I find Sander’s thinking the most holistic.

(3) I present my own synthesis, illustrated by an “ordinary” clinical example.

**A Selective Historical Review and Analysis**

**Kohut**

Taking Kohut as a somewhat arbitrary starting point, his struggle with this tension seems emblematic of the murkiness that the late-mid-century relational models introduced. Initially, Kohut (1959) viewed his formulation of the empathic-introspective listening stance as an advance in the data-gathering, observational capacities of the analyst. In a revolutionary, paradigm changing move, he recognized that a consistent focus on seeking to understand the patient’s subjective experience from the patient’s perspective (as opposed to seeking to discern more “experience distant” dynamics described in psychoanalytic theories and meta-theories) was both a better route to the kind of understanding that was most relevant to psychoanalysts, and, because of the positive effects on the patient of feeling understood in this way, a method more likely to prompt the patient to reveal the most emotionally significant, analytically relevant “data.” This aspect of Kohut’s new formulations could be seen as mainly an advance in the analyst’s capacities to understand. Indeed, wanting to be seen as still doing psychoanalysis, Kohut (1971, 1977, 1984) repeatedly insisted that the self-psychological
analyst’s job was not to gratify or meet patients’ selfobject needs but to empathically understand and validate them. However, in his last formulations of the issue (Kohut, 1982, 1984), dramatized famously in his (1982) clinical vignette in which he allowed a regressed patient on the couch to hold two of his fingers, he acknowledged that the analyst’s empathic responsiveness was also a form of relational engagement with the properties of a corrective emotional experience. In some of his final words on the topic, Kohut (1984) wrote that one of the cumulative yields of a successful self-psychological analysis was the patient’s “increasing realization that, contrary to his experiences in childhood, the sustaining echo of empathic resonance is indeed available in this world” (p. ). One can sense Kohut struggling with the conundrum of understanding and engagement, never quite reaching a clear conclusion about it.

It should be said, however, that although Kohut struggled with the question of what the analyst did and should do to promote the “restoration of the self” (Kohut, 1977), he recognized that on the patient’s side of things, far more was going on relationally than the experience of the analyst’s empathic understanding. In the other truly revolutionary part of his thinking, Kohut recognized that certain patients required new relational experiences with the analyst via the selfobject transferences: mirroring, idealizing, and twinship. That is, he believed that with an analyst functioning in an empathic/interpretive (i.e., fairly traditional) mode, but armed with an in-depth understanding of the psychology of the self and the selfobject transferences, such patients would experience the analyst as serving needed relational/developmental functions
comparable (though not identical) to those served by the healthy parents of young children. Significantly, in order for analysts to perform these functions, Kohut believed they had to be prepared to engage in one particular form of relational behavior that departed from the traditional psychoanalytic stance: they needed to acknowledge, and when appropriate, apologize for, the effects of their own, usually unintentional, empathic errors and/or treatment of the patient that had been experienced by the patient as retraumatizing. This occasional ownership of responsibility, in conjunction with accurate-enough interpretations of the impact of the analyst’s behavior on the patient’s self-states, were the main relational activities the analyst needed to engage in in order to support the patient’s new relational experience of the analyst-as-selfobject. Yet this one move toward explicit relationality was historically significant in that it brought the analyst in as a human being who, with the best of intentions, could make mistakes that had real consequences; but who also, hopefully, had the maturity, sensitivity, and ethical motivation to acknowledge them and repair the damage.

“Developmental Arrest” Theories

Both Winnicott and Kohut were contributors to a paradigm shift in late-mid-20th century analytic thought that moved psychoanalysis in the direction of viewing the analyst as a kind of reparenting figure or new object (Fairbairn, 1958) who, in diverse ways, exerted a positive developmental influence, not only as a transference creation of the patient but as a co-creation of the patient and analyst that included the analyst’s intention to function in this development-facilitating way (Fairbairn, 1952, 1958; Bion,
1962; Balint, 1968; Winnicott, 1965, 1971; Bowlby, 1975; Loewald, 1960; Kohut, 1971, 1977, 1984). The implication of all of these theorists was that our work enlists us in a complex form of developmental influence that is comparable, though not identical, to the complex functions parents serve for their children. Within the unique intersubjective potential space (Winnicott, 1971) of the analytic frame, these empathic, mirroring, idealizing, holding, containing, protective, confronting, educative, supportive, playful, loving, freeing, and other developmental functions tend to be expressed in more subtle, paradoxical, more symbolically mediated forms than they are in actual parenting. But the point is that in all of these developmental models relational/emotional engagement was emerging as a new defining current of an optimal analytic attitude and approach—one which stood in a not-fully-formulated relationship to the traditional current emphasizing progressive understanding and dispassionate communication of the patient’s truth as revealed through the analytic process.

**Relational Theories of the 1980s**

Then, beginning in the 1980s, Bollas, Mitchell, Ehrenberg, Hoffman, Aron, Bromberg, Davies, S. Pizer, and other early relationalists built on these relational trends in “developmental arrest” thinking (Mitchell, 1988), and, influenced by other theoretical traditions, notably the Kleinian/Bionian, existential, and Sullivanian interpersonal traditions, expanded the kinds of relational engagement being advocated to include more adult-to-adult forms that were not framed as analytic equivalents of parental functions. Authenticity, spontaneity, mutuality, and selective, intentional disclosure of
countertransference and other personal feelings and information emerged as new relational possibilities that were shown to carry great therapeutic power in a wide range of clinical situations. These developments reflected a fully “two-person” re-envisioning of the analytic encounter in which the analyst’s more personal engagement was seen to deepen the connection in ways that both deepened the content of what could be talked about and exerted a freeing and transforming influence on the patient’s capacities for both self-delineation and relational/emotional connection. One might say that, in the relational model of the 1980s and 90s, the selective revelation of the analyst’s truth in relation to the patient was found not only to elicit and illuminate but also to transform the patient’s psychic reality (truth) in ways that had not been possible within earlier psychoanalytic models.

The result of this theoretical (r)evolution—one that had been gaining momentum since mid-century in the developmental arrest models—was a subtle shift away from interpretation-leading-to-insight as the primary mechanism of therapeutic action and telos of analytic therapy (Mitchell, 1997, Chapter 5). Given that the real goals of analysis were (and had always been) transformations in the patient’s experience of self-in-relation-to others, and expanded and enriched capacities for navigating both the internal-object and external-relational worlds, if new, non-interpretive forms of relational engagement led directly to such transformations, the central importance of interpretation leading to insight was called into question. Again, none of these theorists denied the importance of understanding, and many continued to view interpretation as a primary vehicle of analytic
transformation (Bollas, 1987; Mitchell, 1988; Davies and Frawley, 1991). But, to say the least, the relationship between relational engagement and understanding was becoming more complex.

Since the early 1980s many theoretical variations have emerged in which these two fundamental currents in our thinking about therapeutic action have begun to be integrated in more complex and sophisticated ways.

Mitchell

Mitchell (1988, 1997) recognized that mutative interpretations were always both an imparting of understanding and a new relational experience, and that unless an interpretation was also felt as a new experience, the content of the interpretation could too easily be conscripted into the patient’s old patterns of relating and meaning-making.

Weiss and Sampson

Coming out of the ego-psychological tradition, Joseph Weiss and Harold Sampson (1986) were among the first to recognize that a patient’s experience of the analyst as responding differently than the patient’s old objects in crucial ways at critical moments (thereby disconfirming the patient’s “pathogenic” expectancies based on past traumas) often leads spontaneously to insight (really, an unconscious opening to formerly warded off affective experience and memory) without the analyst always having to make explicit interpretations. Their “control-mastery” theory was grounded in Freud’s (1940) later thinking regarding the ego’s unconscious regulation of repressions and the unconscious impulse toward mastery, based on criteria of safety vs. danger. Since the
1980s, Weiss and Sampson’s insight has expanded to a general recognition that the felt relational context of each analytic relationship, especially the degree to which the therapist is experienced as a safe new object in the transference, exerts an enormous shaping influence on the content and quality of what emerges in the patient’s verbal and implicit communications, and thus on the quality of insight and understanding that become possible.

**Stolorow et al.**

Stolorow (2006), who, along with his co-authors (Stolorow, Brandchaft, & Atwood, 1987; Stolorow & Atwood, 1992; Stolorow, Atwood & Orange, 2002), recontextualized many of Kohut’s ideas within a contemporary intersubjective, hermeneutic frame, has stressed that the chief function of psychoanalysis is to provide a “relational home” for the patient’s formerly unrecognized and unintegrated, “prereflective” affective experience. The implication is that only insofar as the patient experiences the therapist’s attitude as truly welcoming can an optimal context be established for the illumination, symbolization (putting into words), and integration of the patient’s “experiential world.” One can sense, however, that Stolorow and his associates continued to straddle the same fence that Kohut did in this regard. They regarded an authentically welcoming attitude, sustained empathic inquiry, and the analytic function of putting words to emotional experience, as the primary forms of relational engagement our patients need, or at least the main forms they wrote about. Stolorow (1994) acknowledged a role for “affective responsiveness” as a separate curative factor, and, like
Kohut, recognized that the experience of being understood can in itself constitute a new relational experience. He also believed, following Kohut, that when patients were experiencing the selfobject or “developmental dimension of the transference,” the analyst needed to do little beyond empathic listening for the patient to experience the analytic engagement as a new (selfobject) relational experience (Stolorow, Brandchaft, & Atwood, 1987). But the vast majority of his and his associates’ theorizing pertained to the empathic apprehension, understanding, and articulation of the patient’s experiential world. As they describe it:

Psychoanalysis…is a dialogic exploration of a patient’s experiential world, conducted with awareness of the unavertable contribution of the analyst’s experiential world to the ongoing exploration. Such empathic-introspective inquiry seeks understanding of what the patient’s world feels like, of what emotional and relational experiences it includes, often relentlessly, and what it assiduously excludes and precludes. It seeks comprehension of the network of convictions, the rules or principles that prereflectively organize the patient’s world and keep the patient’s experiencing confined to its frozen horizons and limiting perspectives. By illuminating such principles in a dialogic process and by grasping their life-historical origins, psychoanalysis aims to expand the patient’s experiential horizons, thereby opening up the possibility of an enriched, more complex, and more flexible emotional life. (Stolorow et al., 2002, p 46; italics added)
And in a more recent distillation of this position, Stolorow (2006) wrote:

I have become convinced that it is in the process somatic-symbolic integration, the process through which emotional experience comes into language, that the sense of being is born. (p. 240)

While these quotes constituted an eloquent and comprehensive account of the pursuit of psychoanalytic understanding, and a major advance on the classical model of objectively rendered interpretation leading to insight, the analytic tools Stolorow and his coauthors employed represented an epistemologically more contemporary, intersubjective embodiment of the principle of understanding as the chief engine of analytic transformation, and thus remained only half the story.¹

Only in his most recent writings has Stolorow, on his own, revised his thinking on these issues, moving closer to a recognition of the importance of relational engagement, especially in the analytic treatment of trauma. (Stolorow, ). He has come to the understanding that traumatized patients require a form of analyst participation he calls “emotional dwelling.” In emotional dwelling the analyst not only welcomes the patient’s dissociated and repressed affects, he accompanies the patient in an undiluted encounter with (a not-turning-away-from) the overwhelmingly painful affects and the associated experience of self-in-relational-to-world that are the legacy of trauma. Stolorow clearly intends emotional dwelling as a form of relational engagement. However, it is only one particular form that grows out of his theory of trauma. Thus he still seems to stop short of recognizing that relational engagement can take many forms depending on the unique
process and needs that are emergent within each analytic relationship as it evolves over time.

[Footnote: ¹I should note that Orange (1995, 2013), on her own, has fully embraced a philosophy of responding to patients’ relational needs in the spirit with which Kohut offered his two fingers to his regressed patient, i.e., in whatever form seems to fit the patient’s need of the moment. She even coined a term—“developmental enactment”—to differentiate these more positive, developmentally supportive engagements from the more problematic kind.]

**Contemporary Bionian Theorists**

Coming from a very different theoretical tradition than Kohut and Stolorow, contemporary followers of Bion end up in a surprisingly similar position with regard to the prioritization of the analyst’s understanding functions, broadly defined. While there is no way to do justice to this complex and evolving theory (with many contemporary variations) in a terse summary, I think it is fair to say that this large and rapidly growing international community of analysts and theorists follow Bion (1962) in their assumption that serious forms of psychopathology are mainly disorders of “thinking”—specifically, breakdowns in the essential capacity for unconscious processing (thinking, dreaming, reverie, “alpha function”) through which raw emotional experience becomes transformed into “thinkable” experience now useable for growth purposes (Ogden, 1994, 1997, 2009; Ogden & Gabbard, 2010; Ferro, ; Ferro & Civitarese, 2013; Peltz, 2012; Peltz & Goldberg, 2013; Neri, 2009; Symington, 20 ).
Ogden and Gabbard (2010) describe the telos of this model as follows: “The aim of psychoanalysis…is truth-focused (focused on helping the patient learn from and become the truth of his emotional experience)…” (p. 534). The larger context of their statement is the Bionian (1962; Ogden, 2002; 2009) idea that the analyst’s job is to help the patient to “‘dream’ (to engage in generative unconscious psychological work with his previously unthinkable/undreamable experience)” (p.534). While this current of thought derives historically from Freud’s and Klein’s one-person focus on “objective” analytic understanding leading to interpretation and insight, these contemporary, post-Bionian iterations embed the analyst in a two-person, intersubjective matrix and offer therapeutic narratives in which understanding emerges, not from detached, objective observation, but from the subjective experience of participation in the vicissitudes of the transference-countertransference dynamic, and the intersubjective field more generally (Ogden, 1994; 1997; Peltz, 2012; Peltz & Goldberg, 2013; Ferro & Civitarese, 2015). Specifically, understanding emerges from the analyst’s capacity to observe, process (through reverie), and reflect on his subjective experience within “the intersubjective analytic third” or “analytic field.” To use Bion’s increasingly familiar symbols (which I return to later in this chapter), the critical therapeutic movement in this model is represented as:

\[ O \rightarrow (T) \rightarrow K, \] where \( O \) refers to the total reality (especially emotional reality) of the patient and the analytic interaction of the session, \( (T) \) refers to the (mostly unconscious and intuitive) registration and transformation of this raw reality by the analyst’s “containing” (unconscious processing) function into useable understanding, and \( K \)
designates the yield of these transformational processes in the form of verbalized,
symbolized understandings and meanings (“truth”), often delivered as interpretations or
metaphorical “narrations” of the patient’s unconscious emotional experience.

While the contemporary Bionian version of intersubjectivity is very different from
Stolorow’s intersubjective systems model, the analyst’s containing functions in the
Bionian model and Stolorow et al.’s sustained empathic inquiry leading to illumination of
the patient’s experiential world, both pretty much confine the analyst’s relational
engagement to functions having to do with understanding, thinking, the processing of the
patient’s unbearable feelings, and the illumination of the patient’s psychic reality. Also,
while both of these models recognize the analyst’s inevitable susceptibility to becoming
captured in problematic relational scenarios (in the transference-countertransference
dynamic), potentially leading to impasse, both models have more faith in the analyst’s
ability to catch, process, “decenter” from, and transform such enactments through
intentional self-observation and reflective work (Bion’s “second look”) than does the
American Relational model. Analysts in the latter tradition argue that because
enactments, by their nature, involve the analyst’s unconscious participation (relational
engagement), the analyst can never be fully confident in his ability to “see” and transcend
them (Hoffman, 1983, 1998; D.B. Stern, 2010, 2013a, b, c, d). Accordingly, given the
analyst’s irreducibly subjective participation in all aspects of the process, especially
enactments, relationalists have theorized that the best “way out” of many enactments is
often “through” the analyst’s “finding a voice” with which to authentically express his
subjective experience of what is happening (his current “self state”) in a direct, but non-critical, non-blaming way—a voice that simultaneously expresses and holds his emotional experience and participation as an “analytic object” (Bion, ) to be reflected on and used in the service of deepening understanding (Bollas, 1987; Mitchell, 1988, 1997; Ehrenberg, 1992; Hoffman, 1998).

A Blind Spot in Bionian Theory

Contemporary “Bionian field theorists,” comparing their approach with contemporary relational theory, privilege the “analytic field” over the real analytic relationship itself as the primary system of interest, and source of analytic data. While the intersubjective relationship is viewed as an important “vertex” (frame of reference; point of entry) to which the analyst’s attention may be drawn, and through which analytic data is processed, these authors emphasize the total psycho-sensory apprehension of all that is happening, with maximum openness to whatever emerges or impinges on awareness (especially the edges of awareness.) Thus reverie, sensory-somatic states, fantasy, memory, affects, impulses, images, inklings of both difficulty and promise, the emergence of “selected facts,” “pulls” on the analyst’s attention, aversions, senses of something missing, etc., etc. are what the analyst is trying (in as relaxed and alert a state as possible) to register and process (e.g., Ogden, 1994, 1997; Peltz, 2012; Peltz & Goldberg, 2013). This orientation aligns with the Bionian assumption that many (perhaps all) psychoanalytic patients’ suffer primarily from difficulties in “thinking” and “dreaming” their emotional experience (Ogden & Gabbard, 2010); thus the analyst’s
primary job is to be able register, “think,” “dream,” and ultimately communicate in useable form the (mostly out-of-awareness) emotional reality of what is occurring within the analytic field. They view this processing function as outside of, or superordinate to, “real” happenings in the intersubjective analytic relationship and to “external reality” in general (Ferro & Civitarese, 2013).

This model of the analyst’s participation and function derives from Bion’s (1962) theory of container/contained and the analyst’s capacity for reverie. Contemporary Bionian theorists thus argue that the analyst’s capacities for unconscious apprehension and reverie or “waking dreaming” (the unconscious processing of emotional reality) and the interpretations or “narrations” that emerge from this processing, as opposed to relational engagement, are the primary engine of therapeutic action. The blind spot here is that container/contained is a form of relational engagement—one that falls in the same general category as the various analytic functions identified in the other developmental theories of the late-mid twentieth century, such as Winnicott’s holding and Kohut’s selfobject functions. Like these other early relational functions, container/contained is understood to be needed because of the mother’s failure to have adequately performed this function for the patient as an infant and young child. Once it is recognized that containment is a form of real relationship, it becomes clear that it is a real relationship that carries the therapeutic action, and the question immediately arises: why would one assume that containment is the only form of real relationship that is occurring or the only form that carries therapeutic action? Rather, it seems evident that there is always a real
relationship going on, that that real relationship is in a constant state of flux—just as the
analytic field is—that many other relational possibilities and engagements (some
conscious and intentional, some not) are occurring as part of this relational flux, and that
at least some of these carry therapeutic action.

**Ehrenberg**

Among the early relational theorists, the author who, in my view, articulated the
most fully-realized integration of these two currents in contemporary analytic thought
was Darlene Ehrenberg (1992). However, her ideas about this have not been sufficiently
appreciated or incorporated into the relational theoretical mainstream. Here is
Ehrenberg’s most succinct statement of her position on this topic:

My view is that the combination of a rigorous analytic process and a vital,
personal, affective engagement is crucial and that either without the other is
insufficient. I believe it is the *integration* of both, and their operating not in
 alternation but in actual combination, as each becomes the condition for the other,
that is essential and definitive. The integration of the affective and the analytic
gives each more scope. Either alone could not be carried as far analytically as
each can be when it is combined with the other. (pp. 66-67)

This deceptively straightforward formulation, and Ehrenberg’s 1992 book
illustrating it with many diverse clinical examples, capture much of what I think of as a
holistic approach to the relationship between understanding and engagement in the
analytic process. Mitchell, in his 1997 review and appreciation of the American
interpersonal tradition, recognized Ehrenberg as an important contributor to that tradition, but characterized her contribution as primarily in the area of countertransference disclosure (pp. 91-92). I would argue that, as the above quote testifies, her clinical and theoretical vision was much broader and subtler than this. But because of the way her work was reductively characterized, these broader implications have not been fully absorbed into the relational theoretical canon. Ehrenberg applies her conceptual synthesis in her particular way. “Engagement” for her means a very active, direct, personal expressiveness, and a preference for verbally naming, and opening up for exploration, any nascent enactment as soon as she becomes aware of it. That is her authentic idiom (Bollas, 1987) of participation, and it seems to have worked extremely well for her and her patients. But the general principles she articulated regarding the integration of “analytic rigor” (in the service of progressive understanding), and personal affective engagement, can potentially be adapted by any analytic therapist within his or her own idiom of participation.

**Hoffman**

The other early relational theorist whose thinking “created a space” for the technical integration of disciplined analytic exploration (leading to understanding) and more relationally engaged personal expressiveness was Irwin Hoffman (1998). He approached such issues *dialectically*—that is, with a sensibility in which two seemingly opposing principles are seen as having a complex relationship to each other, and thus held in mind not as an “either/or” binary but as a “both/and” dialectical tension. Hoffman
described a number of such dialectics, but the best known (which provided the title of his 1998 book) was the dialectic of ritualized, disciplined (i.e., more traditional) analytic inquiry vs. spontaneous, personal expressiveness leading to a sense of shared humanity and more intimate, personal connection. In the 1994 paper in which Hoffman first presented his dialectical approach, the case example he chose, one of his analytic control cases, was a patient who, for understandable personal historical reasons, stubbornly resisted traditional analytic dialogue in which the analyst waits and listens, the patient initiates self-reflective associations, and the analyst interprets. Instead she seemed to need Hoffman to deviate from the traditional role and engage with her in more practical problem-solving and, at times, more personal, even somewhat “crazy,” emotional exchange. What Hoffman came to realize was that, if he stubbornly tried to hold out for reflective dialogue, little happened, whereas if he, at times, yielded to the patient’s demand for his more personal, down-to-earth responsiveness, she then became interested in looking more reflectively at her own process. I can’t do justice here to Hoffman’s complex analysis of the relational cross-currents he saw as operating in his negotiations with this patient. But the case and his handling of it, like many of Ehrenberg’s (1992) case examples, vividly demonstrated the complex, case-specific inter-relationship between understanding and emotional engagement, and how a patient’s interest in self-understanding often follows from the enactive co-creation of needed relational conditions.² For another particularly dramatic and instructive example of this sequence from engagement to understanding, see Joye Weisel-Barth’s (2011) paper, “Katherine: A
Long Hard Case.” In this 20+ year treatment of a severely traumatized, chaotically organized, depressed, and often un-lucky borderline patient, it was only after decades of Weisel-Barth going way off the traditional analytic “map” in her protective and ultimately loving responses to Katherine’s suicidal crises and seemingly endless needs for everything but analytic self-reflection, that Katherine came to a point when she finally wanted, and explicitly asked for, a more traditional, restrained, analytic dialogue oriented toward self-exploration, reflection and understanding.]

Aron and Harris

Finally, the post-millennial writings of a number of relational authors, especially Aron (2013; 20   ) and Harris (2009), have carried forward and expanded Hoffman’s dialectical sensibility, taking aim at binary oppositions of all kinds, including the binary of analytic understanding vs. relational engagement. The quote from Aron (2013) that begins this chapter succinctly and eloquently expresses this sensibility, as does the following quote from Harris (2009) in which, referencing earlier work by Aron and herself (1997), she elaborates her own characterization of recent trends in relational thinking:

…the line between speech and action had become blurred and shaky. Embodied cognition, the interdependence of emotion and cognition, the materiality of words and sentences, the transpersonality of mind and subjectivities, the study of intentionality and theory of mind as an outcome of early dyadic life—all these new domains of work and research move us far beyond old dichotomies. The
focus on speech as action, on the embodiment and intersubjectivity of speaking and listening, is at the heart of relational ideas. (p.15)

**The Center Will Not Hold: Explicit vs. Implicit Relational Knowing**

Even as relational theorists like Ehrenberg, Hoffman, Aron, and Harris have been strongly voicing a more integrative, dialectical approach, during the past decade and a half, an increasingly influential trend in relational theory has “pulled” the thinking of many, regarding the relationship between analytic understanding and relational engagement, “to the left.” An expanding group of theorists influenced by infancy research and neuroscience has been emphasizing implicit (i.e., non-verbal), “procedural,” relational factors over explicit, symbolically rendered, understanding as the primary curative agent in analytic therapy (e.g., D.N. Stern et al., 1998; Boston Process of Change Study Group, 2008; Lyons-Ruth, 1999; Schore, 2011; Beebe & Lachman, 2014).

Grounding their arguments in findings from neuroscience and cognitive psychology indicating that there are two “distinct and dissociable” memory systems—one for explicit or conscious memory (“knowing that”) and the other for non-conscious, implicit or procedural memory (“knowing how”) (Lyons-Ruth, 1999)—this group of theorists asserts that, while both learning systems are involved in psychoanalytic interaction and change, the implicit system of intersubjective procedural communication, learning, and knowing, which has its roots in the earliest interactions between mothers and babies, tends to lead, while the explicit system of verbal symbolization tends to follow; moreover, the implicit
system is thought to be more pervasive and thus where most of the therapeutic action takes place. In different language, the emphasis in this line of thought is placed on “right brain to right brain” as opposed to “left brain to left brain” communication (Schore, 2011).

Because of the widening influence of this trend in relational/intersubjective theory, I feel it is necessary to examine its underlying assumptions more closely as part of the process of “working through” toward the more integrated, holistic model implied in the meta-theory of needed relationships. I will refer to this theoretical movement as “IRK theory”—an acronym for the term, “implicit relational knowing,” introduced by the Boston Change Process Study Group (Stern et al., 1998).

The IRK theorists have, in my view, made a major, paradigm changing, contribution by illuminating the nature, scope, and importance of the implicit relational dimension of the analytic exchange, and in so doing have also made a compelling case for greater openness on the part of the analytic community to the explosion of relevant knowledge in the neighboring fields they are drawing from. I will argue, however, that they have framed the issues wrongly by separating implicit engagement from reflective understanding in their therapeutic scheme, especially with respect to therapy with adults, and by privileging the former over the latter (see also S. Stern, 2008). Even though their thinking in some ways extends a trend that was already occurring in relational theory (for example, in the focus on enactments), and even though they frequently cite leading relationalists (such as Ehrenberg) in their writings, because their model loses touch with
the generative tension in contemporary theory between understanding and engagement, their thinking, in my view, loses analytic generality and power. To give the reader a beginning sense of the basis for this challenge, and to take us more deeply into the issues involved in trying to clarify the relationship between engagement and understanding, I offer the following brief clinical vignette.

A 50-year-old patient, Mary, faithfully returns with her husband every year to share Thanksgiving with her family of origin, which at this point includes her mother, her sister, and her sister’s family. During the 5 years we had been working together, she had returned from these visits more or less undone by the all-too-familiar pattern of judgmental scrutiny, criticism, negation, and guilt-induction that she encountered at the hands of her mother (and sometimes her sister), and against which she had remained defenseless despite the slow gains she was making in her analysis. In previous years she had literally spent months anxiously anticipating and trying to gird herself for her visits, and months following the visits working with me to restore her shattered sense of self and goodness. While I have what I consider to be a fairly complex theoretical understanding of the nature of Mary’s struggle (S. Stern, 2002a, 2002b, in preparation), and specifically what happened to her when she went home, on the eve of her departure in our fifth year, seemingly unbidden, the thought occurred to me and I said, “Why don’t you think of your family members as like the raptors in Jurassic Park. You have to keep them locked in their cages!” She laughed out loud at this image, but the surprising outcome was that it worked. She came back essentially unscathed, crediting my “advice” for her progress.
Moreover, the change held up over time: her subsequent trips home have not been quite the ordeal they once were.

Prior to this intervention, Mary and I had been immersed in her struggle with her introjected and real family members for years. The imagery that increasingly had been coloring our dialogue around this struggle—imagery from her vivid dream life and my interpretive elaboration of these dream elements—was that of terrible destructiveness and primitive zero-sum games in which one person’s survival meant another’s psychic murder. The mother had emerged in fantasy images as a ravenous, flesh-eating creature; thus my language came from, and spoke to, Mary’s unconscious experience and creativity. She and I had already lived through a lot together, including a prolonged enactment in the second year of our work in which the viability of the treatment had been called into question. (See S. Stern, 2007, for a detailed account of this impasse.) For several years prior to this Thanksgiving intervention, humor and verbal playfulness had come increasingly into our dialogue, delighting us both, and providing what felt to both of us to be a potent affective antidote (“up-regulation”) to the quicksand-like nature of Mary’s deeply entrenched habits of self-negation and self-excoriation. My quip about keeping the raptors in their cages was a somewhat more forceful and directed expression of the unique form of gallows humor she and I had been co-creating for a while. This verbal playfulness had become an important resource in our relationship that I/we could draw upon at the point I made my comment. Mary’s receptivity to my quip, and her ability to hold and use it when visiting her family, were of course inseparable from her
experience of me as a very particular new object, which she had slowly begun to internalize over years of work together.

How might an informed analyst, an analyst well versed in the past 60 years of analytic thought about needed relationships, parse the relative contributions of relational engagement and the communication of understanding in my two-sentence intervention? It would, I submit, be an impossible exercise. It would be impossible because, in every word that I spoke, understanding and engagement were inextricably fused in an interpenetrating, mutually constituting “mix-up,” to borrow loosely from Michael Balint (1968). My intervention was part of a dialogue that embodied a non-linear coalescence of both Mary’s and my evolving understanding of her struggles and our evolving relational engagement (conscious and implicit) in the service of trying to help her with those struggles. The relationship between understanding and engagement in this intervention was not the parallel one described by the Boston Study Group in which the symbolic dimension is separate from and lags behind its older, faster sister, the implicit dimension. (If anything, symbolization was the leading element.) Rather, the relationship between understanding and engagement exemplified in this vignette was, as Ehrenberg described it two decades ago, and Aron captures in the quote that begins this chapter, one of complete interpenetration—the two dimensions were seamlessly interwoven and mutually constituting. This is so, I would argue, much of the time in every analysis, even in many moments when the analyst’s participation is non-verbal.
Three sources of confusion and murkiness have surrounded this issue: (1) a conflation between what the therapist explicitly says or interprets and her or his total understanding and all that she or he implicitly communicates because of that understanding (2) a conflation between the patient’s conscious awareness and registration of what is occurring and being taken in from a given interaction, and all of the elements that are actually contained and transmitted in that interaction; and (3) generalizations from mother-infant interaction studies to the realm of adult psychotherapy that do not have the same observational, scientific grounding as the studies themselves or the investigators’ inferences regarding child development per se, and therefore may be wrongly formulated.

(1) The Analyst’s Total Understanding. The point I wish to make here is that, however one positions the verbal/symbolic vs. the implicit relational dimensions in characterizing the analyst’s interventions or the therapeutic interaction, the analyst’s commitment to seeking an ever-better understanding of the patient and the unfolding process is (or should be) constant and central to everything the analyst does with a patient, whether verbal or non-verbal, interpretive or enactive (in an intentional, positive sense). A corollary of this premise is that, even though our theories may lead us to conclude that the patient’s verbally symbolized insight or self-understanding is not always necessary for, or central to, analytic growth and transformation, the same does not apply to the analyst’s analyzing subjectivity. The patient implicitly relies on the analyst’s constant dedication to reaching ever-better, fuller understandings of her or him in the
context of the analytic relationship and process. A second, related corollary is that, even though we now understand that the analyst’s evolving understanding is inseparable from the relational processes within which that understanding emerges, and even though the analyst may arrive at implicit senses or “knowings” regarding how to be with a patient at a given point in time without these knowings being fully, consciously symbolized in language, these implicit processes can only occur in an overall context or field in which the analyst is always, ultimately seeking the most inclusive understanding possible, both at implicit/intuitive and explicit/symbolic levels. This therapeutic reality should be evident from the fact that every psychoanalytic text written about the nature and centrality of implicit relational processes are written to enhance analysts’ understanding of such processes, presumably on the premise that such understanding will broaden and enrich analysts’ capacities to understand and apprehend what is occurring at that level, and thereby better respond to their patients’ total process and needs. Thus, whatever the therapeutic yield of seemingly independent, implicit, not-fully-symbolized, relational processes as they occur in certain analytic interactions, there is no such isolation of implicit processes in the analyst’s analyzing subjectivity (except perhaps in a momentary sense): relational engagement and progressive understanding are always interdependent, interpenetrating, and co-evolving in the analyst’s total participation, and thus “saturate” all that is occurring in the interaction.

It is helpful here to again consider the differences between the patient’s and the analyst’s subjectivities, given their different roles in the therapeutic relationship. Terms
such as “intersubjective system,” “two-person psychology,” and “mutual regulation” emphasize the similarities between the patient and therapist—both are human beings engaged in a system involving mutual influence and regulation. But they fail to capture the equally important reality (discussed in Chapter 1) that the analyst’s subjectivity-as-analyst is far more complex than the patient’s subjectivity-as-patient. The analyst’s subjectivity, including his embodied subjectivity, contains all that the analyst has learned (through both scholarship and experience) in the service of performing the transformational functions (Bion, 1965; Bollas, 1987) involved in analytic work. These transformational functions require complex conscious and unconscious processing and relational capacities that reflect both the myriad analytic frames of reference learned and internalized by the analyst through scholarly immersion in analytic (and related) ideas, and the more implicit forms of understanding gleaned from clinical analytic experience (and, of course, life experience). These two forms of understanding are hardly separate or “dissociable,” but rather inform each other, are integrated in infinitely complex ways, and are expressed not only in the content of what the analyst says but in his total presence, voice, and implicit communications of all kinds at all times (see also S. Stern, 2008). They constitute what I referred to in Chapter 1 as the analyst’s wisdom. Understood in this more complex way, the imparting of understanding does not occur only through explicit interpretations but rather through an extremely complex form of the “dyadic expansion of consciousness” (Tronick, 2001) brought about in interactions that are at all times informed, or at least affected, by the analyst’s explicit and implicit understanding.
and his transformational capacities. [Footnote: 3Ironically, although Tronick’s core construct pertaining to the intersubjective foundations of both development and psychotherapy is what he terms “the dyadic expansion of consciousness” (emphasis added), he identifies as an IRK theorist in the sense that he portrays the crucial interactions as occurring at the implicit emotional level as opposed to the presumably more conscious level of verbal, symbolized communication.]

Part of the murkiness here results from the fact that the theorists who emphasize the bifurcation of explicit and implicit processing (for example, D.N. Stern et al., 1998, in their seminal paper on “…the something more than interpretation”) are still using the classical Freudian model of interpretation-leading-to-insight as their prototype of explicit, symbolized knowing and communication. In that model explicit, discreet verbal formulations of the patient’s intrapsychic dynamic structure and process, delivered by a detached, neutral analyst, were seen as the vehicle of transformation.

This stereotype does not take into account the dramatic revisions in the model of the analyst’s reflective activity that have occurred in the past 60 years. Bion (1962, 1970) stands out as offering a different model in which the analyst’s internal processing of implicit emotional experience, much like the digestive processes of the human body, leads to transformations of raw (implicit) experience into more “contained,” metabolized, symbolizable experience, which can then serve as a basis for transformative interaction with the patient. That transformational exchange might or might not take the form of explicit interpretation. Most importantly and tellingly, the analyst’s capacity to process
emotional experience in this way is potentially freeing to both parties—freeing in the sense of an enhanced capacity for generative processing through dreams, reveries, memories, fantasies, associations (including somatic “associations”), thinking in general, and dialogue (Symington, 1983; Eigen, 1996; Ogden, 1994, 1997; 2005; S. Stern, 2009). In other words, the yield of the analyst’s processing capacities, conscious and unconscious, is not so much the communication of discreet understandings as the freeing up of the patient’s own processing capacities in order to be able to think and speak about, and thus grow from, their emotional experience.

[Footnote: I am focusing on Bion’s “theory of thinking” since it offers the most systematic revision of the Freudian model of the analyst’s cognitive processing and interpretive activity. However, other models, for example Loewald’s (1970) more informal, evocative theoretical formulation of the analytic process moves in a similar direction: “It seems to me that an interpretation is not so much the result of understanding as it is the means by which understanding proceeds. This has to do with the intimate interrelations between thought and language… Understanding as an act…is impossible unless the patient lends himself and is open to our understanding… unless the patient feels understood we feel that we have not fully understood him. Understanding would seem to be an act that involves some sort of mutual engagement, a particular form of the meeting of minds’ (1980, pp. 381-382, emphasis added) Elsewhere, Loewald (1960), sounding very much like Bion, characterizes psychic health as the capacity to integrate (move back and forth between) the unconscious and preconscious registers of experience.
Interpretations, to be effective, must emanate from this capacity in the analyst and aim to
develop the same capacity in the patient: “Language, in its most specific function in
analysis, as interpretation, is thus a creative act similar to that in poetry, where language
is found for phenomena, contexts, connections, experiences not previously known and
speakable…” (1960, p.242). Ogden (1997), nearly 4 decades later, with the benefit of
both Bion’s and Loewald’s perspectives, echoes Loewald: “In attempting to capture
something of the experience of being alive in words, the words themselves must be alive.
Words, when they are living and breathing, are like musical chords (p.4).].

(2) Explicit and Implicit Processes in the Patient’s Subjectivity-as-Patient.
Although the analyst’s subjective participation is more complex than the patient’s, the
bifurcation of implicit and explicit processing also oversimplifies the patient’s
subjectivity, especially as an analytic treatment progresses. As I have argued previously
(S. Stern, 2008):

Like the Boston Study Group, I view the analyst’s verbal-symbolic
communication as emerging from IRK [implicit relational knowing], but think
one of its primary functions is the transformation of IRK, including
transformation of the ways the patient implicitly relates to himself or herself.
Once the analyst’s verbal and interpretive statements have served this
transformational function (which may occur in one dramatic interchange or
require repetition of certain themes over years)... they are “reabsorbed” back into
IRK (IRK contains “residues” of verbal-symbolic dialogue). This may explain
why former patients often do not remember specific interpretations. It is not that the interpretations were not significant; it is that their impact is “remembered” at the implicit relational level (pp. 505-506).

Once a good-enough analytic treatment is underway the patient’s subjectivity becomes progressively transformed by all that has occurred intersubjectively, and contains or embodies both the residues of previous analytic understandings and newly acquired processing and reflective capacities that the patient is developing in the context of the analytic work. (Non-linear dynamic systems theorists such as Coburn [1914] and Marks-Tarlow [2008] have been especially clear about this cumulative complexity.)

Taking my “raptor” intervention as a case in point, it was my (implicit) hope, of course, that the particular fusion of implicit and explicit messages contained in my metaphorical quip would impact Mary’s implicit functioning when visiting her family. And indeed, that is what seems to have happened: the subjective residue of our total interchange seemed implicitly to calm and guide her through the treacherous waters of her 3-day holiday visit. Moreover, the same residues, probably in combination with the increased sense of mastery following this more successful visit, continued to help her in subsequent visits. Again I ask: How could one possibly separate the workings of implicit and explicit knowing in Mary’s improved functioning with her family? We don’t necessarily want our patients to remember everything we have said; we want their total functioning (implicit and explicit) to have been transformed by all that has occurred in the analysis.
Another source of confusion and murkiness is the changing understanding of what it is that the analyst (and patient) most need to understand. Insight and understanding are no longer exclusively about the patient’s intrapsychic experience, conflicts, anxieties, defenses, and desires taken in isolation, but rather concern the bi-directional interaction between relational experience and self-experience as it emerges and comes into focus in the analytic relationship, the patient’s outside relationships, dreams, and in associations of all kinds—especially to memories of the patient’s early relationships. Through these progressive glimpses and symbolized “capturings” of the patient’s experiential world, analyst and patient gradually co-construct a “moving picture” of the patient’s experience of self-in-relation-to-others. The analyst approaches this interpretive project with a plethora of models held loosely in the background regarding how different kinds of relational experience affect self-experience and capacities of all kinds, and of how different kinds of self-experience may affect intersubjective interaction. For example, my general understanding of such matters tells me that ultimately Mary will need to grieve the loss of what she never received from her family in order to more fully separate from them internally, but that in order to tolerate this grieving process, she will need to feel connected enough to me as a new object who both understands her and is relationally invested in her in a caring, reliable way (S. Stern, in preparation).

My Thanksgiving intervention implicitly incorporated this understanding as a background factor. The evocation of the raptor image and the ironic injunction to keep her family members “locked in their cages” captured (implicitly interpreted) the dual
reality that (a) at the interpersonal level, her family members actually still behave in destructive (anger and fear-provoking) ways, while (b) at the intrapsychic level, it is Mary who now, at age 50, gives them too much power due to their archaic object status; and it is she who ultimately must actualize her potential capacity to take back this power into herself. At the same time, the contextualization of these implied insights within the affectionate, spontaneous, humorous, and supportive qualities of our exchange performatively conveyed the recognition that her felt connection to me as a new object is essential in order for her to use these insights as I intended them—that is, to embolden her to contemplate separating from her family members in the ways she needs to. And yet, to further underline the complexity of the interpenetration of the explicit and the implicit, the tone and implicit “atmosphere” of my quip was not one of exhortation, reflecting an over-focus on Mary’s “symptom” or a need on my part to get her to change (Ogden & Gabbard, 2010), but rather one of play and irony, reflecting both my understanding of Mary’s susceptibility to feeling criticized and deficient if expected to do something of which she feels incapable, and my respect for the fact that change of this sort can only occur under Mary’s own initiative (or, in Winnicott’s (1960, 1969) language, within her “sphere of omnipotence”). In such ways, I would argue, engagement both reflects and affects understanding, and understanding shapes and influences the moment-to-moment, thoughtfully spontaneous, improvisational generation of ever-changing forms of engagement. How can they be separated? Who would want to?
Inferences from Infant Research to Adult Treatment. One of the lures, and rhetorical strategies, of the proliferating IRK literature applying principles gleaned from mother-infant observation studies to adult treatment is the implication that they are more scientifically-based because the principles are derived from empirical research. I would argue that, while the principles and theories emanating from infancy research have profoundly changed and enriched our understanding of infant and child development, and certain aspects of human nature and learning more generally, their applicability to the adult treatment context needs to be carefully considered. Any comprehensive attempt at such an examination is beyond the scope and purposes of this book.\footnote{Ultimately, to attain the scientific status of the increasingly nuanced understandings emerging from mother-infant observation studies, any such generalizations to the adult treatment situation would themselves have to be empirically tested—a project requiring research methods at least as complex as those being used in the mother-infant studies.} Here, I will only pose the question whether the various generalizations being made have the same levels of “inferential validity” (i.e., are equally logical and compelling). Of the three major generalizations made or implied in this literature, only one seems to me inarguable, while the other two seem at best questionable, and, in my view, are probably wrong.

The first, more credible inference is that, just as implicit (unsymbolized or not-fully-verbally-symbolized) relational processes are central in infant-mother interactions, they are also central or at least pervasive in the communication processes of adult
treatment. Here I believe the, now extensive, literature on the “something more than interpretation” (Stern et al, 1998) has been and continues to be enormously illuminating and clinically compelling. The recognition that much of what is happening in the clinical interaction is occurring out of conscious, linguistically symbolized awareness, including forms of “micro-interaction” that are both too brief and moving too quickly to be consciously registered or controlled (Beebe & Lachmann, 2014), seems both humbling and potentially empowering. It is humbling to realize, once again, that our conscious, intentional subjectivities are but a part (probably the lesser part) of our total “going on being” (Winnicott, 1960/1965), and that our subjective experience at all levels (conscious, unconscious, embodied, fantasized) is embedded in social eco-systems (including therapeutic dyads) that shape and control us outside of our awareness. It is potentially empowering in that such awareness potentially expands our capacities for attunement to our patients at levels not previously consciously perceived, and expands our repertoires of response potentials to include non-verbal and procedural forms of participation and improvisation. These gains in understanding, attunement, and clinical range are well illustrated in the clinical examples adduced in this literature to illustrate the operation of implicit processes in adult therapeutic interaction and transformation (e.g., Stern et al. 1998; Beebe, 2004; Beebe & Lachmann, 2014; Lyons-Ruth, ; Knoblauch, ; Sorter, ). From the standpoint of the meta-theory of needed relationships and progressive fittedness advocated in this book, this extrapolation from infancy research regarding the pervasiveness and nature of implicit, procedural processes in adult
analytic treatment would seem only to advance our capacities to achieve such fittedness with a wider range of patients.

The second and third major generalizations are more problematic. This is really a two-fold contention, first advanced by the Boston Study Group (Stern et al, 1998) that: (a) the implicit, non-verbal forms of communication observed in mother-infant interaction studies represent a distinct dimension of interaction, which, in adult psychotherapy, is separable from a different dimension of interaction—i.e., cognitive, symbolized, linguistic communication, the prototype for which is the classical therapeutic model of interpretation leading to insight; and (b) Interaction in the implicit realm is more centrally involved in analytic transformation than verbal interpretation in the explicit realm. None of the authors at the forefront of the IRK theoretical movement deny that interpretation, and verbal (i.e., symbolized) communication more generally, still constitute an important dimension of analytic interaction and the change process. But they tend to view it as distinct from, slower than, and when it gets down to it, secondary to, what is occurring at the non-verbal, implicit relational level. I have already given most of my arguments against these assertions earlier in the chapter. Here, I will add one further argument that has to do with the logic of how these theorists are extrapolating from mother-infant interaction research to the adult treatment context. To aid in this argument I begin by quoting in full a description of a 20-second interaction between a mother and 4-month-old offered by Beebe and Lachmann (2014) as an example of “disruption and repair” in a mother-infant pair who, the authors know, are on their way to
establishing a “secure attachment” relationship (as assessed at 12 months). I should say that the following is the authors’ summarized narrative of the sequence rather than the “second-by-second microanalysis,” which they also provide.

The film begins with the mother and infant looking at each other. The mother says a drawn-out “Hiii” as she leans in and smiles widely. The infant vocalizes with a slightly positive tone and smiles. His hands play with the blanket on the seat as his head moves a bit forward, while he continues to look at mother. Mother repeats “Hiii” while moving in closer to the infant with a partial “loom,” and she laughs. (“Loom” movements are ones in which the mother’s head and face move in very close to the infant’s face, with a few inches.) The infant quickly becomes distressed, frowns, and moves his head back as he raises his arms. He seems to have reacted to the loom. He looks away from his mother and whimpers. The mother immediately moves back into an upright position and sobers.

The mother offers her hands to the infant, “Here, take my hands,” with a lilting prosody. The infant takes her fingers, while the mother sings, “That’s my fingers.” The infant’s eyes follow the mother’s hand movements until she begins to raise his hands. The infant then looks at his mother. Mother smiles and sings in rhythm with the movements of their hands while the infant gazes at her, with a slight positive expression.

The mother moves her hands down onto the infant’s lap, and the infant still holds on to his mother’s fingers. The mother now has a broad, highly positive
smile. The infant smiles too, almost as broadly as his mother. The mother’s smile slightly decreases as she says, “Can you say “ahhh,” as she slowly leans in close to the infant, another partial loom. The infant giggles and lowers his head, and then moves his head back up, meanwhile continuing to gaze at his mother. Both infant and mother match the rhythm of their mouth and head movements.

The first point I want to make about this remarkably precise and alive rendering of what is apparently a very telling interaction sequence (in regard to the health of this dyad), is that what we are “seeing” here is not a “dimension” of the interaction between mother and baby; it is the total interaction of two whole persons using their entire mind/brains to engage each other in a complex interaction that seems to be mostly about connecting, attuning, enjoying, playing, repairing missteps, and, in two brief moments, teaching language. What stands out to me is that the mother is energetically, even passionately, using her whole self to attune to and play with the child as he is now, in each present moment. While it is true, the infant does not yet have language, the mother attempts to connect with her child using the non-verbal “language” or “languages” he currently does possess, and in fact embeds some language instruction in her play: e.g., “That’s my fingers;” “Can you say “ahhh?” Thus, part of what is going on implicitly (actually, it’s pretty explicit!) is that the mother is “pulling” the infant toward symbolization and linguistic communication with a conscious intention to do so.
My second point follows from the first: To extrapolate from this vignette that the most important “dimension” of adult therapeutic interaction is what is going on at the non-verbal, mostly non-conscious, implicit, procedural level seems illogical and “unfair” to both the mother-infant and therapist-patient dyads. It seems to me the more logical, accurate, and useful extrapolation is from the mother-infant interaction to the total interaction between adult patients and therapists. Just as the mother is using her entire mind/brain/body to grasp and communicate with the infant’s total mind/brain/body within the frame (set up by the investigators) of engaging in enjoyable, playful interaction, so do therapists, within their frame, seek to use their entire mind/brain/bodies to communicate with their patients’ total mind/brain/bodies in the service of their task of helping patients analytically (and relationally) with their struggles.

I would argue further that, in the clinical context at least, the therapist’s efforts to understand or cognitively grasp a patient’s psychic reality is not a separate or separable “dimension” of the clinical task. Rather, all of the ways that an analyst is processing and communicating with the patient, including all uses of language, are, in the clinical context, procedural, and are emergent from the analyst’s implicit processing of the total interaction on an ongoing basis. (Harris, 2009, citing Bahktin [1981] and Lakoff and Johnson [1980; 1999], makes essentially this same point.) That is, everything the therapist says and does, including everything within her or his awareness and therapeutic intention, is occurring in the context of the overall, mostly implicit “procedure” of seeking and achieving progressive fittedness in the service of helping the patient. In this
context, as I argued earlier in the chapter, all efforts to understand, all the processes through which understanding emerges, and all choices about what understanding to communicate to a patient at a given moment and how best to do that, are of a piece with and in the service of the total therapeutic procedure, and are inseparable from all that is happening relationally, emotionally, and unconsciously (or non-consciously). Thus, rather than thinking of “interpretations” as operating at a different, less immediate and powerful level of exchange, it seems to me that, as with the mother and infant in Beebe and Lachmann’s vignette, therapists should think in terms of using their whole mind/brain/bodies (as a complex system) to engage the whole mind/brain/bodies of their patients, including all of the “languages” or registers through which their patients are trying to engage them (the therapists) and make themselves (the patients) known to their therapists. In addition, of course, like the mother in Beebe and Lachmann’s study, one of the ways we engage our patients is a kind of implicit instruction: teaching them the symbolic “language” of psychological/emotional/relational experience and communication, thereby “pulling” them toward greater emotional intelligence and fluency, and making possible what Fonagy and his co-authors describe as the capacity for “mentalization” ( ). [Bucci here]

Framed in this way, much of what therapists say to, or do with, patients, for example, what I said to Mary about “keeping the raptors locked in their cages,” do not tend to fall neatly into pre-existing categories of therapist participation. Rather they are
“contoured” to the patient, just as the mother in the study contoured her “interventions” to her baby. In this regard I share Ogden’s (2009) view that:

A critically important aspect of psychoanalysis is the creation of ways of talking with each patient that are unique to that patient in that moment of the analysis. When I speak of talking differently with each patient, I am referring not simply to the unselfconscious use of different tones of voice, rhythms of speech, choice of words, types of formality and informality, and so on, but also to particular ways of being with, and communicating with, another person that could exist between no other two people on this planet. (p.2, italics in the original).

**What Makes Sander Different?**

Both Sander, in his writings touching on adult psychotherapy (e.g., 1995, 2002, 2008), and, by extension, I, in this book, would seem to be making the same kinds of extrapolations from infancy research to adult treatment that I am finding problematic in the IRK theorists’ work. Indeed, Sander was a member of the Boston Study Group, whose 1998 paper launched the IRK theoretical movement. In fact he was obviously an influential member, given the number of his terms and concepts that the group incorporated into their synthesis in that initial paper. I did not know Sander personally; nor do I know about the inner workings of the BCPSG. Thus I don’t know how he felt about the ultimate end product of the group’s collaboration. What I do know is that Sander’s use of his own concepts, and his thinking in general as I understand it, move in the exact opposite direction of where the BCPSG ended up in that paper.
Sander’s thinking does not focus on, or attempt to parse, the internal sub-divisions of human interaction, but instead looks at the mother and baby (and by extension, patient and therapist) as whole persons coordinating their roles and intentions within a complex human system. Sander’s (1995, 2002) primary interest and concern—indeed, what I sense to have been the generative passion of his life’s work—was his quest to understand the mysterious intersubjective processes through which the individual child or patient, in all of her or his diffuse complexity as a living system, self-organizes into states of relative coherence (identity) and develops a sense of personal agency and well-being. Drawing upon the work of biologist Paul Weiss (1970), Sander proposed the principle of “matched specificities” or, in human psychological terms, “specificity in recognition,” as a central principle and process through which two people interact in the service of the progressive development, competence, agency, and coherence of one of them. In Sander’s (1995) words, the senses of identity and personal agency develop from repeated intersubjective experiences in which the way one “knows” oneself is “matched” by the way one is “known” by the other. Elsewhere Sander wrote: “[Specificity in] recognition can be thought of as a way of representing how one individual comes to savor the wholeness of another…the critical condition for the reorganization of both interacting partners as they progress toward new integration.” (2008,p.169; italics added) Somehow, it seems, these core principles—the essential spirit—of Sander’s views on human development and change got lost in the BPCSG’s strategy of isolating and elevating as preeminent one particular dimension of the change process.
The main “units of analysis” in Sander’s model are each individual, the two-person system, and the evolving developmental/therapeutic task(s) that the system is organizing itself to help (primarily) one member achieve. The idea of two whole persons (therapist and patient) organizing as a complex system directed toward a highly complex form of problem-solving that is simultaneously intrapsychic and intersubjective for both parties orients us to the fact that both the patient and analyst, as members of such a problem-solving system, are at all times utilizing the totality of their individual and joint problem-solving capacities and all of the mental sub-systems (conscious and unconscious, implicit and explicit, reflective and embodied, left brain and right brain) that are “in service to” this overarching organizing purpose. How all of those mental sub-systems are engaged and interact from moment to moment is dictated by whatever emerging proximal form the developmental/problem-solving process is taking in each moment, session, and period of work.

What is it in the patient that determines what dream will be dreamt, what traumatic experience will be remembered, what interactive detail will be seized upon for transferential and associative use, or what new insight will coalesce at a given point in time? Similarly, what is it in the analyst that envisions some potential developmental trajectory for a patient (Loewald, 1960), guides the analyst’s reverie and thought processes as he sits listening, observing, and silently participating (Bion, 1962; Ogden 1994, 1997), or senses how to word, time, and deliver an intervention in a way that is likely to resonate and transform? My sense is that these “choices” are all a function of the
implicit *purposes* of the analytic dyad as a complex system—the largely unconscious developmental problem-solving aims and initiatives of the patient (as a whole person) as these implicitly structure the analytic field, in conjunction with the (partially unconscious, intuitive) facilitation of those problem-solving efforts by the whole person of the analyst. Analytic therapy is always a case of necessity being the mother of invention, where “invention” refers to the total coordination and co-creativity of the dyad in a given moment (i.e., the emergent yield of the particular momentary organization of all of the relevant sub-systems) in the service of aiding the patient in her fitful movement toward implicit, always-evolving, never-fully-namable, developmental/therapeutic aims.

By framing the analytic process in this way I am underlining the *irreducible density* of the analytic dialogue or exchange (see also Coburn, 2014). My two-sentence intervention with Mary was irreducibly dense, representing an emergent “invention” of mine (in the context of our *total* relationship and shared understandings) in the moment when I made it. In Sander’s terms, it proved to be a good “match,” in that moment, with Mary’s current state and her implicit developmental aims and struggles.

**Synthesis**

To return to the main question of this chapter—the relationship between understanding and relational engagement in psychoanalytic treatment and theory, now hopefully, disentangled from, but also informed by, the discourse on implicit vs. explicit knowing—I will offer my own current take on the question. It seems to me that the two currents of thought in psychoanalysis that I have identified—the current pertaining to the
progressive illumination of the patient’s truth (the aim of which is the patient’s increasing
capacity to “live from” or in accord with that truth—see Ogden & Gabbard, 2010 and
Symington, 2012), and the current pertaining to the optimal forms of relational
engagement for bringing about transformations in the patient’s ways of being, relating,
and experiencing in directions the patient implicitly wishes to move, come together under
the rubric of Sander’s ideas of specificity of recognition and fittedness, and my meta-
theory of needed relationships. That is, the analyst is at all times seeking both to expand
and deepen his understanding of the patient and what is occurring interactively in the
analytic field, and to engage the patient in ways that are optimally and uniquely
conducive to the patient’s growth and transformation (as these transformational aims are
progressively revealed, and evolve, over the course of treatment). Seen in this way, it
becomes clear that the analyst is never “off the hook” of seeking simultaneously to
achieve maximal understanding and optimal engagement, and thus (as Ehrenberg was the
first to articulate) to combine them in ways that best advance the analytic process in the
moment.

Moreover, in this framework it is recognized that the analyst’s understanding and
forms of relational engagement are mutually constituting dimensions of the
intersubjective analytic experience and change process (Aron, 2013). The analyst’s
complex understanding of the elements at play in the analytic process infuse and shape
his implicit experience and ways of being an analyst at all times. Further, the analyst’s
current level or quality of understanding, including his moment-to-moment relationship
to his own “internal” experience, even if not explicitly formulated or voiced, exerts an implicit influence on the patient’s current experience—her experience of the analyst, the analytic process, and herself (Symington, 1983). Conversely, the quality of relational engagement, moment to moment, exerts enormous shaping influence on the quality of the patient’s participation, including her unfolding capacities to reflect on, “feel,” and “speak” her previously “unthinkable” emotional experience; on what both parties are able to “hear,” “see,” and sense within the field; and on how that data is processed, formulated, creatively elaborated, and communicated. In short, the synergistic combination of understanding and engagement creates an intersubjective medium through which the mysterious, transformational alchemy of analysis—the cumulative “dyadic expansion of consciousness” (Tronick, 2002)—takes place.

To distill the ideas developed in this chapter down to their abstract essence, I borrow from, and take the liberty of adding to, Bion’s (e.g., 1962, 1970) famous symbols. In the ceaseless flow of interaction between patient and analytic therapist there is always the intention and effort on the analyst’s part to understand, and the current yield of that effort—Bion’s “K.” But there is also the constant flow of relational engagement (Ehrenberg, 1992; Grossmark, 2012) and the analyst’s constant effort to find ways of engaging that are optimally productive or connecting, which I will call “R.” I think of the total flow of K and R as emergent from Bion’s “O” (the ultimate, total, implicit, mysterious, largely unknowable reality of the patient, the analyst, and their interaction within the analytic field). Following Bion (1970), the optimal attitude for the
apprehension of O is a radical openness signified by his famous injunction to approach
the session “without memory or desire.” I think of this state as a creative, intuitive
receptivity and surrender to the process; and in an analytic couple working well together,
this can at times become a co-creative co-receptivity and mutual surrender at the implicit
level. Bion believed that this radical openness to the psychic realities which lie beyond
current understanding, combined with a necessary capacity for tolerating ambiguity,
confusion, and uncertainty, sometimes for extended periods (Keats’ “Negative
Capability”), has the best chance of yielding an “evolution” from the experience and
apprehension of O to new, emergent (though always incomplete) understandings: O------
→ K. What I am adding is that the effort to “enter” and apprehend the O of the interaction
also leads to emergent evolutions in R—the evolving forms of relational engagement
within which K is embedded and communicated, but which also are, to some degree,
shaped and framed by K. Thus I would modify Bion’s formulation to: O------→RK,
where RK represents the evolving, interpenetrating, mutually constituting, multiplicative
relationship between understanding and relational engagement. By “multiplicative” I
invoke Ehrenberg’s (1992) idea that “the integration of the affective and the analytic
gives each more scope.” These evolutions in RK generate transformations “(T)” in the O
of the total ongoing interaction and mental states of both parties—transformations that we
hope are productive but are always complex, emergent, and unpredictable. We then,
goingly, turn our attention, our “analytic instrument,” our creative receptivity,
curiosity, and relational “readiness” to the now-transformed O, which in turn yields new
evolutions in RK. Thus the analytic process over time could be represented as: $O_1 \rightarrow R_1 \rightarrow K_1 \rightarrow (T) \rightarrow O_2 \rightarrow R_2 \rightarrow K_2 \rightarrow (T) \rightarrow \ldots \rightarrow O_\infty \rightarrow R_\infty \rightarrow K_\infty$.

This symbolic account requires one further clarification of the meaning of $R$. The analyst’s moment-to-moment relational engagement, we know, is complex and tricky because there are always at least two general aspects to it: the forms of relating that fall within our more-or-less conscious therapeutic intentionality, and our total relational engagement of the moment, which always includes unconscious, unintentional, enactive elements. Indeed, these elements have become, in our post-Bionian era, an important component of $O$—i.e., an important part of the total inter-psychic reality of the session that we are seeking to apprehend, understand, and transform. The relationship between these two relational dimensions is extremely, really impossibly, complex. In fact, I will be taking up some of the complexities inherent in the interactions between them in the next chapter. For the purposes of the synthesis I am trying to represent here with these symbols, $R$ is being used to refer primarily to the first aspect: those elements of the analyst’s relational engagement that fall within her or his more-or-less conscious therapeutic intentionality. The second aspect—the unintentional, unconscious, enactive elements of the analyst’s relational participation—are, in this symbolic synthesis, considered part of $O$. This is appropriate because, even as the unconscious aspect may be pervasively present, my interest in this chapter mainly concerns the forms of relational engagement that are part of the analyst’s therapeutic intentionality, very broadly construed.
Though admittedly “experience-distant,” and thus perhaps off-putting to some readers, I find this symbolic distillation helpful because it captures the essence of the holistic sensibility intended in the meta-theory of needed relationships, and, I believe, in Sander’s theory of specificity of recognition and progressive fittedness. Rather than approaching the analytic process armed with theoretical categories—categories of patient participation (implicit vs. explicit; emotional vs. cognitive/reflective; etc.) or therapist participation (non-verbal, interpretive, empathic, self-expressive, containing, etc.)—the abstractness of RK orients the analyst away from theory toward: (a) the unique and ever-changing complexity of each patient from session to session; (b) the importance of trying to apprehend the uniqueness of what is happening in every session, moment to moment (Ogden, 1999; Peltz, 2012); and (c) the uniquely improvised amalgam of communicated (and uncommunicated) understanding, and expressed (and unexpressed) relational/emotional “with-ness,” that constitute the therapist’s live effort to “meet” what is happening in a way that causes the patient to feel “met,” “known” and helped. This is not to say that we don’t need our theories. How we understand RK at any given moment is always, necessarily, theory saturated; without our theories RK would be an empty, useless term. But my intention, similar, I believe, to Bion’s (1970), and more recently Ogden’s (2009), is to place the irreducibly unique patient, and the unfolding analytic process, which is unlike any other, above theory in the live moment that we encounter them, such that our total response in a given moment or session is a unique amalgam of RK, inspired by, and fitted to, the need of the moment.
The term RK can also serve as a reflective tool for processing difficulties in the ongoing interaction. For example, if an analyst’s interpretive efforts to convey certain understandings repeatedly fail to connect with the patient at an affective level, or at any level that makes a difference, this could reflect problems with the content/meaning of the interpretations; but it also could reflect problems in the relational conditions within which the interpretations are embedded. One patient with whom I found myself having many insights, and sharing them in what I thought was an attuned, well-timed way, kept being disrupted and silenced by my interpretations, leaving both of us in an awkward, anxious place. She was as perplexed and disturbed about this as I was, as she experienced most of these interpretations as on point and useful. Gradually I figured out that what I wasn’t taking into account was the rhythm of her thought processes. She processed things deeply and creatively but at her own pace—a pace that was slower, sometimes, than my process of insight-generation. We came to understand her sensitivity to this in terms of the lack of affect attunement of both of her parents—no one had been even slightly tuned in to the quality or rhythms of her experience and processing. This led to a dramatic change in my ways of communicating with her. The rhythms of our dialogue, the dance between silence and speech, became as important as the content of what was said. Here, problems in R—my attunement and coordination with the rhythm and pace of her processing style—were interfering with the communication of K. Once these became better integrated, the synergy between K and R was dramatically enhanced as never before, and the analyzing capacities of our co-created “analytic instrument” deepened considerably.
Conversely, one way to think about problematic enactments is that the essential RK relationship and synergy is breaking down because of a progressive impairment in K—the ability to think about, reflect on, and process fully and freely all that is occurring in R. The signal and most dangerous example of this imbalance occurs when an a transference-countertransference engagement that has been functioning therapeutically (i.e., has been held in “potential space”) begins to feel real to the analyst in such a way that he or she is no longer able to process what is happening as an “object of analysis.” I described this, in Footnote _ in Chapter 1, as a loss of the necessary complexity in the analyst’s analyzing subjectivity. If the analyst can recognize the deterioration in K as a signal, or itself an object for analysis, the possibility exists for the analyst to take steps to process what is happening (with or without supervisory help) until K is fully restored.

**An Ordinary Clinical Example**

At a certain point I became aware that, in my work with Judy, an accomplished, successfully married, but obsessively anxious woman in her late 40s whom I had been seeing for about 6 months, I was offering a lot of helpful advice and “wisdom” regarding how to deal with her adult children and her family-of-origin members, all of whom caused her great “stress” and worry in different ways. With her children this often took the form of worry, after the fact, about things she had done or said with them by way of offering concern or guidance. Once I noticed what I was doing, I began to worry about this myself, in a non-specific way (Why am I talking so much? Why am I engaging with Judy in this particular way?), so decided to say out loud that I noticed myself doing that
more than is usual for me, and wondered why. She was surprised by my odd question because we hadn’t previously done much talking about our relationship. But she was also intrigued.

We both agreed that the things I said in the service of enlightening her usually felt pertinent and were helping her both to gain understanding and to reposition herself in various ways in these familial relationships. From that point on, however, I tried to be more aware of what I was doing. It wasn’t long before I saw, and shared with her, the parallel between my experience with her and her feeling of over-involvement with her children in the sense of offering protective/supportive guidance and then worrying about having done so. I also made a link between these patterns and the lack of any helpful guidance received from her parents as a child. Judy’s father was self-absorbed, hypochondriacal, and preoccupied with his business, while her mother was highly critical and controlling, frequently traumatizing her with unpredictable, rageful attacks for failing to conform to the mother’s moment-to-moment, often unstated, expectations. “How could you do this to me?” was the mother’s angry refrain. Interestingly, during this period in our work, one of Judy’s adult (college age) children had a dream that his mother was in danger, and he was trying to warn and protect her—a dream that made Judy worry about why he felt a need to protect her!

At this point a shift began to occur in our interactions—a move in the direction of “staying with” Judy’s states of worry and tension as opposed to the more active mode of “helping her gain perspective” that I/we had been in. It became clear that she was in a
more or less constant state of tension or worry about one thing or another. She associated to her mother growing up—her intrusive, unstoppable rages. All Judy could do was hide in the closet. I labeled her mother’s unpredictable rages a childhood trauma, and her constant anxiety a form of PTSD. Judy wondered how we should “approach” the problem, how she would “work it through.” I said we would have to look to her, follow her lead.

In the next session she began by saying: “This is like Yoga class: I have to work hard to stop my swirling mind in order to focus on what’s happening internally.” I asked: “But what is the quality of your swirling mind?” Both of our thoughts again went to her childhood. I said I imagined a child living in a constant state of vigilance, fear, and pain. She recalled using reading as an escape—an escape from her world and into other worlds. She associated to the book she was now reading in her women’s reading group—David Foster Wallace’s *Infinite Jest*. She described Wallace as “brilliant and tortured” and the book as creating “a swirling chaotic world.” I wrote down after the session that I “relaxed and was quieter as I simply took an interest in her mind and how it works.”

Several sessions later, after a two-week break, Judy described having, one night, felt panic as she lay in bed unable to get back to sleep. But then “I thought of your voice, encouraging me to look at what’s there and to stay with it. That was comforting, calming, and I got back to sleep.” She also reported several situations with family members in which she found herself feeling calmer and “less apologetic” about her actions.
Then, in a subsequent session, I found myself again having the strong impulse to offer her perspective and “wisdom” about struggles she was reporting with her adult children. After telling her I was feeling that impulse again, I went ahead and offered the “guidance” anyway. She found it quite helpful and grounding. I ended the session saying that I was now aware of a back-and-forth pattern in our sessions between offering guidance and support on the one hand, and simply staying with her anxious states on the other, both of which I assumed were related to her traumatic disregulation, and the help she didn’t receive with self-regulation, as a child.

**Discussion**

During this early period in my work with Judy I became aware of an aspect of the O (total reality) of my interactions with her—a certain pattern of relating (R). By calling attention to it as I did—notice it out loud without judging it or necessarily trying to do anything about it—I expanded both the R and K of our interaction to include a new form of engagement—verbal reflection on, and curiosity about, how we had been spontaneously engaging with each other. The result was the beginning of associative links to other relational patterns and experiences in Judy’s childhood and adult life. R and K were both evolving and interacting, seemingly in synergistic ways, all the while impacting the O of Judy’s experience and our relationship. Significantly, one of the ways R and K interacted here involved the uniquely analytic “relationship” we, at my instigation, were developing with the process of seeking understanding. That is, not only was our relationship to each other evolving, so was our relationship to the process of
investigation and understanding itself. In this sense, R and K became even more fused and mutually constituting.

Out of this fusion of R and K a shift in R occurred in the direction of a more standard analytic “staying with” and empathically exploring the sources of Judy’s constant anxiety states. This led to a deepening of K, as the traumatic nature of Judy’s childhood experience of her mother came into focus as never before. This in turn led to a further shift in R: When Judy asked how she would “work through” her early trauma, I expressed confidence that “following her lead” was the necessary and best approach. This in turn led to a further expansion of K as we approached her “swirling mind,” less with the intention to immediately relieve the swirling than to understand it. This generated memories of her dissociative, self-regulatory use of reading novels as a child. Finally, all of this coalesced in some evidence of Judy’s beginning internalization of both R and K: As she lay in bed in a panic she could hear my voice encouraging her to “stay with” whatever is there, and this was calming.

This brief period of analytic work, understood as a co-evolution in R and K, provides a simple example of what I mean by *contouring*. The co-occurring, evolving transformations in understanding and forms of relational engagement were uniquely and progressively fitted to my, mostly intuitive, implicit, sense of what Judy and our analytic process “needed” in the service of her mostly implicit aim of mastering her early trauma and resulting chronic anxiety. Part of this contouring was a subtle, unplanned rhythm of my “first taking the baton, then handing it back to Judy” as I alternated between offering
helpful guidance and encouraging Judy to “stay with” whatever she was experiencing and see where her associations took her and us.

Summary

To summarize the major points in this long chapter:

(1) The relational paradigm and theoretical movement (broadly construed) has introduced many forms of relational engagement as potential contributors to therapeutic action.

(2) With these expanding relational possibilities, the theorized relationship between communicated understanding (so central in traditional psychoanalysis) and relational engagement has become increasingly complex and murky.

(3) Some of the major formulations of this issue by prominent relational authors and schools of thought were selectively reviewed and critiqued. Weiss and Sampson, Mitchell, Ehrenberg, Hoffman, Aron, and Harris, each in their own way recognized the inextricability of understanding and relational engagement, which I view as a core principle in the process of achieving progressive fittedness between patient and analyst.

(4) I reviewed and critiqued the current trend in relational theory, which (influenced by findings from neighboring scientific fields, especially mother-infant observation studies) privileges the “implicit” (non-verbal, procedural) relational dimension of analytic interaction over the “explicit” (verbal, cognitive) dimension.
(5) I singled out Sander from other psychoanalytic mother-infant researcher/theorists as adopting a more holistic systems approach that does not parse or privilege one dimension of therapist-patient interaction over another.

(6) I presented my own current synthesis, represented by the symbolic formulation: \( O \rightarrow T \rightarrow RK \ldots \), a modification of Bion’s (1970) famous formulation: \( O \rightarrow T \rightarrow K \).

(7) I offered a brief clinical sequence (which took place over several months) in which there was a progressive contouring of my understanding in tandem with various forms of spontaneously arising relational engagement (both with the patient and the process).