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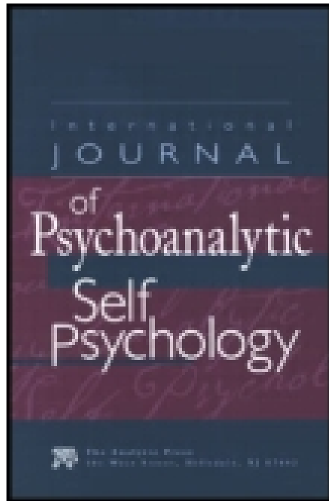

International Journal of Psychoanalytic Self Psychology
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/hpsp20

Conversations With Paul

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Published online: 06 Mar 2015.

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To cite this article: Richard A. Geist Ed.D. (2015) Conversations With Paul, International Journal of Psychoanalytic Self Psychology, 10:2, 91-106, DOI: 10.1080/15551024.2015.1005795

To link to this article: http://dx.doi.org/10.1080/15551024.2015.1005795

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International Journal of Psychoanalytic Self Psychology, 10:91–106, 2015
Copyright © The International Association for Psychoanalytic Self Psychology
ISSN: 1555-1024 print / 1940-9141 online
DOI: 10.1080/15551024.2015.1005795

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Conversations With Paul

Richard A. Geist, Ed.D.

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In a tribute to Paul Ornstein, this article describes how Paul was one of the rising generations of self psychologists that embraced radical ideas that were opposed to the philosophical, theoretical, and therapeutic ideologies of the day. After highlighting his unfettered courage and optimism, I describe how Paul built on Kohut's innovations, helping to spearhead a seismic shift in our philosophical and theoretical understanding of the underpinnings of psychoanalysis. I was fortunate to have the opportunity to discuss these major transitions with Paul during two years of taped Wednesday afternoon conversations. The article shares with you excerpts on selected issues from our conversations, covering topics such as how Paul found self psychology, empathy, the unconscious, the therapeutic alliance, curative fantasy, supervision, transmuting internalization, selfobject transference, and interpretation. It is through these exchanges that the breadth and depth of Paul's clinical wisdom is most apparent.

Keywords: empathy; interpretation; self psychology; transference; unconscious

It is an honor and a personal privilege to participate in a volume that celebrates Paul Ornstein's prolific contributions to psychoanalysis in general and self psychology in particular. An honor because, as many of you know, Paul (and Anna) are among the pre-eminent self psychologists in the world today. A personal privilege because whatever it is that I know about psychoanalysis, I have learned much of it from the writings, teachings, supervision, and personal discussions with the Ornsteins. Their clinical acumen, friendship, insight, generosity, passion, and wisdom have been a sustaining force in my life for decades. Each of them embodies an independent spirit, a strong sense of self and a wealth of original ideas. And while this volume is honoring Paul, you will have to allow me poetic license to paraphrase Winnicott by saying that, despite their independent accomplishments, unique lives, and separately proud self organizations, there is no such thing as a Paul without an Anna, and there is no such thing as an Anna without a Paul.

Kohut (1977) once said that his deepest wish was to "motivate the rising generation of psychoanalysts to pursue the path . . . that will lead us further into . . . that aspect of reality which can be investigated through scientifically disciplined introspection and

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empathy" (p. 312). Paul was one of the rising generation who has fulfilled Kohut's wish. He embraced radical ideas that were opposed to the philosophical, theoretical, and therapeutic ideologies of the day; he advanced our understanding of self psychology around the world and generously shared his clinical and theoretical insights with the next generation of self psychologists, for which I will be forever grateful.

For several years I was fortunate to spend Wednesday afternoons with Paul as we tape-recorded our discussions of his many articles: challenging old concepts, playing with new ones, and imagining where self psychology might take us in the ensuing years. The combination of clinical and theoretical discussions in which we engaged offer more than a lifetime of Paul's wisdom (which we plan to share in a forthcoming book). While metabolizing much clinical knowledge through these encounters with Paul, I also learned about life, the conquering of adversity, and the incredible capacity to remain open to change as we age.

Paul has always been a man of unfettered courage and optimism, both fueled by a healthy sense of omnipotence. Jean Peck (1998), in her moving book *At the Fire's Center*, tells the story of Paul's experience in the labor camps in 1944. I will give you an abridged version:

> He was stationed between the fighting Russians and the Hungarians while digging ditches. At one point on this hot summer day, Paul removed his jacket. At that moment the Russians opened fire, and the Jewish laborers began a hasty retreat. When he was 200 yards away from the front lines, Paul turned in horror to a friend, George. "I left my jacket out there!" he cried. "All my pictures of Anna and my family are in the pocket!"
>
> "You'll have to leave it there," said George. "It's too dangerous to do anything else."
>
> "I'm going back for it," Paul insisted. "I have to have those pictures."
>
> "You can't go back," declared George. "You'll be killed!"
>
> But Paul was already crawling on his belly back to his jacket. Paul picked up his coat and the two friends dashed to safety. As Jean Peck wrote, "Paul knew he was depending on those pictures of Anna and his family to keep him alive." (pp. 112–113)

Nowhere is there a better demonstration of Paul's courage, and nowhere is there a better understanding of selfobject functions than in this description of the sustaining role that Anna's (and his family's) pictures played in Paul's life during those oppressive years; in fact Paul intuitively understood selfobject functions long before Kohut coined the term.

Paul's professional and personal journey carried him from ego psychology through object relations to self psychology, from a theory based understanding of psychoanalysis

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to a patient centered understanding of the treatment process. An incident from his supervision with Kohut stands out as representative of the change in atmosphere that Kohut taught and Paul internalized in his own way. On a Friday afternoon before a long weekend Paul was sitting in Kohut's waiting room anticipating his supervisory hour. A patient left the office and shortly thereafter Kohut came dashing out, chasing his patient down the hallway to the elevator. When Kohut returned, Paul asked what was going on. Kohut replied that his patient had been feeling quite anxious, and after he left Kohut thought of an interpretation that might be helpful in calming him over the long weekend; he wanted to convey this understanding to his patient before he exited the building. Today we might say that Kohut's implicit communication to his patient was equally important as his interpretation. However we conceptualize it, Paul has been instrumental in helping to translate such patient centered treatment into a psychoanalytic theory of understanding and explaining that has both depth and rigor while maintaining a humane approach to a more symmetrical analytic dyad.

In fact, through his writings and teachings, Paul built on Kohut's innovations, helping to spearhead a seismic shift in our philosophical and theoretical understanding of the underpinnings of psychoanalysis—modifications that freed psychoanalysis from the hobbling restrictions of its American translators. I think mentioning some of these transitions will provide a context for sharing with you important fragments from our Wednesday afternoon conversations. The major shifts include several metamorphoses:

From a psychoanalysis which postulated that healing involved dissecting the layers of the patient's personality to an understanding that healing requires the fitting together, not the dissection, of the fragmented parts of our patients so they may regain their wholeness.

From a psychoanalysis which posited a ubiquitous, destructive, aggressive drive that is incessantly present to an understanding (supported by 40 years of infant research) that rage is always secondary to narcissistic injury and will dissipate as we empathically understand the shameful indignities and hurts experienced by the patient.

From a psychoanalysis that proposed frustration is necessary (both developmentally and therapeutically) to facilitate maturation to an understanding that empathic responsiveness and connectedness, not frustration, are what promote both growth and healing.

From a psychoanalysis which assumed that independence is the sine qua non of mental health to an understanding that individuals need relationships with self-sustaining others throughout life, in other words that mental health is based on our capacity to seek out meaningful self–selfobject relationships.

From a psychoanalysis which embraced the oedipal complex as the bedrock of development to an understanding that the development and maintenance of our sense of self in the context of empathic responsiveness is the foundation underlying healthy growth.

From a psychoanalysis which conceptualized transference as a distortion, displacement or projection to an understanding that transference represents tendrils of health to be welcomed as they are remobilized in the context of a deep connectedness between patient and analyst.

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From a psychoanalysis which taught that the methodology for collecting data in the clinical situation is implemented from an observational vantage point outside of the patient to an understanding that empathic immersion in the patient's subjective reality is the primary position from which we apprehend our patients.

Through his writings, Paul played a major role in each of these transformations, many of which have been incorporated into post-modern theories under different names. The important transformation in philosophical and theoretical beliefs was concretized when Paul (together with Anna) modified and combined the ego psychologist's view of psychoanalysis as an explaining psychology with Jaspers' and Ferenczi's transitional portrayal of psychoanalysis as an understanding psychology. This resulted in the Ornsteins' (1985) seminal article on understanding and explaining. Rather than analyzing and discussing the implications of this article, as well as Paul's other voluminous writings; however, I would like to share with you excerpts on selected issues from our Wednesday afternoon conversations. For it is through these exchanges that the breadth and depth of Paul's clinical wisdom is most apparent. Because Paul has been interested in empathy as the structural foundation of self psychological treatment during most of his professional life, I have chosen to focus on those comments that are intimately intertwined with empathy.

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On the Road to Self Psychology

Dick: Paul, you came to self psychology via ego psychology and object relations. With your traditional training, what pulled you in the direction of self psychology?

Paul: I was not a priori treatment oriented. Like Freud and traditional analysts, I was theory oriented. I felt I knew how to make relationships with patients, so in the beginning I wanted to know how you do analysis, which made me focus on theory. But I quickly became treatment oriented because I had the feeling that if you don't connect the theory to the treatment, you will never have evidence that your theories are valid and not just speculative. And, importantly, I had two treatment failures with my control patients.

Dick: Do you have a sense of what caused the two treatment cases to fail?

Paul: Yes, although neither of my supervisors knew. They had some explanation that didn't make sense to me. The first patient was married with two children. He was drawn to black prostitutes. In short, my interpretation, based on theory, was that the black prostitutes were so different from his mother that he was using them to defend against oedipal feelings toward his mother. But in my translating that theory into an interpretation, my patient heard it as my wanting him to stop seeing the prostitutes. After a while he got sick and tired of hearing me suggest (implicitly through my interpretations) that he should stop, so he left. Later on, after he was no longer my patient, I thought I should have said that even though pursuing black prostitutes was frightening, he feels this is the only thing that can restore his good feelings about himself and make him fully sexual. This would have enabled him to feel understood and allowed us to analyze it from his perspective.

The other case was a very smart, competitive woman. In those days she would have been labeled a phallic woman. I obviously didn't say she wanted a man's penis, but that's what she heard when I commented on her competitiveness and pointed out how intensely she was struggling to surpass her husband in some of their activities. Like my male patient, she felt criticized. I was taught to think that she could not improve if she didn't get insight into what she is doing. So I didn't know what to do, until she finally got tired and left also. I don't know why neither of my supervisors thought that these interpretations must have sounded critical. What they said when the idea of criticism came up is that you're not criticizing them, they are hearing it as criticism. So that's how I lost two out of four controls. They stayed about 350 hours so I must have also been conveying something other than criticism too.

Dick: Your supervisors were searching for the patients' pathology rather than how you were impacting them or the healthy aspects of what they were doing?

Paul: Yes, that began to teach me what happens when there is no empathy.

Dick: It reminds me of a time in my initial analysis when, after the end of an analytic hour I was walking down several flights of stairs to leave the office, and at one of the landings I heard a woman screaming at a crying infant, "I'll kill you or beat you if you don't stop crying." I assumed that my analyst rented out part of her house, so the next day, I told her that it sounded like the nanny taking care of the baby on the first floor was threating to kill him or her. She reacted by saying, "You were listening at my door?" I responded by reminding her that there were no doors, only curtains separating the stairs from each floor of the house. Needless to say, I felt criticized for being ostensibly voyeuristic, which was of course the implied interpretation. I did manage to say that if she didn't do something about it I would call the appropriate social agency. The iatrogenically induced anger was of course discerned as pathology.

Paul: She was looking for an external, dynamic interpretation instead of empathically understanding your difficult position.

Dick: Yes, or covering over a defensiveness with analytic artifice. But that brings us back to the actual topic of empathy.

EMPATHY

Paul: Somehow I failed to see back then how central empathy was to our approach; even some self psychologists have demoted it since Kohut's death to just one of the observational modes.

Dick: But you've devoted many years to studying and using empathy. Maybe we have to communicate why empathy, as defined by Kohut, is so difficult to accept?

Paul: Yes, because it is so important to see things from the patient's subjective vantage point. A lot of therapists are empathic, but they use it to mean they are compassionate rather than discerning it as a means for entering the patient's subjective world. Analysts like to use their knowledge; that is what gives them a feeling of

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competence. It's stressful sitting behind the couch, and if they can't rely on their knowledge, for which they are paid a lot of money, what else do they have? But if they would accept the fact that what they would have is the changes within themselves that now makes them the appropriate instrument for treating patients, they wouldn't be so quick to reach for the specifics of theory.

Balint (1968) said in the *Basic Fault* that you have to be with the patient, but he never explained how to do it. Kohut did explain it, so that's why I shifted away from Balint even though he was more human in his treatment than what I was exposed to in Cincinnati. Even now I'm still trying to articulate what it is like to be with somebody. It's almost a life-long task to work out with each new patient what it means to be with them. Many of my initial flaws in doing analysis had to do with not understanding how to be with a patient. When a patient asked for something, I heard it as the patient being demanding, and I was taught that if you satisfy a patient's wish you cannot analyze it. Kohut said at one point that is not really so. For example, if the patient asks where you're going on vacation, he answers because that is the polite thing to do. And he learned that after answering, it is easier to analyze because the patient will not feel rejected. But if you act like it's something mystical, and you don't reveal anything about yourself, it's distancing. I had to struggle with that concept based on my prior training.

One time a patient brought in his diaries, and he was upset with me when I didn't accept them. I realized later that he wanted me to be the protector of his whole life history. I should have welcomed that. Kohut pointed out to me that when people bring you something, you need to accept it because there is something important behind it that won't be available for discussion if you refuse it. He said, sure you talk about it, but not by first refusing it. Empathic immersion is for the purpose of living with the patient.

Dick: Some therapists say the idea of empathic immersion makes the therapist feel required to completely immerse himself in the patient's experience, banishing his psychic organization from the therapeutic dialogue, which they claim is impossible.

Paul: My rebuttal is that we can decenter. We don't have to banish ourselves; we can immerse ourselves in the patient's world and explore from that position of immersion. By immersing yourself, Kohut meant that you basically live that experience with the patient, but living that experience also means processing it. You formulate and articulate your understanding and offer it to the patient for correction or emendation. Immersion is the only position that is quasi inside; those who are in touch with their inner experience can tell you that. If you look at your patient that we've talked about—the one who didn't do well in her first treatment—with you empathizing with her, she became exquisitely in tune with you and herself. With her former therapist, there was observation; he knew how to ask questions and she knew how to answer them. But he was not inside her. There was no feeling of living the experience with her. There are two elements to this empathic immersion. First, the patient doesn't experience you as observing her from the outside, and second, you're formulating what you say from the patient's perspective.

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Dick: Yes, that reminds me of the incident from my own treatment. Of course there was voyeurism involved, but it was a fragment of the whole picture. If the analyst had said something like, it's so difficult to hear that kind of threat, especially because you see children, and you must have not known quite what to do about it at that moment, then I would not have felt like she was outside critically observing, and I would have felt she was formulating from within my perspective. Without those two elements there can be no connectedness.

Paul: Yes, Kohut taught that analysis does not mean taking things apart or dissecting them. He always felt you speak to the whole person, and if you respond to the parts you will fragment the patient. He believed that what was most helpful was putting things together, looking at the fragments and integrating them—seeing the whole picture and responding to it. How to talk to the whole person is the catch in the treatment. He also believed that empathic immersion meant not going in and out of the patient's subjective world. You have to live inside the patient, but living that experience also means processing it. You formulate and articulate your understanding and offer it to the patient for correction or emendation. Historians and biographers have known that all along. They live with their subjects, so much so that their families and spouses complain.

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THE UNCONSCIOUS

Dick: There's been much criticism of self psychology for not focusing on the unconscious. In fact empathy is often discerned as antithetical to understanding the unconscious. When Kohut used the phrase "potentially grasped," he was referring to the unconscious, so how would you say that empathy helps us to get in touch with the unconscious?

Paul: Empathy cannot, in and of itself, penetrate to the unconscious because through our empathy we can only understand what's in the patient's experience. Things not experienced can only be inferred and that inference is merely an experience distant hypothesis. Because of this fact, some have argued that self psychology does not deal with the unconscious. This couldn't be further from the truth. If you grasp what the patient is expressing, convey it to the patient, and ask the patient if it feels correct or if we have missed the mark—in other words if you engage in what Anna and I have called a therapeutic dialogue (Ornstein and Ornstein, 1996) that invites the patient to correct us or add to what we tentatively apprehend, then the patient will slowly feel more understood.

As the patient feels more deeply understood, unconscious material begins to emerge. But what emerges from the unconscious is fluid and depends not only the patient's past, but on the relationship between analyst and patient. Something becomes unconscious because of fear of re-traumatization. When development does not proceed because the response to the infant or child was inadequate, there will be a deficit in the development of the psychic structures. So what is unconscious is what's beneath the deficit; it is the consequence of the thwarted

need to grow. So the unconscious is the content of all that was never adequately responded to. The dearth of empathic responsiveness creates the deficits in the self, and these deficits are filled in by defensive structures that prevent the emergence of affective states. What was at one time knowledge and part of the patient's experience is kept out of current experience either by repression or dissociation, but this always occurs in the context of a two-person relationship.

For unconscious material to emerge requires the analyst's understanding.

The more the patient feels understood, the fewer defensive measures he will need to protect himself, and the freer he will feel to reveal more. In other words the defensive barriers are penetrated by whatever is beneath them as a result of feeling understood.

Dick: I think what you're saying is that empathy lets us understand that the unconscious is no longer thought of as a system. It is an experiential state that is fluid; when and how the unconscious becomes conscious depends on the safety and connectedness that the patient feels with his or her therapist.

Paul: That's right. The unconscious is a quality of experience, and how understood and safe the patient feels, both interpersonally and internally, will determine what aspects of that experience will become conscious. Empathy facilitates the emergence of unconscious feelings in the context of a connected relationship.

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The Therapeutic Alliance

Dick: What about the notion that empathy has replaced the therapeutic alliance?

Paul: Brenner rejected the notion of the therapeutic alliance some time ago. If you hold with the original definition—that the healthy part of the patient makes an alliance with the healthy ego of the analyst, that's nonsense, it wouldn't keep an analysis going. It is the expectation on the part of the patient that in the treatment he or she will be understood and valued and appreciated, and the hope that he will get whatever he never got emotionally growing up, that fuels the treatment. That is what Anna and I have called the curative fantasy, which will differ from patient to patient. If that curative fantasy is not inadvertently or deliberately rejected, it will become the basis, the foundation, on which the selfobject transferences evolve.

Curative Fantasy and Molding the Analyst

Dick: Let's stay with the curative fantasy for a moment, because it often seems that even our colleagues differ over how one should respond to the fact that the patient brings with him fantasies of what he needs to heal. After all, Kohut did once say that the patient knows far better than the analyst what he needs to get better.

Paul: Yes, he did believe that. Let me give you an example of one of my patients whom I've written a lot about. Mr. K. never thought that his parents really knew him or really saw him. He was very inventive and had a tremendous capacity for

expressing things. As a child he built bridges and the parents couldn't appreciate it. At the breakfast table if he asked for the salt shaker, no one would get it for him. No one came to make contact with him, no one was available for him. That's why in the initial phase of analysis, when I talked about my way of understanding him as an external observer, he was very injured. It repeated the family situation. He taught me. He said give me evidence that you listen and have heard me by repeating it. He needed a form of mirroring.

Dick: That was his curative fantasy—to be heard and known?

Paul: Yes, and later on in life he felt that since he had a mask (a defensive structure), he could never show himself. His self-esteem was non-existent. "How could they see me, I never allowed myself to be seen?" That's the role he assigned to me; to be a person who could see him accurately. All the interpretations didn't work for him even though he liked them. He said all of that didn't matter if I didn't admire his capacity to interpret his dreams. And initially I felt I did admire him, he's fantastic, but I wondered, would explicit appreciation help? My old analytic training said no, I should explain what I've understood and that's it. But once we understood that I had to find a way to convey how rich his dreams were, and how without his input it would have been difficult to understand them, it allowed him to achieve what he needed from the dreams.

When I presented this case to my colleagues, however, they said how can you let him control you? I said you know it's interesting you say that. I didn't feel controlled. I felt that I understood him. But when he felt I was controlling him, it repeated some earlier experiences that were hurtful to him. I did not feel controlled. I just wanted to know more. My colleagues thought the patient has to be confronted with his need to control. I said suppose I tell him that he's controlling? Well, they said, then, he'd change. In the second part of his analysis, I became more spontaneous. When he felt seen, he wanted more. There's nothing better than an intelligent, sensitive, demanding patient who asks for what he needs because analytic candidates, especially when they are in analysis, they are cowards, often afraid to be challenging.

Dick: Yes, if you hold onto a frustration model of development, which many contemporary therapists still do, then you react in a much different way than letting the patient teach you what he needs. I remember in my initial analysis, I came in one day excited to find out if my analyst had seen the movie that I had watched the previous night, so I dared to ask. She responded with, "did you notice you asked me a question?" Angrily, I said I was quite aware of asking her a question; I was looking for an answer. Her response was "we need to understand where all this anger comes from," which of course provoked more reactive anger.

Paul: She was pointing out a fragment of you rather than being with your whole self and then once again iatrogenically evoking anger.

Dick: Yes, assuming there was always aggression that must be tamed, neutralized, or sublimated rather than discerning it as reactive to narcissistic injury. But even more to the point, she was ignoring the emergence of the tendrils of a healthy twinship

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selfobject transference—wanting to share the same excitement and opinions about the movie. Needless to say, it never developed.

Paul: That's an important point—letting the patient shape you to be what they need, just as Mr. K molded me to see him in the way he needed. This really is what the curative fantasy is all about. The patient comes with this life long effort to seek out what will be curative, and the therapist has to capitalize on that.

Dick: I (Geist, 2008) once used the analogy of dropping a stone in the water. It gets wet but doesn't become part of the water. I think being part of the water is what you call "living with."

Paul: Yes, we used to think that the patient has to put on the table his issues and we look at them together and try to solve the puzzle. Well, that meant non-participation. You didn't get the patient involved because you weren't involved.

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SUPERVISION

Dick: Even though we believe in the centrality of empathy, remaining in an empathic stance is much more difficult than analysts and therapists realize. How do we, or can we, teach therapists how to imaginatively feel and think their way into their patient's world?

Paul: The word "teach" has many meanings. If we use it in the broadest sense of the word, which goes beyond conveying information, and define teach to mean finding ways to enhance the learner's potential capacities, I would say yes, we can teach empathy. For example, first, we portray it for the trainee by being empathic with him or her; second, we ask questions that guide the learner to focus on his or her own experience with the patient and articulate the meaning of these experiences; third we demonstrate how we attempt to put ourselves in the patient's shoes, using all that the learner has presented to us—and thereby highlight what information we need in order to be guided in this process of empathic entry.

Dick: What you're saying is that it's a process of transmuting internalization, even in supervision, because you're providing the function that enables the supervisee's empathic capacities to unfold.

Paul: And that's so important. That's why I argue that we shouldn't use our precious time to teach dynamics and genetics. Instead we should show the student how to participate meaningfully, and in depth, in the treatment process. If I am empathic with the supervisee's position, the experience of having been empathized with might liberate in him the not fully developed capacity. Kohut said you can't be deliberately empathic. I disagree with that. I think I can be deliberately empathic and I can sustain it. Kohut's empathic immersion is an important part of it. What he says is you have to remain immersed; you have to live with the patient's feelings.

Dick: Liberating some not fully developed capacity—this is part of transmuting internalization?

Paul: Yes, but I understood transmuting internalization in a different way than our usual understanding of the term. Most self psychologists define it as the patient taking

over the functions of the analyst during the repair part of the disruption repair cycle. I always felt that Kohut meant that we were born with certain potential capacities, which, through the empathic responsiveness of the selfobject milieu, develop and becomes a part of you. It's like we are all born with the capacity for language, but if you grow up with wolves, you won't learn to talk.

Dick: So there are no functions that are transferred from the analyst to the patient or supervisee.

Paul: That's not how I like to think of it. Internalization is when something you already know how to do becomes a sustained capacity or abiding psychological function. This is different than taking over a function that the selfobject is performing as an external psychic structure.

Dick: This obviates the need for us to explain how something is transferred from me and gets into you.

Paul: Yes, the environment catalyzes inborn potential—tension regulating or soothing capacities for example. The child's innate capacities unfold in the context of the parents' empathic responses, and they will eventually mature and become structure. Transmuting internalization was for Kohut the process whereby selfobject ministrations facilitate what is potentially there to develop from within.

Dick: This makes more sense to me than the breaking down of functions and metabolizing them. It fits more with the notion that the child is born with healthy capacities that are sustained if the selfobject milieu responds.

Paul: Yes, the child is born with the capacity to evoke what it needs to develop—it is hard wired. But without the proper milieu it still could not develop.

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Transference and Selfobject Needs

Dick: Which brings us to the very different ideas about transference inherent in self psychology. Some self psychologists even down play the role of transference in the analytic process.

Paul: I believe the transferences are still important. They emerge as the analyst welcomes the curative fantasy. To simplify it, transferences contain all the hopes and needs and longings that were not met as the patient was growing up. If you didn't get it when you should have, then you strive to get those needs met when you encounter an analyst who understands you. So it's the empathic immersion that facilitates the patient feeling understood, and this reactivates the hope that unmet needs will finally have an opportunity to be satisfied. In other words there exists in the patient an irresistible urge to heal. Translated into everyday English, transference is when people direct their hopes, wants, needs, and feelings toward other people.

Dick: But what's so important about what you're saying is that transference in this model—defined as the remobilization of selfobject needs—is always healthy. In fact I would argue that self psychology is the only theory extant in which transference is discerned as healthy.

Paul: Yes, that's an important point. Transference from our perspective is never a displacement or a projection. It encapsulates the patient's subjectivity, but it is never a distortion, never pathological.

Dick: So instead of needing to correct the patient's distortions and replace them with the analyst's reality, we welcome them as healthy attempts to heal.

Paul: I don't think people recognize how important this subtle difference is in the treatment. As long as transference was conceptualized as a distortion, we didn't deal with it in terms of what was wanted and needed. Rather we conveyed to the patient that it was infantile and he should grow up.

Dick: Yes, I'm reminded of my patient who was feeling deeply pessimistic about therapy helping her to feel better. I told her that to feel so deeply pessimistic, she must have been stuck with these feelings for an awfully long time. She said, yes, as far back as she could remember. And then she added, so if I'm so stuck, fix me. It's your job to fix me not mine. And I agreed with her that it was my job to fix her. She reminded me that her previous therapist could never have said that. Rather than educate her about the importance of working on this together, I could empathically appreciate the emerging healthy tendrils of an idealizing transference and welcome them.

Paul: Kohut called attention to how much these little things matter. Minute things become central. Your patient is coming with this life long effort for a powerful, all knowing selfobject who can fix her, and the therapist has to tune in to what the patient is longing for and help it develop to its desired end.

Dick: Yes, the therapist has to become part of the selfobject transference in an important way.

Paul: And participate. As I emphasized before, we used to think that non-participation was important, that the patient has to put out on the table his issues and look at it together and try to solve the puzzle. Well, that meant non-participation, or unemotional participation. In that model you didn't get the patient involved because you weren't involved.

Dick: But the selfobject concept was so important to Kohut. If we can hold onto that concept, which many self psychologists don't, then we recognize that selfobject transference always refers to the idea that the patient experiences us as part of herself and that we experience the patient as part of our self-organization. It seems to me that was one of Kohut's most important ideas.

Paul: Yes, and that means that on an experiential level the patient does not recognize the analyst as an independent center of initiative even though cognitively the patient always knows that the analyst is separate. Experientially the patient feels that either you are part of him or he's part of you. This has two important implications. The first is that the analyst patient relationship is not always intersubjective in the specific sense of the word; in the general sense, yes, the two people affect each other, that's valid throughout even though in traditional analysis they denied it. But where the patient builds you into his self-structure, he does not experience two people in the room, which means it's impossible for it to be intersubjective. The second implication of experiencing the analyst as part of the patient's self is that there will be a healthy need for absolute control over the analyst. Remember

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Kohut used the analogy that when we want to raise our arm, it raises. In an archaic transference the patient feels the need to have the same control over the therapist as his body because the therapist's selfobject functions are so important to the patient. As a therapist, you consider yourself to be a person. That's where the object relationists and some interpersonalists falter when they try to insist that the patient should also recognize that. They are uncomfortable when the patient does not recognize it too.

Dick: Maybe that's where many selfobject disruptions or empathic failures occur?

Paul: Yes, and that brings up another interesting point. Because we are welcoming selfobject transferences as healthy rather than interpreting them as pathological distortions, we often function with the selfobject relationship quietly in the background. And often the interpretative emphasis occurs at times of disruption; we use it in an attempt to restore the self-selfobject relationship that carries the treatment.

Dick: How important do you think it is for the patient and analyst to understand the extra therapeutic transferences?

Paul: Transference is both ubiquitous and constant both in and out of analysis. The only difference is that in the treatment the transferences are directed toward the therapist. All intimate relationships, marriages, friendships are likely to activate transferences. Some people think only intra analytic transference is important to interpret and that the interpretation of extra analytic transference is neither helpful nor necessary. I disagree with that. I used to do a lot of interpretative work and not assign it to intra or extra transference. The patient assigned it outside or inside. For example, if the patient was telling me something about his wife, I could have interpreted it as something about me, but I didn't. I would stay with his experience of it, and it was just as useful.

Dick: Along these lines, I would guess you're comfortable explaining the dynamics of the important people in the patient's lives too?

Paul: Yes, and you know why it is important, it frees them up from feeling guilty. For Kohut it was very important. He said we should reconstruct the parents' personalities and their impact on the patient as she was growing up. One of my patients, Mr. K, analyzed his parents for years and he dealt with it in such great detail that I became convinced of its importance. But we need to be careful to differentiate this from parent blaming. We don't know how it really was, and when we reconstruct we are not reconstructing any reality here; we are reconstructing on the basis of the patient's experience. So I might say to the patient, the importance of what you're saying is very great because if you experience your parents that way, I can understand why you feel that way about them now.

Dick: So when you are engaged in reconstructing extra analytic transference, you are still doing this from the patient's perspective.

Paul: Yes, always. This ties in with what I said when we discussed using many modes of observation, but eventually channeling them through an empathic listening perspective. I have never found the external observer's statements to be helpful unless I could offer them from the patient's vantage point.

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INTERPRETATION

Dick: Yes, Winnicott said interpretation was more for the analyst than the patient. How do you see the role of interpretation at this juncture in self psychology's evolution?

Paul: Winnicott made that statement because the analyst needs interpretation to sustain his feeling that he is doing good work with the patient. Many have said the theory helps the analyst more than the patient, and that is probably true. Even though some self psychologists keep saying that interpretation is the central modality of treatment, I no longer believe that. Understanding can be more powerful than interpretation (although presently we think of interpretation as just deeper understanding). But interpretation in its original meaning indicates that the analyst has something to say that the patient doesn't know, and when people don't know something, they don't particularly appreciate you telling them. When I was able to interpret from within the patient's reality—fitting in with the patient's background, psychology, what he wanted from me—things turned out better. What seemed unanalyzable before then became analyzable. Kohut talked about psychopathology and the nature of deficit, but his emphasis was always on what did this person want in life and how did he want to get better. Kohut said when the patient puts the tendrils of his vision forward, not to recognize them is very painful, as in the example of wanting your analyst to have seen the movie you watched.

Dick: Kohut said that clinical work would lead only to ephemeral results if it did not include insight that goes beyond empathy. But he also said in his final paper and book that empathy is curative. Can we reconcile this difference?

Paul: I no longer accept the idea that empathy based understanding is ephemeral. At the end of his life, Kohut did imply that understanding was more important than explaining. But he also probably felt that if he totally minimized explaining, he would be read out of the congregation. I do believe that the emphasis should be on understanding and not on explaining. The explaining part came from the analyst's thinking interpretation was the only thing he had to offer. My own interpretation of Kohut's last statement is that if you treat the patient empathically, you are always understanding him from within his subjective world. The patient's reaction to being treated with consideration for his inner feelings, while not being judged from an external perspective by a therapist who ostensibly offers neutral dynamic and genetic explanations, will definitely have a curative impact. When I finally put interpretation in a less important position, I felt a little lost, but that new discovery had a lasting impact on both me and my patients. It meant that by entering into an empathy guided relationship with the patient, one cannot remain in an external listening perspective e; an empathy based approach already puts me inside the patient. In this sense interpretation becomes deeper understanding. So when we talk about empathy being curative, we still mean interpretation is useful, but only if it is offered from inside the patient's subjectivity.

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Conclusion

To capture the importance of Paul's understanding of empathy in the context of theory, I will leave you with what Paul told me when I asked him how he combined his theory with his profound understanding of empathy. Here is what he said:

> Our choice of guiding theory tames our subjectivity and keeps it within limits. If I am a psychoanalyst guided by self psychological theory, ultimately all of my subjective and empathic understanding has to fit that broad framework, but it shouldn't be put between us and the patient. It should remain in the back of our minds to guide us while we make our empathy the instrument of treatment; it should keep it disciplined. Disciplined subjectivity means guided by and framed with our total theory.

A patient of mine once captured this spirit when she said, "it's Dick that's engaged with me here in the room; it's Dr. Geist that's guiding the treatment." Reading Paul's spontaneous thoughts on how empathy impacts many aspects of the treatment process, I hope that it will be clear how this consummate clinician came to stand outside the traditional, safe haven of psychoanalytic convention and use self psychological theory to discipline his empathic immersion.

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Translations of Abstract

En homenaje a Paul Ornstein, este artículo describe como Paul fue uno de los pioneros de la *self psychology* que desarrolló ideas radicales que se oponían a las ideologías filosóficas, teóricas y terapéuticas de aquellos tiempos. Después de destacar su coraje y optimismo sin límites, describo como Paul desarrolló las innovaciones de Kohut, colaborando en desarrollar un cambio fundamental en nuestra comprensión filosófica y

teórica de las bases del psicoanálisis. Tuve la suerte de discutir con Paul estos grandes cambios durante las conversaciones que teníamos los miércoles por la tarde durante dos años, las cuales gravábamos. En este artículo comparto con el lector extractos de temas que he seleccionado de nuestras conversaciones, en los que se trataba de cómo empezó con la *self psychology*, la empatía, el inconsciente, la alianza terapéutica, la fantasía curativa, supervisión, internalización transmutativa, transferencia de *selfobject*, e interpretación. Es a través de estos intercambios que la profundidad y amplitud de la sabiduría clínica de Paul se pone de manifiesto.

Cet article se veut un hommage à Paul Ornstein, ce psychologue du soi faisant partie d'une génération qui s'est magistralement opposée aux idéologies thérapeutiques et philosophiques de son temps. Saluant son courage et son optimisme sans égal, je fais valoir que Paul a prolongé l'apport de Kohut dans l'établissement d'une nouvelle compréhension philosophique et théorique de la psychanalyse. J'ai eu le privilège de discuter avec lui de ce mouvement de fond au cours de conversations enregistrées qui se tinrent tous les mercredis après-midi pendant deux ans. Des extraits choisis en sont présentés, allant de sa découverte de la psychologie du soi, aux thèmes de l'empathie, de l'inconscient, de l'alliance thérapeutique, du fantasme curatif, de la supervision, de l'internalisation de transmutation, du transfert objet-soi et de l'interprétation. À travers ces échanges la sagesse clinique du personnage se révèle dans toute son ampleur et sa profondeur.

In omaggio a Paul Ornstein l'articolo descrive come Paul sia stato tra gli psicologi del sé della prima generazione uno di quelli che abbracciarono idee radicali in contrasto con le ideologie filosofiche, teoriche e terapeutiche del momento. Dopo aver messo in luce il suo indomabile coraggio e il suo ottimismo, descrivo come Paul abbia costruito sulle innovazioni di Kohut così da contribuire a creare quella leva che avrebbe prodotto un capovolgimento sismico nella nostra comprensione filosofica e teorica dei fondamenti della psicoanalisi. Sono stato fortunato ad aver avuto l'opportunità di discutere queste transizioni essenziali con Paul nel corso di due anni di conversazioni registrate il mercoledì pomeriggio. Questo articolo condivide con voi estratti delle nostre conversazioni su temi prescelti che spaziano da argomenti relativi a come Paul abbia fondato la psicologia del sé, l'empatia, l'inconscio, l'alleanza terapeutica, la fantasia curativa, la supervisione, l'interiorizzazione trasmutante, la traslazione d'oggettosé e l'interpretazione. E' attraverso questi scambi che l'ampiezza e la profondità della sapienza clinica di Paul massimamente si rivela.

Als Tribut an Paul Ornstein beschreibt dieser Artikel ihn als Mitglied der aufsteigenden Generation von Selbstpsychologen, die radikal neue Ideen aufnahmen, welche im Gegensatz zu den damals anerkannten philosophischen, theoretischen und therapeutischen Ideologien standen. Nach der Unterstreichung seines unerschrockenen Mutes und Optimismus beschreibe ich, wie Paul auf Kohuts Innovationen aufbaute und als Speerspitze einer die Landkarte verändernden Wandlung unseres philosophischen und theoretischen Verständnisses der Grundlagen der Psychoanalyse fungierte. Ich hatte das Glück, diese größeren Umwälzungen in den sich über zwei Jahre erstreckenden, auf Band aufgenommenen, Mittwoch-Nachmittag-Veranstaltungen mit Paul diskutieren zu können; dort sprach er darüber, wie er zur Selbstpsychologie gekommen war, und unter anderem über Empathie, das Unbewusste, das therapeutische Arbeitsbündnis, die kurative Phantasie, Supervision, transmutierende Verinnerlichung, Selbstobjektübertragung und Deutung. In diesem Austausch wurde die Bandbreite und Tiefe seiner klinischen Erfahrung besonders deutlich.

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