THE LIMITS OF CONCEPTUALIZATION AND INTERPRETATION:
Raw Observation's Place in Analytic Treatment

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Formulating and articulating interpretations is so central to the practice of psychoanalysis that it can eclipse an appreciation of a more process-oriented approach to treatment. Clinical material is presented from the supervision of a candidate from an out-of-town institute whose initial clinical interventions had chiefly been interpretative in nature. The case reached an impasse at the end of the first year of analysis and his supervisor opined that the case lacked "psychoanalytic process," meaning the candidate would receive no credit toward graduation. The candidate sought outside consultation, resulting in a de-emphasis of the tasks of conceptualizing and interpreting and a shift toward noting and valuing processes taking place in the room and within himself. This shift in emphasis ended up placing the candidate in close personal contact with the patient's own experience, which alternately could be considered from an intersubjective perspective of projective identification or from the perspective offered by Ofra Eshel, who advances the concept of "At-one-ment." The authors argue it is high time psychoanalytic training de-emphasizes the primacy of interpretation in favor of promoting an appreciation of a more process-oriented approach to treatment.

Without a doubt, the *practice of interpreting* is generally considered the quintessential tool of psychoanalysis, in line with Freud's dictum that analytically-induced change comes about by making the unconscious conscious, and *psychoanalytic process* is generally considered the quintessential sign that psychoanalysis is taking place. The practice of interpreting and psychoanalytic process are integrally linked; the former is widely thought to be instrumental in bringing about the latter. While most analytic institutes measure a candidate's clinical progression in terms of his or her ability to conduct analyses that demonstrate psychoanalytic process, we will cite evidence that calls this claim into question. We also aim to challenge the proposition that interpretation is far and away the most essential psychoanalytic tool, which gives short shrift to the art of observation which often proves indispensable in helping analysts regain their analytic perspective once they've become unknowingly lost in the intersubjective maze of a countertransference enactment.

Psychoanalytic training focuses on the art of interpreting and supervisors further this emphasis by helping supervisees conceptualize case material as prelude for the task of fashioning deliverable interpretations that serve as the mainstay of treatment. Candidates are expected to be on the lookout for manifestations of unconscious content that goes on to become the basis upon which to crystalize their nascent notions about the patient into elaborate, therapeutic interpretations. Unfortunately, emphasizing interpretation distracts candidates and practicing analysts alike from appreciating the benefits of a more observational, process-focused stance, which is the topic of this paper. Interpretations are often essential and invaluable, but there are times when observing and offering observations for the patient's and/or the analyst's consideration prove to be the more efficacious approach.

The efficacy of a chosen clinical intervention depends, in part, on the patient's underlying psychopathology—in particular, whether the defenses being employed are repressive or dissociative in nature[1]. Instances when repression has rendered intolerable psychic content unconscious (what we refer to as the "dynamic" unconscious) call for a treatment approach that aims to restore to consciousness psychically represented/formulated psychic content. Cases in which pathogenic historical events had not been comparably represented—either because they occurred at too young an age and/or were highly traumatic in nature—involve patients who are

[1] Naturally, patients may simultaneously employ both defensive maneuvers simultaneously, so this division is somewhat artificial. Nevertheless, there is utility in drawing this distinction to illustrate a general principle. Seen from the perspective of "fuzzy logic"—the idea of "degrees of truth" vs. true and false—one can think of representation existing along a continuum from non-represented, to weakly represented, to not yet represented to fully represented (Laub and Auerhahn, 1993; Levine 2012, 2014).

plagued by memories that are not recallable in the usual sense of the term—placing these implicit, pathogenic memories beyond the reach of interpretation that aim to undo repression. Such traumas oftentimes are not "experienced" in the usual sense of the term, notes Winnicott (19545), because the not-yet-fully-formed subject ("I") had not yet developed into a subject capable of the experience as an experience per say.

Clinically addressing such lived events often requires a more observational stance that considers *psychologically-significant processes* noted to be taking place within the patient, within the analyst, or between the two parties. What we have in mind are techniques that draw attention to *raw observations* that eventuate in an analytic perspective that—to whatever extent possible—is not laden or saturated with implied meaning but, instead, facilities a greater latitude of thought. Such observations help turn sheer experience (the experience itself) into observed experience (an object of observation), thus facilitating a consideration of the experience from a perspective outside a near-total, mindless absorption in the present moment[2]. From this outside perspective, analyst and/or analysand can reflect on the experience by "going meta" relative to the experience itself. Such a process-orientation includes, but is broader than *close process monitoring* (Gray, 1994; Busch, 1995), which aims to catch a patient's defenses in the act of disrupting his or her free associations. A process observing orientation, in this broader sense, considers intrapsychic processes noted to be taking place in the analyst's mind as well, which helps the analyst—for example--transcend a mindlessly emersion in a countertransference enactment. Manifest

[2] This brings to mind Britton's (2004) description of his struggle, in the treatment of a most difficult woman, to maintain his analytic perspective: "It seemed impossible to sufficiently disentangle myself from the to-and-fro of the interaction to know what was going on . . . . In such situations, what I felt I needed desperately was a place in my mind that I could step into sideways from which I could look out at things" (pp. 48-9).

intersubjective processes noted to be taking place when analyst and analysand thoughtlessly interact with one another in a repetitive, patterned fashion are another focus of this process observing stance.

In the supervised case that will be described shortly, the candidate—who initially assumed an interpretive stance in line with his original supervisor's orientation and instruction—gradually become more attentive to, and aware of his own internal processes, which he eventually realized provided more commentary about the patient's inner life than he had initially imagined. Attending to his own intrapsychic processes, which came to be recognized as a manifestation of projective identification, offered the candidate-analyst a window into the patient's mind. After attempting to maintain a decidedly positive (complementary) stance that countered the patient's unrelenting negativity, the candidate ultimately succumbed to the gravitational pull of the patient's nihilism by joining him (concordantly) in believing in the futility of expect things to change. While the candidate-analyst feared this shift might well spell an end to his capacity to serve as a productive force in the patient's life, the outcome was much to the contrary.

The Case under Consideration (TR)

This paper is co-written by a supervisor (Richard Tuch) and a supervisee (Matt Shatzman, who I will refer to throughout as "Matt")—a candidate from another city whose institute agreed to reconsider his supervisor's opinion that the case under discussion lacked evident psychoanalytic process, which meant the case would not count toward graduation. After almost a year in

analysis, the case showed no sign of progressing and the treatment seemed at a standstill. The candidate terminated his supervision at this junction.

Matt had been treating his patient, R., for almost a year in four-day-a-week, on the couch psychoanalysis when his supervisor opined that the case showed no sign of "analytic process." With the pleasing of his institute's progression committee, Matt contacted me and asked if I would be willing to consult on the case to determine whether I agreed with his supervisor's assessment. In relatively short order, this consultation morphed into outright supervision that spanned an eight-month period. Matt and I met remotely on a weekly basis during which time he presented recent process notes as well as notes from sessions that had taken place earlier in the year—material that presumably formed the basis of his supervisor's conclusion that the case lacked evidence of psychoanalytic process.

I learned about how Matt had recommended that his patient—a single man in his late 30s—enter analysis after a five-year course of twice-weekly psychodynamic psychotherapy, which Matt had conducted, failed to make a dent in R.'s nihilism, cynicism, and pessimism. Matt realized that undertaking analysis with such a negativistic man—one who seemed to clung to negativity for dear life and seemed to be refusing to get better—amounted to a heroic effort, but he believed it was worth a try given that nothing else had helped. His supervisor concurred.

Matt largely focused his therapeutic efforts on the patient's inability to find good in himself, in others, or in life itself. While his planned approach was to discover the root causes of the patient's dedication to negativity, his method bordered on bolstering R.'s sagging sense of self as

a worthwhile human being. It seemed to me that Matt was working hard to protect himself against the ever-present danger of succumbing to the pull of the patient's steadfast negativity, which threatened to land him in a pit of hopeless despair much like that which the patient chronically inhabited.

Months before Matt and I began meeting, R. precipitously changed jobs while Matt was away on vacation and this change eventuated in their inability to meet on a more than twice weekly basis, which heightened Matt's feelings of discouragement, limited his access to material, and lessened his clinical leverage, all of which compounded the difficulty making clinical headway.

Matt described his sessions with R. as tedious, mind-numbingly repetitive, and utterly predicable. In his six-month write up, he wrote about how R. "created confusion by talking in circles and using excessive abstraction to keep us both from making much sense." The patient spoke of how poorly he was doing, how disappointed he was in others, and how impossible it was for him to imagine things ever changing for the better. The glaring lack of progress required we try and account for the patient's ongoing devotion to treatment. He feared his unrelenting negativity would turn the analysis into an interminable, worthless, meaningless exercise, which—albeit—would permit him to remain in treatment forever, even though he never admitted as much. All he could say was that the analytic relationship "is the only stability I have other than my nastiness."

Matt's interventions chiefly involved offering interpretations, which—by his account—was in keeping with the supervision he had been getting. He interpreted R.'s destructive and self-

defeating impulses—his tendency to spoil and destroy anything good in himself and/or in others. He interpreted the patient's unconscious fear of his own destructiveness: "You're afraid I won't survive the fullness and intensity of your nastiness," to which the patient responded: "I am more afraid I won't be able to stop. That once I get started, I'll just keep going and going until there's nothing left of either of us." The candidate saw surviving the onslaught of the patient's negativity as his central charge. Paradoxically—as we shall see—succumbing to the negativity turned out to be his ultimate salvation—the most likely route to change.

Matt viewed R. as exhibiting a *Bartleby-the-Scrivener* type "refusal" to work toward modifying his tenacious negativity. In Herman Melville's short story, Bartleby refused every request made of him. He refused to move when circumstances required he do so, refused to eat and, ultimately, refused life itself. "I would prefer not to" was Bartleby's declaration of desire *made in the negative*—a statement not of what he wanted but of what he was *not* wanting, which left Bartleby—and the patient—seemingly *wanting for nothing* in the literal sense of the term.

The patient seemed intent on remaining entrenched in sameness, which the candidate described as his "cohesion via deadness produced by the maintenance of what's already known." As he saw it, R. was refusing to be open to the possibility of change, refusing to open-mindedly consider the suggested meanings of the emerging material, refusing to take in and consider much of what the candidate had to say. Matt considered this refusing to be a part of the patient's character—the fact that he was a stubbornly obstinate man. He interpreted this refusal in terms of its adaptive function—refusing to acknowledge a confusing and overwhelming reality that was beyond his ability to psychically represent—but interpretations along these lines went nowhere.

The patient's nihilism was infectious, which required that Matt try to find ways to keep from becoming swept into the vortex of the patient's dedication to deadening sameness. After telling the patient that the patient "lived in the known," Matt recognized how stale his comment sounded and how futile it was to have said as much: "Even what I just said feels rote and known." In his write-up, Matt described how he felt he had become "a lifeless therapist with an interpretation that is predicable." To the extent his mission was to discover the point (the motive) of the patient's behavior, the patient's core nihilism and unwavering claim that everything was pointless threatened to grind down Matt, risking his becoming drawn into believing that the therapy was pointless, particularly seeing that no change had yet occurred.

Refusing Desire

Over time, Matt and I expanded our understanding of what the patient's refusing seemed to be about—what it intended to accomplish. Rather than see his negativity strictly in characterological terms, we began to consider how the patient seemed to be refusing to experience any hint of personal desire—in particular, his desire for the analyst. Like Bartleby—who wanted nothing, whose desire was to not desire—it began to appear as if the patient was operating out of a similar dedication and defensive need.

The patient's dismissive refusal to consider transference interpretations that addressed conflict over his transference needs —along with his steadfast claim that everything was pointless—eventuated, over time, in a circumscribed loss in Matt's ability to think analytically about the patient's need for and attachment to him. The following vignette took place after Matt instituted

changes in their now twice-weekly meeting schedule; they had been meeting Mondays and Wednesdays but would now meet Mondays and Tuesdays. During a Monday session, the patient spoke of how angry he had gotten waiting for a pizza to be delivered to his apartment complex the Friday before. Given the pandemic, the pizza could only be left outside the complex, necessitating he go down repeatedly to check to see whether the pizza had finally arrived. On the last trek down, the patient, who'd grown increasingly irritated by having to wait for the pizza, tripped—painfully injuring his toes—which he interpreted as self-punishment for having let himself dare to care—dare to desire something that left him relying on others. Later in the session, the patient spoke proudly of how he had devised a plan at work to circumvent his reliance on co-workers to complete a project.

It occurred to me, but apparently not to Matt, that the patient's associations might be obliquely referring both to his anger over being made to wait an extra day between sessions as well as to his self-directed anger for having allowed his analyst matter that much to him. Whether this speculative interpretation was correct matters not; for our purposes, the only thing that mattered is whether such a possibility had occurred to Matt—which it had not. In exploring why such a thought had not occurred to him, Matt explained that he and the patient had a "covert agreement"—as he called it—that they "not go there"—that they *not* address the patient's transference needs for his analyst. By observing Matt's difficulty permitting transference, in the broadest sense, to come to mind I was alerting him to an evident process that I felt had intersubjective implications—the patient's successful attempts to render such observations off limits to the detriment of the treatment.

When a patient is dismissive of, or expresses contempt upon hearing certain sorts of transference interpretations, such behavior can take a toll on the analyst's capacity to keep certain sorts of transferences in mind. For example, if the patient turns a deaf ear (e.g., patiently listening while the analyst offers his thoughts, then abruptly changing the subject) or becomes overtly hostile (e.g., eye rolling) whenever such interpretations are made, such behaviors can discourage the analyst from even thinking in terms of these transference possibilities, making it less and less likely such transferences will spring to mind over time, and—if they do—harder and harder to make such interpretations given the expectation that the patient will, yet again, dismiss such thinking out of hand.

Matt had lost track of the fact that he had succumbed to the patient's successful efforts to keep his nose off the scent of the patient's transference needs. Such things happen to the best analysts, so faulting a candidate or practicing analyst for such breaches is patently unfair and decidedly unrealistic given the extent to which an analyst's capacity to think reflectively waxes and wanes from hour to hour, from patient to patient. This patient's incessant discounting of Matt's efforts to remain transference-focused in the broadest sense of the term took a mighty toll on his ability to recognize instances when the patient's *transference needs* were coming into view.

It wasn't that Matt failed altogether to think in terms of transference. Rather, his concept of the transference had narrowed considerably and only involved the patient's projecting disowned (good/positive) parts of himself into the analyst, turning the candidate in the process into goodness incarnate, while the patient—hollowed out—experienced himself as devoid of anything worthwhile. And while Matt had hoped that addressing the effects of projection—the

patient's active disowning of his goodness—might help the patient retrieve his sense of goodness and worth, efforts along these lines were for naught.

Refusal from an Intersubjective Perspective

Up to this point, the patient's pattern of refusal was alternately characterized either as a manifestation of his character or as a refusal to experience anything resembling desire. Matt and I now turned to a third, intersubjective (two-person perspective) possibility: that the patient was refusing to change in the face of what he surely must have known to be Matt's desire for him to change not just for the patient's sake but for Matt to feel clinically effective and have his therapeutic skills recognized, appreciated, and validated—in particular, by his supervisor and the progression committee of his institute. The patient was refusing, and his analyst was refused—the analyst's desire for the patient to change was thwarted by the patient's steadfast refusal.

When therapeutic progress is lacking or a clinical impasse has developed, it is worth considering to what extent the intrusion of the analyst's desire might be a contributing factor. Wilson (2013) notes how "we feel frustrated if the patient does not appear to be aided by an intervention or does not seem to be improving over a longer-term horizon" (p. 472). Surely, this must have been the case with this candidate-analyst who, despite all his well-meaning efforts, found the patient unmoved.

The Turning Point

At this juncture, Matt described to me—in a novel fashion—his experience of feeling as if he was constantly trying to pump up the patient as one might a tire, only this tire had a hole through

which the air leaked out as fast as it was pumped in. Realizing as much left Matt feeling completely depleted, which—as it turns out—paralleled the patient's own often-expressed complaint about how he himself was left feeling whenever he would try to help others. Putting his experience into words during one particular supervisory session brought Matt in closer emotional contact with his own sense of futility and despair—feelings that were much like those the patient himself had felt all his life. At this moment of realization, Matt felt as if he'd lost all ability to hope, which left him unable to maintain his previously unrelenting ability to meet each session with renewed optimism that maybe today was the day things would finally turn around.

When Matt told the patient how his clinical efforts left him feeling—as if futilely attempting to inflate a tire with a hole that could not hold air—he noted how he expressed himself with a sigh of pained resignation, as if to say: "It is pointless, all of my efforts are for naught." After trying valiantly to fight off the gravitational pull of the patient's negativity, Matt had finally succumbed and, in the process, experienced intense discouragement he could no longer fight off. This was experienced by him as a defeat of his efforts to help the patient observe, reflect on, and make sense of his dedication to refusing.

The moment Matt surrendered hope marked a turning point in the treatment. Things changed for the better in many ways. This is reminiscent of Eshel's description of her lengthy analysis of a chronically suicidal, sado-masochistic man that left her grappling with the real possibility this miserable man, with whom she'd become deeply involved, would eventually end his suffering by ending his life—a prospect she implicitly understood she had better prepare for least she meet it naively. Picturing him dead, rather than struggling to maintain hope, had a profound effect on the

course of treatment. During one session that marked a turning point, Eshel responds to the patient's repeated declaration that he was dead by admitting to him: "We're trying to do the best we can in this fateful encounter of ours, but we really don't know whether we'll succeed in crossing this huge dead place. It's like sailing on a tiny boat in an ocean of death . . . " Then, Eshel pictured a faceless woman wandering about with a dead body in her arms, which led first to a feeling of distress, followed by acceptance and profound sorrow as if it had already happened.

The embodiment of pain

Ferro (2010) makes the point "that the field must get ill with the patient's own illness in order to be then cured of it" (p. 418), in line with Grotstein's (2010) thoughts about the analyst's task: "[It is] the necessity for the analyst to experience his own inner version of what the analysand is suffering from; to 'become' the analysand's anguish and agony" (p. 25). Somewhat paradoxically, this became the point from which the analytic couple could now, together, begin to emerge from the darkness of their years together. Eshel (2013) writes that analytic presence is constituted when the analyst hits bottom and is "present within [the patient's] suffering and become(s) at-one with it" (p. 933), whereas feeling pain "is a process in which the pain-inducing event cannot be endured and worked through within the bounds of the [analyst's] ego" (p. 956).

Matt and I began to appreciate how treating R. left him feeling, which echoed the patient's own life experience. We wondered whether his alluding to feeling utter discouragement when speaking to the patient might turn out to have a salutary effect to the extent the patient now knew his analyst had feelings comparable to those the patient himself had known throughout his life.

Finally, someone else knew—from the inside out, on a first-hand basis—what it was like to live a life utterly devoid of hope, satisfied desire, or the gratification of feeling that the patient could have an uplifting effect on his deadened mother. Finally, we imagined, the patient might no longer feel so utterly alone.

As it turns out, this event proved to be one of the most consequential events of the analysis. A remarkable shift was noted to take place directly after Matt shared his feelings to despair with the patient. The patient mentioned for the first time the fact he had been experiencing a renewed interest in learning to play the guitar and gotten "really into it." He bought a few new instruments and spent real money on this burgeoning hobby, in contrast with his previous pattern of limiting purchased to practical items only rather than spend money in pursuit of a heart-felt desire, as he was doing now with elan.

From this point forward things began to change for the better. The patient found ways to make room for an additional session each week. He became more open to considering what his analyst had to say, and there was a notable heightening of feeling and desire on the patient's part, including an expression of deep pain unlike anything he had previously expressed in the analysis. There was a diminution in his former steadfast refusal to experience desire.

Speculating as to Cause

Clearly, something had shifted in Matt's work with R., given the extent of the changes seen to be taking place in the wake of Matt's own self-observation and his articulation of his experience having been overtaken by a sense of futility much like that which the patient himself had

suffered. But it would be a tall task to prove these shifts were caused either by Matt's self-realization or even by his mentioning this realization to the patient. The fact these changes took place in close temporal proximity is, at best, empirically suggestive as to cause. Had a succinct, empathic, to-the-point interpretation been made that directly addressed the underlying reasons for the patient's experience of futility, we might be better positioned to track, via the patient's subsequent associations, whether that interpretation could reasonably be considered to have caused these shifts, but no such interpretation was made at this juncture—though the candidate had previously attempted to interpret along these precise lines to no avail.

Together, Matt and I pieced together something speculative about the root cause of both the patient's psychically-protective refusal of desire as well as his ongoing entrenchment in the experience of futility. This possibility came to mind when I suddenly remembered, during the supervisory hour when Matt shared the depth of his despair, an important aspect of the patient's history I had known about but had forgotten until this precise moment. The patient had lost a younger brother to SIDS when the patient was 2½ years old, after which time his mother fell into a deep depression. Trying and failing to enliven a deflated mother might have resulted in the patient's concluding his efforts amounted to a futile expenditure of energy, much like how Matt now felt trying and failing to pull the patient out of his deep morass.

Andre Green's (1986) paper on "The Dead Mother" sprung to mind—the idea of a mother who was once available to the child but suddenly ceases to be so because of a traumatic loss—chief amongst which, notes Green, is the loss of a young child. The mother's psychic deadness is a catastrophe for the surviving child; the mother is experienced as if she is dead to the extent the

child has lost who the mother had once been to him, leaving a blankness or deadness at the core of the child. Under such conditions, Eshel (1998) notes:

> The child forms a desperate, intense need to revive the mother and himself. He strives to cure her, to bring her back to life, to repair this primary relationship that is crucial to his life; to make her smile, respond to him, capture her interest and participation, and not remain with this open hole of emptiness, loneliness and annihilation inside him. (p. 1117)

I mentioned Green's concept of the dead mother to Matt, who told me that when he'd presented this case to a leading analyst when she was in town for a conference, she had come up with the same idea, though Matt had never mentioned this until now. Matt and I began to wonder whether he himself had become drawn into playing the role of the patient-as-child who was desperately attempting to awaken/enliven the dead mother. In the role of the child—so we imagined—Matt was trying his hardest to desperately pump air into a deflated mother, leaving him experiencing the utter futility of trying to revive the deadness of the patient (identified with his dead mother). To resuscitate this analysis, Matt would have to experience first-hand his desperate, futile attempts to resuscitate the dead mother in the guise of the patient.

The patient had experienced this period of his life behind the veil of infantile amnesia, when recallable-type memories are *not* laid down, leading memories from this time of life to be more implicit than explicit. As a result, we would anticipate that such an experience would be *unrepresented* and, as a result, not susceptible to repression from which a recallable memory might then be retrieved once the need to repress had been worked through. Furthermore, to the

extent the loss of the mother was likely to have been highly traumatic, we had a second reason that the experience had failed to be verbally encoded.

Back to the topic of observing process

A process orientation is readily identifiable when the patient, the analyst, or the analytic couple go "meta" by momentarily stepping out of the here-and-now to reflectively consider—right then and there—"what's up"—what's been "going down" between the two of them (if the identified process is intersubjective in nature) or, what's been going on within one or the other individually (e.g., what they are feeling and thinking; what psychic processes—such as defensive maneuvers—are seen to be operating). Process observations can result in the offering of a "process comment" that highlights what's been taking place—a now-noted process that, moments before, had either gone completely unnoticed (e.g., was preconscious rather than conscious) or, if noticed, had gone unmentioned, and might even have seemed unmentionable until the very moment such matters finally got mentioned. I think most would generally agree that the more often such instances occur during an analysis, the more assured we are that analysis is taking place.

This consideration of process brings us to the question of what analysts mean when they speak of "psychoanalytic process." Remember, Matt had consulted me to see whether I agreed with his supervisor's fateful conclusion that this analysis lacked evident analytic process. A review of the literature reveals something remarkable: efforts to settle on an agreeable definition of psychoanalytic process have plagued our field for decades (Abrams, 1987; Boesky, 1990; Schachter, 2005; Smith, 2002; Vaughn et al., 1997; Weinshel, 1984). In the latter half of the

1980s, the COPE (Committee on Psychoanalytic Education[3]) study group on supervision, after meeting for five years on a biannual basis, was unable to reach consensus regarding a workable definition of psychoanalytic process (Boesky, 1990; Schachter, 2005). The same occurred in 2002 when nine analysts convened as an international panel to see whether they could reach agreement as to what constitutes psychanalytic process and—again—came away failing to find common ground (Smith, 2002). Furthermore, while it is generally presumed that the development of psychoanalytic process is integral to the efficacy of psychoanalytic treatment, after studying 700 cases of psychoanalysis, Weber et al. (1985) concluded that psychoanalytic process was only moderately associated with psychoanalytically mediated improvement. Furthermore, studies indicate the only 40% of the analytic cases studied developed psychoanalytic process. (Kantrowitz et al., 1987a, 1987b; Vaughan & Roose, 1995).

Given the status of psychoanalytic process as an ill-defined something or other that is purportedly readily identifiable when examining analytic work, it's a bit surprising that psychoanalytic process remains a commonly used metric by which to judge the quality of a candidate's clinical abilities. In their study of psychoanalytic candidates, Cabaniss et al. (2003) note:

> If the [candidate's] patient is unable to engage in treatment so that the supervisor will vouch for the presence of analytic process, the [candidate's] progression is in jeopardy [even though] there is no empirical evidence—or systematic research data—to suggest

[3] A function of the American Psychoanalytic Association.

that this method of evaluation is a good indicator of the candidate's clinical abilities (pp. 83-87).

Rethinking Psychoanalytic Process

A process orientation can be seen in moments when the patient, the analyst, or the analytic couple sidestep the lost-in-the-moment to-and-fro of the here-and-now to reflect on what has been happening and what the now-identified process might say about the patient, the analyst, and/or about the interacting analytic couple. The process by which an analyst gains perspective on the moment—the experience presently taking place—requires he shift his attention away from the subjective task of "being present with" to the assumption of a somewhat removed stance that permits enough distance to be able to "think about" (reflect on) the unfolding events taking place.

Many writers insist on including *the offering of interpretations* as part of what they consider "psychoanalytic process" (Abend, 1990;Arlow & Brenner, 1990; Gill, 1954; Rangel, 1954; Stone, 1954; Vaughan and Roose, 1995; Waldron, Scharf, Hurst, et al., 2004a; Waldron, Scharf, Crouse, et al., 2004b). We take issue with such a narrow definition of the term, and—furthermore—believe the concept "psychoanalytic process" can be saved from extinction by defining the term more broadly as the process of observing and reflecting on the unfolding events noted to be taking place on a moment-by-moment basis in the consulting room. If one adopts this alternate way of defining psychoanalytic process, one ends up measuring a candidate's clinical skills in terms of that candidate's ability to work with process—to recognize it as such, to awaken to it when it takes form as an enactment, and—at times—to engage the

patient in a mutual consideration of process. The analyst's capacity to extricate himself from the enactment is both the result of—and, at the same time, results in—a regaining of the analyst's capacity to think in a self-reflective manner. The analyst's presence of mind (his ability to think on his feet) is typically clouded when he becomes caught up in an enactment (Chused, 1991). When he disengages sufficiently from the enactment, he regains his self-reflective capacity sufficient to explore the enactments unconscious determinants (Chused, 1991, 1996, 2003).

When process involves a countertransference enactment, the analyst's capacity to work with process takes place in two step fashion. For the enactment to take hold, the analyst must be openly receptive to the projection, which requires the existence of something in him that is his that resonates with what the patient is transmitting. The analyst responds to the projection by falling headfirst into the enactment even before he knows what hit him. For a time, he becomes lost in the maze-like quality of the enactment, but for the enactment to be clinically useful the analyst must find his way out of the maze after realizing he'd succumbed to a process he didn't see coming and, for a time, didn't even realize he was in. The second step of this two-step process takes place after the analyst comes to his senses and realizes he had become swept up in a process unthinkingly. This is where observation come in. Once the analyst regains his or her capacity to self-reflect (think analytically), he/she begins to imagine why the enactment had been necessary and what it might mean—how his own internal processes were aligned with those of the patient. Ideally, this leads the analyst to understand an aspect of the patient's unconscious that might have been hard for him to access in any other way, which—in turn—might result in his helping the patient be better able to experience what he'd previously been incapable of experiencing, which is why he'd resorted to projective identification in the first place.

The ability to maintain one's "presence of mind" waxes and wanes as a function of many factors, some that strictly have to do with the analyst, others that relate to the nature of how the analytic couple interacts (e.g., the extent to which the patient effectively engages in projective identification). A candidate's clinical abilities can be assessed in terms of this two-step process. First, is the candidate available for engagement—can he be induced to respond to the patient's projections? In fact, Matt had clearly been able to resonate with his patient's experience. Second, is he capable of extricating himself from the embroilment sufficient to then be able to reflect on the process to see what his internal processes might say about the patient's situation?

Several months into our work together, I sent an earlier version of this paper to the Progression Committee at Matt's institute. In that version I illustrated, in greater detail, the degree to which psychoanalysts could not agree on what constitutes "psychoanalytic process," which makes the concept a dubious one upon which to measure a candidate's progress. After considering the results of our consultation, the progression committee voted unanimously to grant him credit for the case. Since then, Matt and I have deepened our understanding of the case along the lines outlined in this paper.

Discussion

In this paper, we have proposed that there is more for candidates to learn about than the formulation of interpretation; observation is a critical, overlooked, and essential psychoanalytic tool that, at times, trumps interpretation as the timeliest and most effective clinical intervention in certain instances. In the case presented, believing that one could find just the right

interpretation to part the Red Sea proved to be a fool's errand. More would have to happen; more, in fact, did happen. As a result, change came about which we believe had to do with changes the candidate-analyst experienced firsthand, changes he himself was primed to experience given his own background, changes that we believe contributed to the patients finally having, once and for all, what amounted to a moving experience.

In the supervised case presented here, the candidate's desire to be helpful and effect a "cure" was completely thwarted for the longest time. The candidate and I suspected the following formulation was conceivable: Matt tirelessly pumped air into the patient, who remained steadfastly dedicated to refusing his own desire, born of devastation trying to enliven his mother who had been lost to him after his younger brother passed on. The patient in turn refused the analyst's desire by refusing to be affected by most of what he did or said. Feelings of frustration and despair, which the patient could not bear, became what the analyst covertly was being asked to experience and tolerate (contain) to the extent the analyst's desire to see the patient change (to feel clinically effective; to be proven to be clinically effective in the eyes of others) was thwarted. This, then, becomes a central feature of the treatment unbeknownst to the candidate for the first year of the patient's analysis. Not until the candidate succumbed, falling into near-despair about whether he would ever be able to help the patient change—not until he suffered first-hand the patient's tortured failure to satisfy his desire to resuscitate the mother—could the analysis itself be revived.

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