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Thinking with, and about, patients too scared to think:

Can non-interpretive maneuvers stimulate reflective thought?

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Patients incapable of higher-order (symbolic) thinking can often not tolerate evidence of the analyst's separate existence, particularly when that 'otherness' becomes evident in the process of the analyst's reflecting upon and interpreting how the patient experiences or represents the analyst. The patient's intolerance of the analyst's efforts to think (reflect upon and interpret) renders the usual psychoanalytic maneuvers employed to stimulate reflective thought ineffective with such patients. Such patients have to learn to tolerate multiple perspectives before they can allow the analyst, or themselves, to think in the other's presence. The author presents two clinical vignettes that illustrate how the analyst's efforts to think about the patient were experienced by the patient as both intolerably distancing and as rejecting of an aspect of the patient's subjective reality. Working psychoanalytically with such patients requires the analyst to forgo the use of narrow interpretations that elucidate unconscious meanings and motives in favor of alternate technical maneuvers capable of facilitating the development of symbolic thinking and reflective thought (insightfulness). These maneuvers include a demonstration of the analyst's willingness and ability to withstand (rather than 'interpret away') how he is being psychically represented by the patient, without becoming destroyed by, or lost within, the patient's characterization of him. Beside modeling a tolerance of alternate perspectives of one's self, other non-interpretive maneuvers that help facilitate the development of self-reflective thought include: stimulating the patient's curiosity about the workings of his own mind by identifying incompletely understood behaviors or reactions worthy of greater psychological understanding, and insinuating doubt about the adequacy of the patient's explanations of such phenomena.

Keywords: reflective thought, concrete thinking, theory of mind, separation anxiety, symbolic thought, insightfulness, multiple perspectives, otherness

A patient's tolerance of the analyst's efforts to think (to reflect on and interpret) depends in large part on whether the patient can tolerate moments when the analyst disengages from being fully emotionally present so that he can reflect upon the material from a more removed perspective. Whether the patient understands what the analyst is attempting to accomplish when he does so depends on the patient's capacity for higher-order thinking (e.g. symbolic and reflective thinking).[1] Patients

[1]For the purposes of this paper, the following four cognitive capacities will be taken to constitute higher-order thinking: 1) to think on higher symbolic planes (e.g., to think metaphorically), 2) to engage in reflective thought (facilitated by a shift from being "in the moment" to a more observational stance), 3) to employ a "theory of mind" approach (to infer mental states and use these inferred states to explain and predict behavior, and 4) to grasp the constructivistic nature of the mind—to understand that the mind interprets reality rather than faithfully recording it.

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capable of such thinking tend to be more tolerant of the analyst's efforts to think, more likely to view the analyst's intentions as benign—as meant to be helpful—and better able to engage with the analyst in the task of self-reflection. By contrast, patients incapable of higher-order thinking (those who think more concretely) are often less tolerant of instances when the analyst momentarily transcends his immersion in a here-and-now emotional engagement with the patient long enough to reflect upon the material. Accompanying the patient's realization that the analyst has been *thinking about* him, rather than just *being with* him, is the sense that the analyst is no longer as present as he once had been. This realization often triggers intense separation anxiety that may result in the patient's 1) intolerance of the analyst's efforts to think; 2) suspiciousness of the analyst's motives for interpreting; and 3) inability to join the analyst in the task of self-reflection.

Patients who lack the capacity for higher-order thinking manifest what Josephs (1989) refers to as a 'concrete attitude'. For these patients, 'the concrete is more immediate, compelling, and real than the symbolic [and] the abstract may seem no more than just empty words' (p. 493). These patients look to the analyst 'not as much for interpretation of the facts but for consensual validation of the accuracy of the account' (p. 478) With such patients, the analyst's task is a bit more complicated than merely deciphering the unconscious wishes that arise in minds that are no different *structurally* from the mind of the analyst. These patients exhibit a deficit in their ability to symbolize and haven't a clue what the analyst is referring to when he uses metaphors to make his point.

While psychopathology has traditionally been viewed as a product of unconscious conflicts and unrecognized mental contents (wishes, drives, fantasies, etc.) that need to be rendered conscious in order for psychic change to occur, more recently some authors have taken to viewing psychopathology as the product of an individual's failing to develop, or losing the capacity for, symbolic thought (higher-order thinking), seeing psychic change as resulting from the patient's gaining or regaining a capacity for symbolic thinking and reflective thought (Busch, 1995; Herzog, 2001; Friedman, 2002; Sugarman, 2006). Sugarman (2006) argues that interesting a patient in the general workings of his mind—helping him view himself as a thinking self by regarding him as such—helps facilitate the development of higher-order thinking (including a capacity for reflective thought or insightfulness), and is more important therapeutically than the acquisition of specific insights into one's unconscious conflicts or unrecognized mental contents. 'All psychological functions', he notes, 'seem to work better and to facilitate greater self-regulation when they work in symbolic ways' (p. 971), and 'a variety of benefits accrue from patients gaining insightfulness at an abstract–symbolic level of functioning': 'self-boundaries are strengthened', 'empathy improves', 'interpersonal interactions are more easily understood and navigated', 'relationships feel safer', 'reality testing is facilitated', 'separation–individuation is promoted', 'primary and secondary thinking is enhanced' and 'affect regulation is improved' (p. 981).

In this paper, I present and explore three related topics. The first is the way concrete patients sometimes react when the analyst's primary mental preoccupation shifts from being with the patient (fully affectively present 'in the moment') to reflecting upon the material (noticing, thinking about, and interpreting what has transpired). When

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the analyst shifts from an 'experiencing' to an 'observing/reflecting' mode of psychic functioning (Busch, 1995; Gray, 1986; Greenson, 1967; Sterba, 1934), he expects the patient will identify with the analyst's observing ego and follow suit by adopting an observing stance of his own (Greenson, 1967; Sterba, 1934). But not all patients are capable of this psychic feat. When a concrete patient is confronted with the evidence (i.e. reverie) or results (i.e. interpretations) of the analyst's reflective thinking, he may feel distanced in the process, which threatens him with the realization of his essential separateness triggering intense feelings of anxiety.

The second issue concerns the ways in which concrete patients tend to experience and react to interpretations. The fruits of the analyst's reflective thinking, which become crystallized in the form of interpretations that provide alternate constructions to the ones held by the patient, underscore the ways in which patient and analyst are unalike. This confrontation with the analyst's otherness furthers the patient's realization of his separateness, often producing levels of anxiety beyond what he is developmentally ready to face. If this weren't reason enough for concrete patients to be hostile toward the process of interpretation, their misunderstanding of the analyst's motives for offering interpretations intensifies their suspiciousness of the interpretive process. Rather than viewing interpretation as the analyst's way of expanding the patient's self-understanding, concrete patients may instead view such efforts as defensive and self-serving, as a manifestation of the analyst's inability to accept what the patient knows to be true. In this light, an interpretation comes to be seen as an attempt to refute or 'explain away' who the analyst *has become* for the patient. But the concept 'has become' is nonsensical to concrete patients who leave no room between perception and reality for an intervening perceptual process that does more than just represent reality as is. This tendency to view the analyst as desperately attempting to maintain the superiority of his view over competing views reflects the attribution/projection of the patient's own intolerance of alternate perspectives. Under such conditions the patient may become hostile toward the analyst's efforts to think, potentially leading him to attempt to disrupt the analyst's capacity to think (Bion, 1959).

My third focus is to raise questions about how an analyst might work psychoanalytically with patients who are intolerant of reflective thought and suspicious and hostile toward the process of interpretation. How might an analyst work around the limitations posed by concrete thinking? If a patient becomes overwhelmingly anxious in response to the analyst's interpretations, must the analyst abandon the practice of interpreting in favor of some other maneuvers? Can these non-interpretive maneuvers stimulate the development of higher-order thinking and reflective thought? If so, by what means? The model I am proposing, based on theory of mind research, links reflective thought with one's ability to comfortably entertain multiple, competing constructions/representations of the same phenomenon—to keep an open mind and resist tendencies to premature closure. According to this theory, a patient can be helped to appreciate and tolerate multiple perspectives and multiple views of himself and his objects to the extent he participates in an analytic experience with an analyst who demonstrates a capacity to accept and tolerate, rather than prematurely 'interpreting away', the varied ways in which the patient represents the analyst. Witnessing the

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analyst's capacity to genuinely absorb and consider how he is being viewed by the patient, without being destroyed by, or lost within, that characterization (i.e. survive projective identification), provides the patient an experience with which to identify, thus helping establish a capacity for reflective thought.

While identification with the analyst's capacity to entertain and tolerate multiple perspectives may contribute to a process that ultimately leads to the patient's development of a capacity for reflective thought, identification, in and of itself, is not likely to be sufficient to bring about such psychic change. The analyst needs to work to interest the patient in the *broad* workings of the patient's mind, rather than relying on traditional interpretations that elucidate unconscious content. He needs to persistently draw the patient's attention to behavioral and psychological phenomena indicative of underlying psychic processes, particularly when the patient has deemed such phenomena meaningless or, alternately, fully explained by the patient's beliefs about the phenomena. While insinuating doubt about the adequacy of a patient's explanations threatens to leave the patient feeling as if his very sanity is being questioned, getting a patient to question the adequacy of certain of his beliefs to account for his behavior or reactions is often the first step in the process of opening a patient's mind to the task of self-reflection.

The development of higher-order cognitive capacities

In order to understand how individuals develop a capacity for higher-order thinking, it is necessary to review theory of mind research. Theory of mind refers to the practice of making inferences about one's own and others' mental states (beliefs, desires, intentions) and, on the basis of those inferences, offering explanations and predictions about one's own behavior and the behaviors of others (Dennett, 1978; Leslie, 1988; Premack and Woodruff, 1978; Wellman, 1988). Theory of mind explains and predicts human actions in terms of what we believe to be so, what we desire to have happen, and what we think we intend to accomplish.

The ability to think psychologically about our own minds and the minds of others is predicated on the ability to make 'second-order' mental representations of one's own and others' mental contents (beliefs, desires, intentions). Second-order representations are representations of representations (e.g. thoughts about thoughts, thoughts about beliefs), which indicate an individual's awareness that minds actively create representations (mentally process perceptions via interpretation, inferential thinking, conjecture, etc.). An awareness of one's own, as well as others', mental representations leads to such recursive statements as: 'I believe you knew that I was thinking that …' (Flavell, 1988). Such thinking reflects the interaction of minds concerned with the other's mental states and, as such, is the basis of the ability to function socially (Forguson and Gopnik, 1988; Perner, 1988). By contrast, first-order representations are those that represent the world in a literal way (Leslie, 1988, p. 24). Young children who don't appreciate the meaning-making nature of the mind are said to posses a 'copy' (e.g. photographic) model of the mind (Chandler, 1988). They believe that the mind faithfully reproduces the external world without any intervening interpretive process.

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As children begin to think in terms of second-order representations, they can be said to be on the verge of appreciating the 'constructivistic' nature of the mind—the fact that the mind's way of representing the world involves a great deal more than merely picturing reality as is. Once one appreciates the constructivistic nature of thinking, one understands that 'we have beliefs about the world that may or may not be true' and 'our actions are a function not of the way the world is but of the way we think it is and want it to be' (Forguson and Gopnik, 1988, p. 228). A constructivistic model of the mind leads to the realization that there are multiple perspectives that one could adopt regarding any given situation.

A constructivistic model of the mind is not something that develops in a sudden quantum leap; rather, it emerges in progressive stages over the course of several years, usually culminating sometime, though not invariably, during adolescence in a sophisticated postmodern appreciation of epistemological relativism when:

> …young persons begin to understand that divergent views are not always or even primarily the consequence of correctable ignorance or personal bias, but come about instead as a function of all beliefs being inescapably relative to the framework of the entire knowledge constitutive enterprise. (Chandler, 1988, p. 407)

This level of cognitive sophistication has been referred to as the 'Rashomon Phenomenon', a reference to the 1950 Kurosawa movie *Rashomon*, where four characters witness the same events yet come up with radically different interpretations about what happened.

A capacity for reflective thought: Case in point

A capacity for reflective thought requires an appreciation of the constructivistic nature of the mind, which entails a realization that there are a seemingly endless number of competing perspectives that could explain any given situation. The ability to employ higher-order thinking (to think abstractly and metaphorically) combined with an ability to regress in the service of the ego keeps the mind open to alternate interpretations and helps counter the tendency to either think concretely about the matter or employ reality as a defense, both of which might be seen as precluding the need for any further understanding. Accepting that there will always be other, yet to be discovered, interpretations beside those one has already discovered helps prevent tendencies toward premature closure.

Reflective thought requires that one notice a configuration of phenomena (e.g. patterns, slips of the tongue, behavioral repertoires) as constituting, in and of itself, a significant phenomenon worthy of further investigation—even though one has yet to pinpoint its significance. So *noticing* and *resisting premature closure* about what the noticed phenomena mean (open-mindedness) are prerequisites to reflective thought. Once phenomena have been selected for consideration, the mind must think about the material in a particular way. If the patient is capable of self-reflection but has failed to apply such thinking to phenomena the analyst deems significant, the analyst may draw the patient's attention to what, in the analyst's estimation, constitutes evidence of a psychodynamic process. In this way the analyst helps the patient recategorize as significant phenomena that the patient had tended to overlook or

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downplay. Suggesting, for example, that uncharacteristically forgetting one's wallet at home likely reflects an unconscious conflict worth knowing more about invites the patient to reconsider behavior he had, up to that point, dismissed as meaningless. Once the analyst has the patient's attention, he may insinuate doubt about what the patient accepts as a perfectly adequate explanation (including the inclination to not give the situation a second thought), thus opening the patient's mind to a consideration of alternate perspectives (Tuch, 2001).

Reflective thought is similar to the concept of 'psychological-mindedness'. Many view a patient's psychological-mindedness as predictive of a positive psychotherapeutic outcome (Appelbaum, 1973; Coltart, 1988; Farber, 1985; Piper et al., 1985). Appelbaum defines psychological-mindedness as 'a person's ability to see relationships among thoughts, feelings, and actions, with the goal of learning the meanings and causes of his experiences and behaviour' (1973, p. 36). McCallum and Piper define it as 'the ability to identify dynamic (intrapsychic) components and to relate them to a person's difficulties … (a receptivity) to the hypothesis that current difficulties are linked to unconscious conflicts' (1997, p. 28). Farber defines it as 'the disposition to reflect upon the meaning and motivations of behavior, thoughts and feelings of oneself and others' (1985, p. 170).

Of the theories offered to account for the development of reflective thought, those proposed by Sterba (1934), Britton (1989), Gergely and Watson (1996), Bion (1962) and Aron (2000) are among the most widely cited. While he never refers to it as such, Sterba (1934) offers the first psychoanalytic account of how the psychoanalytic process induces reflective thought. Sterba references Freud (1933), who writes about how 'the ego can take itself as an object' as the result of a 'split' within the ego between one part that observes and another that is the object of observation. Sterba proposes that such a split is the 'fate of the ego in analytic treatment', and he suggests this split is brought about by the analyst's offering of explanations 'uncoloured by affect' (p. 120) that establishes within the patient a '*new point of view of intellectual contemplation*' (p. 121, original italics). Through identification with the analyst's capacity for reflective thought, the patient is expected to approach the material from this new vantage point.

Might Sterba's clinical theory also account for the development of reflective thought in childhood? In fact, experimental research has demonstrated a positive correlation between a mother's capacity for reflective thought and the child's developing capacity to mentalize (Fonagy, 1991) and reflect (for a complete review of the research, see Bateman and Fonagy, 2004, chapter 3). Mothers who engage in reflective thought, who think of their children in mentalistic terms (theory of mind), and who see things through their children's eyes produce children who are securely attached, and being securely attached greatly facilitates a child's capacity to mentalize and reflect (Bateman and Fonagy, 2004).

By contrast, Britton (1989) locates the origins of this observational/reflective mode of functioning in the 'triangular space' formed by the infant's recognition of the link joining the parents together—a link that excludes the infant, forcing him into the position of witness rather than participant. From this experience, Britton reasons, the child learns that, between three relating individuals, one either becomes

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the observer of the linked pair, or the observed member of that pair. Britton posits this as the basis of an individual's capacity for self-reflection: 'This [developmental step] provides us with a capacity for seeing ourselves in interaction with others and for entertaining another point of view whilst retaining our own, for reflecting on ourselves whilst being ourselves' (p. 87).

Gergely and Watson (1996) have identified a developmental process they believe accounts for the ability to form secondary representations of internal states, thus leading to a capacity for emotional self-awareness. These authors refer to a 'biofeedback training procedure' whereby:

> …the repetitive presentation of an external reflection of the infant's affect-expressive displays [by the mothering figure] serves a vital 'teaching' function that results in gradual sensitisation to the relevant internal state cues as well as to the identification of the correct set of internal stimuli that correspond to the distinctive emotion category that the baby is in. As a result of this process the infant will eventually come to develop an awareness of the distinctive internal cues that are indicative of categorical emotion-states and will become able to detect and *represent* his/her particular dispositional emotion-states. (p. 1190, my italics)

Though these authors do not tie this process to reflective thought, it stands to reason that the capacity to psychically represent internal states is the necessary precondition for an individual's ability to step back and reflect upon these states since the representation offers an intervening mental process between the direct experience and the individual's thoughts about that experience.

This theory sounds remarkably like that proposed by Bion (1962) 30 years earlier, which envisions the process of projective identification as a healthy developmental stage responsible for the integration of experience and the development of the capacity to think. According to this theory, the infant first experiences life in a raw, sensory fashion ('sense impressions' referred to as β-elements) and, literally, has no idea what to 'make' of the experience. In order for the infant to begin to understand this experience, it must first be contained, processed, and re-presented to the child in a modified form (as α-elements such as thoughts) by the caregiver, who functions as the 'container' for the infant's experience. Only then can the infant begin to *think about* the experience since it is no longer experienced in so direct and raw a fashion. Until the infant learns how to think for himself, he will continue to need the object to think for him (convert β-elements into α-elements), to supplement the functioning of the infant's own ego.

Knowing he cannot psychically manage on his own, the infant experiences intense anxiety (the realization of his inability, when alone, to be able to provide for his most basic needs) at the mere prospect of being apart from the much-needed caregiver. Furthermore, lacking a way to mentally represent the circumstances that will satisfy his mounting drives/needs, the infant cannot tolerate much frustration since he has no idea what it will take to calm or satisfy him. The infant must be helped by the caregiver to develop a thought ('oh, *this* is what I've been needing all along!') in order to be able to tolerate a period of non-gratification of the need, representing, as it does, the object's functional absence even in the object's physical presence.

Bion's theory functions both as a developmental theory as well as a clinical theory that suggests a treatment approach best suited to facilitate the development

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of higher-order thinking such as reflective thought. Bion's theory emphasizes: 1) the *role* of the analyst in opening the patient's mind to a *consideration* of the analyst's thoughts and thought processes (the first sign of reflective thought) and 2) the developmental importance of acquiring a capacity to tolerate an awareness of the analyst's separate existence, which, by necessity, simultaneously brings the patient face to face with an awareness of his own separate existence. Bion's theory favors early and active intervention. Bion envisions the process as one in which the analyst *actively* interacts with the patient in ways that require he take the analyst's thoughts and thought processes into consideration (thus hastening the patient's ultimate acceptance of the analyst's separate existence).

Differentiating self from other establishes the existence of two distinct mental representations, which contributes to the establishment of the ability to distinguish between the experiential modes of 'being fully in the moment' and 'observing from a distance'. Being at a distance from the immediacy of the experience offers the child an opportunity to think about it, via identification with the second-hand viewpoint of the observer, in a way he previously was unable to do when he was mindlessly immersed in the first-hand experience. This differentiation within the ego is facilitated by the working through of separation anxiety (Quinodoz, 1993, 1996), a heightening of the individual's frustration tolerance, and heightened tendency toremain in the depressive, rather than in the paranoid–schizoid position.

Recently, Aron has introduced the term *self-reflexivity*, which he distinguishes from the type of *self-reflection* ['a cognitive process in which one thinks about oneself with some distance, as if from the outside' (2000, p. 668)] that Sterba (1934) had in mind when he noted a differentiation in the ego between experiencing and observing parts. By contrast, Aron regards self-reflexivity as more than an intellectual observational function, viewing it as an intellectual, emotional, experiential and affective process. He describes self-reflexivity as 'the capacity to hold in mind both the subjective and objective aspects of both self and object' (2000, p. 668), 'the capacity to move smoothly between subjective and objective perspectives on the self' (p. 673), and 'the capacity to maintain the dynamic tension between experiencing oneself as a subject and as an object' (p. 673). He quotes Bach (1985, 1994) who attributes severe psychopathology to a patient's difficulties in moving back and forth between subjective awareness and objective self-awareness and his difficulties integrating these two perspectives into his representational world. Lacking the ability to move smoothly between these two perspectives results in an individual's 'inability to tolerate ambiguity and paradox; to deal with metaphor (which is inherently ambiguous and may simultaneously express contradictory points of view); or maintain multiple points of view, especially about the self' (2000, p. 673). Aron feels self-reflexivity can only arise within a relational matrix—the product of a mind reflected in the mind of another—and never arises intrapsychically independent of other minds.

Separation anxiety, reflective thought, and prohibitions against the analyst's efforts to think

For patients who think concretely and who are incapable of reflective thought, the invitation to set aside a familiar and orienting belief in order to consider a new

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view threatens to leave the patient feeling psychically unanchored and adrift. Under such conditions, interpretations aren't primarily resisted because they represent unconscious material; rather, they are resisted because they threaten the precarious balance of the individual's belief system. Furthermore, if the analyst's interpretations run counter to how the patient is accustomed to viewing matters, the concrete patient may experience intense anxiety as he becomes aware that he and the analyst are not of like mind with regard to their understanding of things, which tends to heighten the patient's awareness of the analyst's separate existence. Having not yet adequately individuated, these patients continue to rely on the analyst's ego to supplement the functioning of their own ego. Since they cannot function autonomously, realizing the object's separate existence generates intense anxiety. The analyst cannot hope to facilitate reflective thinking in such patients until he attends to the patient's separation anxiety, the working through of which plays a critical role in readying the patient to think reflectively (Quinodoz, 1993, 1996).

In order to develop a capacity for reflective thought, one must become sufficiently individuated from one's objects, which depends largely on the acceptance of one's own, and the object's, separate existences. But in order to arrive at this point, one must first resolve the following (depressive position) dilemma: is it better to risk becoming a differentiated, independent entity—capable of thinking one's own thoughts, clear about who's who, yet admittedly powerless over the much-needed object and aware that one's object-based needs might go unmet—or remain hopelessly compromised, an undifferentiated nonentity whose entire existence seems to depend upon the object without whom one feels terrifyingly alone, incapable of functioning or even surviving on one's own, yet, at the same time, 'safe' within the illusion one has omnipotent control over the needed object?

How does a patient resolve such a dilemma? Having the object survive one's own murderous impulses without retaliating (Winnicott, 1969) and being provided the words and concepts needed to be able to think about, not just live, one's experiences (Bion, 1959, 1962) represent two of the environment's contributions to the working through of this dilemma. But there are other feats the patient himself must accomplish, chief amongst which is the working through of anxieties associated with the realization of one's autonomous existence.

Separation anxiety proper

Clinically, separation anxiety typically appears in response to the discontinuities of treatment imposed by the weekend breaks and holidays apart. But a more basic type of separation anxiety is experienced by patients who cannot tolerate being made aware of the analyst's separate existence even when they are in the analyst's presence. For instance, when the analyst shifts from an *experiencing* to an *observing* mode in order to gain a perspective on 'the situation', he ceases to be in the room with the patient in quite the same way. No longer will he be experienced by the patient as intersubjectively immersed with the patient in a first-hand experience. The effect this has on patients who cannot tolerate the analyst's otherness can be quite dramatic, as will be illustrated in the case material that follows.

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Patients who suffer from this level of separation anxiety may not welcome times when the analyst is absorbed in reverie, communing with himself, or reflecting on the process in order to better understand the patient's situation. Learning that the analyst was *thinking about*, rather than just *being with*, the patient can feel like a rejection—a sign that the analyst cannot tolerate the full force of the patient's being. It may also be experienced as an abandonment—a betrayal of the imagined promise that the analyst would remain qualitatively with the patient in the same way at all times. The *product* of the analyst's reflective activity—delivered as an interpretation—is the most obvious sign that the analyst has been doing more than just 'being with' the patient, and some patients react more to the *act* of being interpreted (thought about analytically) than to the manifest content of the interpretation. For these patients, 'being interpreted' may mean being objectified—made into an object of observation—which can be off-putting.

The interpretation itself may be experienced as the analyst's speaking a language that goes over the patient's head in so far as it involves a level of symbolic thought that lies beyond the patient's cognitive wherewithal to understand. Interpretations can also stimulate a patient's envy since the interpretation causes the patient to realize that the analyst possesses cognitive capacities the patient lacks, that the analyst can creatively synthesize material in ways the patient cannot. Interpretations can force the patient into an unwelcomed confrontation with the analyst's otherness, thus heightening the patient's awareness of just how *unalike* the two are. Aspects of the analyst's otherness inevitably dump cold water on the warmth of intersubjective immersion, thus threatening to disrupt the patient's illusion of oneness—making him aware that he had been mistaken in thinking that he and the analyst were of one mind about all matters.

Clinical vignette 1

Britton (1989) presents a case that illustrates the difficulties an analyst may encounter whenever he tries to psychically disengage from being fully present in order to gain a perspective on what was going on in the room. In this paper, Britton presents the case of Miss A., a woman who could not tolerate times when Britton would try to think about her, leaving him to realize:

> What I felt I needed desperately was a place in my mind that I could step into sideways from which I could look at things. If I tried to force myself into such a position by asserting a description of her in analytic terms, she would become violent. (p. 88)

Once Miss A. had calmed down, she was able to put her experience into words, demanding that the analyst: 'Stop that fucking thinking' (p. 88).

Based on his theory, referenced earlier, that reflective thinking is the product of the infant's experience of *witnessing*, rather than participating in, the oedipal dyad, Britton reasons that his efforts to consult his 'analytic self' left the patient feeling as though she'd been forced into witnessing an act of 'internal intercourse' between different aspects of Britton's ego, which Britton reasoned was analogous to parental intercourse. This illustrates how patients may feel intensely jealous and painfully excluded to the point of nonexistence when the analyst engages in the practice of

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self-reflection, causing the patient to fragment and/or become rageful in response to the analyst's activities.

What people most readily remember and quote (e.g. Aron, 1995; Astor, 1998; Caper, 1997; Schoenhals, 1995) from Britton's paper is his understanding of what 'fucking thinking' meant—his satisfying, understandable and believable *symbolic* understanding of the patient's words. What typically goes unnoticed, however, is the fact that Britton's conceptualization went far beyond what Miss A. was capable of grasping. Given what Britton goes on to say, it cannot even be said for sure that the patient's words had meant the same thing to her as they had to Britton. Britton tells us that these moments of 'communing with myself about her' led the patient to feel that '*I was eliminating my experience of her in my mind*' (pp. 88–9, my italics). Hence, the patient was left feeling excluded *to the point of not existing*. Ultimately, Britton concluded that the only way he could proceed was to keep his thoughts to himself 'whilst communicating to her *my understanding of her point of view*' (p. 89).

Clinical vignette 2

Mr. A, a young, gay attorney, came to see me complaining of his inability to form relationships with others. He complained of feeling anxious and depressed. At the age of 4, his mother had placed him and his three younger siblings in separate foster homes because she could no longer afford to care for them as a result of divorce. Two years later, her financial situation changed and she was able to reunite the family.

I saw the patient three times weekly. Use of the couch was contraindicated for reasons that will shortly become clear. The patient and I couldn't have been less alike with regard to race, social background, religion and sexual orientation. These differences formed an important basis for our relationship—causing the patient to alternate between envying me for who he thought I was and what he thought I had, devaluing me for being the dorky, slimy Jew-boy who he intermittently saw me as being, and lamenting the gap between us which he felt could not be bridged.

Mr. A's behavior toward me was unlike anything I had ever experienced. He would impulsively act out his feelings in whichever way he saw fit. For instance, he would physically trespass into my physical space and thought nothing of touching me whenever, *and wherever*, he wanted. I had no privileges in this regard. My attempts to help him understand this behavior were treated by him as an annoyance—as just something I *had* to do because I was, after all, an analyst. And he forgave me these distractions on that account. Slowly it dawned on me how radically different our views were about what therapy entailed. The patient did not seem to be coming for the type of help I imagined providing—psychological change through a heightened awareness of unconscious processes and content stimulated by the interpretations I would offer.

Sometimes when I offered an interpretation, Mr. A responded in a dismissive manner that gave me no sense that he had even considered what I had said. At other times he became enraged by my inconsideration for bothering him with my ideas when he had more important, pressing matters to discuss. When I invited him to share his thoughts, feelings or reactions about a particular matter, he would ignore my query, acting as though I'd said nothing. He was unabashed in his insistence

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that I think for him—that I tell him what he was thinking and why—rather than having to think about his own thoughts and share them with me, and he reacted with suspicious hostility when I encouraged him to tell me what was going on in his head because having to tell me what he was thinking meant I didn't already know, and thinking that was intolerable.

It seemed that Mr. A could not allow either of us to momentarily separate from the other in order to 'huddle' alone with our thoughts in a moment of self-reflection. To think to myself in his presence was seen by the patient as a betrayal of my promised presence, and it left him feeling as though he momentarily ceased to exist in my mind. For him to think in my presence was, for him, unthinkable. The very act of thinking—on my part or his—seemed to represent a kind of intolerable separation.

When Mr. A used a particular word, he then expected me to parrot it back. If I used a slightly different word or term, he charged me with not listening. In fact, my inability to remember the patient's precise words indicated that I had *processed* what he had told me and was now, through this slight variation of words, reflecting back an internal process of my own. This introduced into the room my otherness, proof that I was experiencing the patient in my own way, translating his words into my own, which left him feeling separate and alone.

Mr. A would rail against every conceivable boundary. He had strong reactions to the beginning and end of every session, as well as to anything that demarcated my separate life, be it evidence of my separate subjectivity, my private thoughts, or my life away from him. Limits were a particular problem. The time-limited nature of our sessions was something he particularly couldn't stand, and any sign that I had been looking in the clock's direction produced rage and charges that I did not love him and couldn't wait to be rid of him. He often turned my clocks around so that I wouldn't know when the session was drawing to an end.

Sessions typically began in the waiting room. On the way in, Mr. A would rub up against me the way a cat would its owner, pressing up against me long enough to leave a scent of his cologne, ensuring that I'd become similarly scented—a sort of olfactory forget-me-not that would linger for hours. It was as if the patient had marked his territory, and it left me wondering how my wife would react to my coming home doused in an unfamiliar scent of another's body. Once in the room, Mr. A took the liberty of sitting anywhere he chose, including at my desk where he would rifle through my papers. He enjoyed my obvious annoyance, which left me feeling outraged and on edge, unable to consistently maintain an ability to think analytically.

Any evidence of my separateness produced intolerable anxiety. At the end of sessions, Mr. A would first deny that the time was up. 'How could it already be over?' he would whine in dismay with a pained expression on his face. Then he would physically cling to me as a child might to his mother's leg. I would have to peel him off me in order to get him to leave. He would then plead with me, asking, 'Why do we have to stop?'

Whenever I would announce I'd be away from my practice for a time, Mr. A would demand I tell him how I'd make it up to him, as if making it up could somehow

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undo the separation and reassure him that I still loved him. Again, there seemed to be no way to get the patient to explore what his demand meant. He would threaten to 'go to war' when he felt abandoned. He took my leavings as indisputable evidence that I didn't love him, and he was unwilling and/or unable to consider this feeling worthy of analysis. Things weren't much better when *he* initiated the separation. He would return demanding that I declare how *I* had missed *him*. When I pointed out that he seemed incapable of speaking about his own feelings of having missed me, the most he would settle for was a statement that we had 'missed each other'. The words 'we' and 'us' were demanded in place of first-person pronouns. The idea that we might not be exactly of like mind was intolerable, causing more feelings of aloneness, disintegration and rage.

But it wasn't just these actual separations that were difficult for the patient. When I ceased to be in my usual state with him (i.e. vigilant, on edge, even a bit fearful, focused on content), Mr. A would begin to feel intolerably alone. At times when I slipped into a more relaxed mode—one that might permit a moment of reverie—the patient became alarmed and would act in ways he would later admit were designed to recapture my 'full attention'. If he found me to be anything less than sharply focused on his every word, the patient would treat me as a drill sergeant would a private who had been caught at something less than 'full attention'. Evenly suspended attention (Freud, 1912) was strictly out of the question.

When I shifted my physical position or engaged in some gesture such as scratching an itch, Mr. A demanded an explanation for the behavior, resulting in a level of self-consciousness on my part that was incompatible with reflective thought. When I asked him about the effect my change in posture or actions had on him, he refused to explore how this change in my behavior made him feel or why it concerned him. Rather, he insisted that I tell him what my changed posture said about my feelings about him. It was as if he suspected these changes in my posture came *from within me* and were *solely about me*, and he tried hard to deny this awareness by making these changes always *about* him, which they only occasionally were. Considering the idea that such changes were a manifestation of something within me that had *nothing to do with him* was an absolutely intolerable idea!

Discussion: Intolerance of the analyst's otherness

The case of Mr. A dramatically illustrates how the patient and I were forbidden by the patient from engaging in any activity that heightened his awareness of our differences. Anything I did that threatened to crack the illusion of our oneness produced a violent reaction on his part. He suffered from intense levels of separation anxiety, and reflective thought was bilaterally prohibited. Under no circumstance could he sustain what Winnicott (1958) refers to as the capacity to be alone in the presence of another, and he worked hard to restrict my ability to be alone in his presence long enough to think.

When the analyst offers his *understanding* of the patient, it draws the patient's attention to a more cognitive, distant, less direct and immediate way of being known, subtly emphasizing the existence of an intervening process by which one comes to know another. Acknowledging this intervening process objectifies the

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act of perceiving, which may be experienced by the patient as a disruption of the intersubjective experience of *being with* the analyst.

Psychic reality is representational and not at all synonymous with the thing itself. A metaphoric lens exists between that which is signified and its signifier. The awareness of this metaphoric lens—this thing between us and the world—heightens our sense of separation and aloneness, in the same way that remaining cognizant of the *act* of seeing disrupts the transparency of vision to the extent that one's attention is drawn to the intervening physiological processes and apparatuses upon which sight depends, thus diluting the immediacy of the experience.

Paradoxically, words can be the thing that stands between one's primary experience of the world and secondary ways of knowing. The most direct, primary way of knowing is, by definition, nonverbal. As much as we gain from the acquisition of language, which helps capture and communicate our primary experiences, we simultaneously lose a direct connection with 'the force and wholeness of the original experience' (Stern, 1985, p. 177). So verbal understanding and communication, upon which psychoanalysis depends, has this inherent limitation.

Recognizing that one's experience of another necessarily involves an intervening interpretive process—that our minds stand between us and a direct experience of the world—brings one face to face with our essential separateness. For Mr. A to recognize that who he thought I was and why he thought I did what I did was, in part, a product of his own ways of organizing relationships is not a thought he found thinkable. He steadfastly insisted that who he knew me to be was unquestionably true and he was hostile toward the suggestion that it wasn't necessarily so. In this way, Mr. A functioned like a child who has yet to realize that such a thing as a false belief exists. Before the age of 4, children cannot accept the concept of a 'false belief' because it threatens to undermine their tenuous hold on reality (Premack and Woodruff, 1978). Struggling to understand the world, the young child cannot afford to question what he 'knows' to be true. Realizing that one's beliefs could be false is the first in a series of cognitive achievements that ultimately culminates in a sophisticated theory of mind—in the development of higher-order thinking. At the outset, Mr. A could not tolerate recognizing his essential aloneness, so it became impossible for him to imagine that his interpretations of me were just that—products of a mind that separates the world from the world perceived.

Clinical development of reflective capacity

For the longest time, it seemed as if my treatment of Mr. A offered us no way out. Interpretations proved ineffective, which I slowly realized had little to do with their content and had more to do with the fact that the patient found the process of interpreting neither acceptable nor helpful. I got to the point of feeling that tolerating the treatment was about all that I could muster and all I had to offer. While my intermittent ability to think analytically helped me withstand and emotionally survive the treatment, developing ways to tolerate a patient cannot pass as an adequate explanation of therapeutic action. Something more has to have happened in this patient's treatment to account for the substantial changes he has, in fact, undergone over time. He has moved

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from a strict reliance on action, is no longer wholehearted in his expressed rages, can better tolerate separations, and has ceased to invade every nook and cranny of my office and psyche. He can better tolerate having his curiosity frustrated, now makes requests rather than demands, and no longer possesses a sense of entitlement. In addition, he is beginning to consider what I have to say without reflexively dismissing it.

If the capacity for self-reflective functioning is a necessary prerequisite to undergo psychoanalytic treatment, this patient was ill-suited for psychoanalysis and would be viewed by most analysts as unanalyzable. But there are those who believe psychoanalysis can actually help patients develop a capacity for self-reflexivity, making self-reflexivity a goal rather than a prerequisite for psychoanalysis. Aron suggests, 'at the end of an analysis it is not insight or other knowledge of psychic content that would best demonstrate the patient's growth or the success of the treatment, but rather it is the capacity for self-reflexivity' (2000, p. 677) and he sees analysis as 'the only treatment that operates directly to improve the capacity for self-reflexivity' (p. 674).

If my work with Mr. A is to be considered psychoanalytic in nature, then it succeeds to the extent it can help him develop self-reflective functioning. What about our work together has helped Mr. A begin to establish self-reflective functioning? It was not the knowledge I attempted to impart that made a difference. I had plenty of knowledge that might have proven useful to the patient, but he was having none of it. He did not, or could not, conceive of my helping him in that way, and my insisting on that form of help only made matters worse. I suspect that interpretations only tended to make him anxious to the extent they highlighted our differences, putting him in touch with a feeling of aloneness. Mr. A envisioned a different sort of help, one that involved my ability to withstand aspects of his being that he knew would challenge my very being—ideas he knew I'd find distasteful, at best, and might prove hard—if not impossible—for me to tolerate.

The following situation is prototypic of many that occurred during the analysis and illustrates how my insistence on interpreting only tended to worsen matters.[2] For the longest time Mr. A persisted in telling me how dorky I was. I ultimately came to understand and accept that the patient truly felt this way about me and wasn't just saying it for effect. But this is not what I initially thought. Being characterized in this way was very painful, which fueled my need to focus on the sadistic motives behind his expressed view.[3] It seemed to me that Mr. A felt driven to express this opinion in

[2]This example is but one of many I could provide. For instance, the patient was also inclined to express the most noxious opinions about Jews, knowing me to be one. He talked about how concerned Jews were about money, and he insisted that the word 'slimy' was reserved just for Jews. While I suspect he actually envied aspects of my being Jewish, pointing this out prematurely would also have been experienced by him as defensive on my part.

[3]There are a number of other functions also served by the patient's holding, and expressing, this view of me. It was a provocation. It was also a way to lessen his envy of me by viewing me as less than ideal. Our racial differences were encapsulated in this offensive view that stereotypically captured an aspect of my whiteness. But it was also a disappointment to the extent it rendered me less than ideal, and it angered him that I could not live up to what he sometimes needed me to be. Finally, it was a test to see whether I could bear the thought of myself as a dork—to see whether I could accept the validity of this representation and find myself within it, no matter how painful doing so might be.

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response to times he was feeling deeply hurt by me. But suggesting that he was now feeling the need to hurt me in retaliation for my having just hurt him caused him to feel that I could not tolerate learning about the 'me'—or more precisely, one of the many 'mes'—he carried around in his head.

The patient saw my insistence on interpreting his sadistic motives as evidence of my inability and/or unwillingness to take in and consider one of the ways he truly viewed me. The patient was right, in part. For quite some time I did regard his characterization of me as groundless and unworthy of consideration—a feigned opinion adopted just to hurt me. Dismissing what he had to say about me made it hard for the patient to hear what I had to say about him. He could neither consider my interpretation of his retaliatory wish to hurt me back, nor accept an empathic expression of my realization that I had hurt him untied to an interpretation about his wish to retaliate, because he interpreted both of these offerings as self-serving—a defensive maneuver meant to save my own hide at his cost. The patient characteristically used such maneuvers so he naturally assumed the same of me. But, if I was more concerned with protecting my narcissism and was willing to dismiss his expressed views of me to that end, then I could not help him. What I considered valid and useful pieces of information—the fact I now recognized how I had hurt him, and that he needed to do something to me to rectify matters—were not experienced by the patient as empathic and, instead, felt like a further rejection of him. Not until I realized how deeply disturbed I was by Mr. A's view of me as dorky, and considered the evidence that permitted such an opinion—that there were, in fact, aspects of my behavior that justified such an opinion—could I relax my need to explain away the patient's views of me by getting him to focus on the reason he felt the need to share his views at this particular moment. Understanding the basis of his view of me as dorky, and not coming unglued having to see myself through his eyes, propelled the analysis forward, demonstrating for the patient how one might survive the consideration of another's views no matter how threatening they may seem at first.

Aron notes, that by permitting himself to become *a subject* within the analytic process, the analyst allows the patient 'to observe some of the relations among the analyst's multiple selves' (2000, p. 677). He goes on to note how a triangular space is thus created within the analytic dyad by the analyst's 'inviting the patient to observe the analyst's relation to him- or herself as both subject and object' (p. 677). In this way,

> the patient learns to establish a more complex self relation by playing out an exchange of roles with the analyst, who is not locked into any single view of this exchange because he or she has a more complex and multiple relationship with him- or herself. (Aron, 2000, p. 680)

This results in an 'internalization of a multiplicity of perspectives' (pp. 680–1), which lessens the patient's tendencies to adhere to a single aspect of the self.

Summary

Psychoanalysts are driven to make contact with a particular aspect of the patient—that part capable of joining the analyst outside the in-the-moment frame in order to think together about what has transpired between them. Analysts hunger to know the patient in this particular way, and if the patient shares this same appetite the couple

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stands a good chance of connecting in a deep and meaningful way. If, however, the patient neither understands nor tolerates the analyst's wish to engage in this sort of activity due either to the concreteness of his thinking or his paranoid inclinations, and, instead, wishes to be known in a more experience-near fashion, frustration is likely to arise and problems are likely to develop.

Not all patients share an ability to reflect upon the material created in the session, and those who lack a capacity for higher-order thinking present a particular challenge to psychoanalysts since they often cannot tolerate instances when the analyst disengages momentarily in order to think about what has transpired in the room. For patients who have yet to establish a sense of themselves as separate entities, the separation anxiety that develops when the analyst 'goes away' in this fashion proves more than the patient can bear, giving rise to the patient's intolerance of the analyst's efforts to think.

Patients who think more concretely, who cannot engage in reflective thought nor tolerate times when the analyst is so engaged, challenge the analyst's capacity to continue to reflect upon the material from a vantage point that transcends the analytic couple's moment-to-moment existence. In the end, the analyst needs to meet the patient where he finds him, adapting his approach accordingly. But this comes with its regrets—even anger, disappointment and a refusal to accept the situation as it is.

Part of psychoanalysis involves a consideration of both how the patient internally represents the analyst and why he chooses to share this representation at a particular point in time. Offering interpretations that are technically correct in so far as they accurately capture and communicate the whys and wherefores of a patient's shared representations may, in another sense of the term, be technically incorrect in so far as these explanations prove to be, for this phase of treatment, beside the point, or—worse—counterproductive. Patients who have yet to develop a sophisticated theory of mind and, as a result, lack a capacity for reflective thought may not be able to work with certain sorts of interpretations. Suggesting, for example, that the patient is expressing sadistic impulses by sharing an unflattering representation of the analyst may be dismissed by the patient as the analyst's desperate attempt to explain away unacceptable ideas—a projection of the patient's own tendencies to do likewise.

If the most developmentally pertinent, and most clinically relevant, motive behind a patient's need to express a particular representation of the analyst is to test the analyst's capacity to entertain, tolerate, and live with a representation counter to the ones included in the analyst's self-representations, therapeutic success may hinge on the analyst's ability to demonstrate the workings of his own theory of mind that affords him an appreciation of the relativity of perspectives and, as a result, a capacity to accept the patient's representation non-defensively. If a particular representation is repugnant, and disruptive to the analyst's sense of him- or herself, he or she may rush to interpret the patient's motives for sharing this representation as a way of asserting it isn't so. If, instead, the analyst resists the urge to explain away this representation and 'wears' the attribution long enough to demonstrate to the patient his or her capacity to survive being viewed in this way, real headway can be made toward helping the

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patient develop a capacity to tolerate multiple perspectives within himself, which, in turn, may stimulate a capacity for reflective thought. Whether one views such work as preparatory for subsequent psychoanalytic treatment, or, alternatively, as the earliest stages of a genuine psychoanalytic process, it seems a necessary approach in the treatment of patients lacking a capacity for reflective thought.

Translations of summary

Denken mit und über Patienten, die das Denken allzu sehr fürchten: Können nicht-deutende Manöver das reflexive Denken anregen? Patienten, die zum Denken auf höherer Ebene (zum symbolischen Denken) nicht in der Lage sind, empfinden Hinweise auf die getrennte Existenz des Analytikers häufig als unerträglich, vor allem dann, wenn diese „Andersheit" in dem Prozess evident wird, in dem der Analytiker reflektiert und deutet, wie er selbst vom Patienten erlebt oder repräsentiert wird. Die Intoleranz des Patienten für die Bemühungen des Analytikers, zu denken (über etwas nachzudenken und es zu deuten), bewirkt, dass die üblichen psychoanalytischen Manöver, die das reflexive Denken stimulieren sollen, bei solchen Patienten folgenlos bleiben. Solche Patienten müssen lernen, mehrere verschiedene Perspektiven zu tolerieren, bevor sie es dem Analytiker — oder sich selbst — gestatten können, in Gegenwart des Anderen nachzudenken. Zwei klinische Vignetten illustrieren, wie die Bemühungen des Analytikers, über den Patienten nachzudenken, von diesem als unerträglich distanzierend erlebt und als eine Zurückweisung eines Aspekts der subjektiven Realität des Patienten empfunden werden. Mit solchen Patienten psychoanalytisch zu arbeiten setzt voraus, dass der Analytiker die Formulierung von Deutungen vermeidet, die unbewusste Bedeutungen und Motive erhellen, und statt dessen alternative technische Manöver benutzt, die die Entwicklung des symbolischen Denkens und reflexiven Denkens (Einsichtigkeit) zu fördern vermögen. Zu diesen Manövern zählt eine Demonstration seiner eigenen Bereitschaft und Fähigkeit, der Art und Weise, wie der Patient ihn psychisch repräsentiert, standzuhalten (statt sie „wegzuinterpretieren"), ohne durch diese Charakterisierungen, gleichgültig wie sie ausfallen, zerstört zu werden oder in solchen Repräsentationen verloren zu gehen. Der Analytiker demonstriert nicht nur eine Toleranz für alternative Sichtweisen auf das eigene Selbst, sondern setzt darüber hinaus weitere nicht-deutende Manöver ein, die die Entwicklung des selbstreflexiven Denkens fördern. Dazu zählen: die Stimulierung der Neugierde des Patienten auf die Funktionsweisen seiner eigenen Psyche durch Aufdeckung von nur unvollkommen verstandenen Verhaltensweisen oder Reaktionen, die psychologisch gründlicher verstanden zu werden verdienen, und die Anregung von Zweifeln hinsichtlich der Angemessenheit der Erklärungen, die der Patient selbst für solche Phänomene findet.

Pensando con, y sobre, pacientes demasiado asustados para pensar: ¿pueden las maniobras no-interpretativas estimular el pensamiento reflexivo? Los pacientes incapaces de pensamiento (simbólico) más elevado suelen no tolerar la evidencia de la existencia separada del analista, sobre todo cuando la "alteridad" se hace manifiesta en el proceso en el cual el analista reflexiona sobre cómo el paciente experimenta o se representa al analista y lo interpreta. La intolerancia del paciente ante los esfuerzos del analista para pensar (reflexionar sobre e interpretar) hace que las usuales maniobras psicoanalíticas empleadas para estimular el pensamiento reflexivo sean ineficaces. Estos pacientes tienen que aprender a tolerar múltiples perspectivas antes de permitir al analista, o a ellos mismos, pensar en presencia del otro. Se presentan dos viñetas clínicas que ilustran cómo los esfuerzos del analista para pensar sobre el paciente fueron vividos por el paciente tanto como una toma de distancia intolerable, que como el rechazo de un aspecto de su realidad subjetiva. Trabajar psicoanalíticamente con tales pacientes requiere que el analista renuncie al uso de interpretaciones estrictas que muestren los significados y motivaciones inconscientes y favorezca, en cambio, maniobras técnicas alternativas capaces de facilitar el desarrollo del pensamiento simbólico y reflexivo (insightfulness). Estas maniobras incluyen una demostración de la voluntad y la habilidad del analista para soportar (más bien que interpretar) la manera en la que está siendo representado psíquicamente por el paciente, sin destruirse por, o perderse dentro de la caracterización que el paciente hace de él. Además de desarrollar una capacidad para tolerar perspectivas alternativas de su propio self, otras maniobras no interpretativas que ayudan a facilitar el desarrollo del pensamiento autoreflexivo incluyen: estimular la curiosidad del paciente por el funcionamiento de su propia mente mediante la identificación de comportamientos o reacciones no entendidas plenamente, que merecen una mayor comprensión psicológica, e insinuar dudas sobre la adecuación de las explicaciones del paciente a tal fenómeno.

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Penser avec, et sur, des patients trop effrayés pour penser : des maniements non interprétatifs peuvent-ils stimuler la pensée réflexive ? Des patients inaptes à une pensée d'ordre plus élevée (symbolique) peuvent souvent ne pas tolérer l'évidence de l'existence séparée de l'analyste, en particulier lorsque cette « altérité » devient évidente dans les processus au cours desquels l'analyste réfléchit et interprète la façon dont le patient vit ou se représente l'analyste. L'intolérance du patient aux efforts de l'analyste pour penser (réfléchir sur, et interpréter) rend inefficaces les maniements psychanalytiques usuels utilisés pour stimuler la pensée réflexive de ce type de patients. Ces patients doivent apprendre à tolérer plusieurs autres aspects avant de pouvoir permettre à l'analyste, ou à eux-mêmes, de penser en présence de l'autre. Deux vignettes cliniques sont présentées, qui illustrent comment les efforts de l'analyste pour penser à propos du patient sont vécus à la fois comme mettant le patient à distance de façon intolérable et comme rejetant un aspect de sa réalité subjective. Le travail psychanalytique avec ce type de patients nécessite que l'analyste renonce à l'utilisation d'interprétations étroites, qui mettent en lumière le sens inconscient ; il conduit à des maniements techniques alternatifs, capables de faciliter le développement de la pensée symbolique et de la pensée réflexive (pleine en insight). Ces maniements comprennent une démonstration de la bonne volonté de l'analyste et de sa capacité à supporter (plutôt qu'à interpréter) la façon dont il est représenté psychiquement par le patient, sans être détruit par, ou perdu dans, la façon dont le patient le caractérise. En dehors de la formation d'une capacité à tolérer des perspectives alternatives de son propre self, d'autres maniements non-interprétatifs qui peuvent contribuer à faciliter le développement d'une pensée auto-réflexive comportent : la stimulation de la curiosité du patient sur les productions de son propre esprit, en repérant des comportements et réactions insuffisamment compréhensibles, qui mériteraient une plus grande compréhension psychologique ; et l'instillation du doute sur l'adéquation des explications que se donne le patient sur de tels phénomènes.

Il pensiero con e su pazienti troppo terrorizzati per pensare: é possibile stimolare un'attivitá riflessiva con manovre non-interpretative? I pazienti con difficoltá di simbolizzazione, sono spesso incapaci di tollerare l'evidenza di un'esistenza separata dell'analista: in particolare quando l'alterità dell'analista si manifesta nella riflessione e interpretazione di quest'ultimo sui modi in cui il paziente si vive o rappresenta il rapporto con l'analista.Tale intolleranza del pensiero (riflessione e interpretazione) da parte dell'analista, rende inefficace la comune tecnica psicoanalitica tesa a stimolare il pensiero riflessivo. I pazienti che non tollerano il pensiero dell'analista devono imparare a tollerare prospettive multiple prima di poter consentire all'analista o a sé stessi di pensare in presenza dell'altro. Vengono presentati due esempi clinici per illustrare come gli sforzi dell'analista di riflettere sul paziente vengano interpretati da quest'ultimo come una presa di distanza insopportabile nonché come il rifiuto di un aspetto della sua realtá soggettiva. Il lavoro psicoanalitico con questo tipo di pazienti richiede la disponibilità da parte dell'analista a rinunciare a interpretazioni che descrivano strettamente motivazioni e significati inconsci, in favore di manovre tecniche alterne che siano in grado di facilitare lo sviluppo del pensiero simbolico e dell'attivitá riflessiva (insight). Queste manvore implicano una dimostrazione della disponibilitá e della capacitá da parte dell'analista di sopportare (piuttosto che interpretare) il modo in cui egli viene rappresentato psichicamente dal paziente, senza venire eccessivamente coinvolto o devastato da tale rappresentazione. Oltre che a sviluppare una capacitá di tolleranza di prospettive esterne alla propria persona, esistono altre manovre non interpretative che possono facilitare lo sviluppo di un'attivitá autoriflessiva nel paziente. Fra queste si annoverano lo stimolo della curiositá del paziente circa il proprio funzionamento psichico mediante l'identificazione di reazioni o comportamenti non pienamente compresi e degni di una maggiore considerazione psicologica e l'insinuazione di un elemento dubitativo circa l'adeguatezza del paziente nello spiegarsi tali fenomeni.

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